## Virginia Medicaid Regulatory Updates to Provider Agreements

The Virginia Department of Medical Assistance Services ("DMAS") has announced a policy change, the consolidation of the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs into a single program, "Cardinal Care."

Pursuant to the Provider Agreement, if any state or federal laws, regulations or policies change or affect any provisions of the Provider Agreement, the Provider Agreement shall be deemed to be automatically amended to conform with such changes in the laws, regulations or policies effective as of the date on which such laws, regulations or policies become effective.

In order to assist with the transition to Cardinal Care and to clarify the automatic amendment to the Provider Agreement triggered by the announced change in state policy, the following changes shall be effective **January 1, 2023:**

1. The following terms in the Provider Agreement and related documents shall be deemed automatically updated as follows:

    - "Medicaid Contract" shall mean "a contract entered into between any SHP Affiliate and any state Medicaid agency, such as Virginia Department of Medical Assistance Services ("DMAS") for the provision of Covered Services to Members receiving coverage through any Medicaid program."

    - "Family Access to Medical Insurance Security Program", "FAMIS", "Commonwealth Coordinated Care Plus Program", "CCC Plus", or "Medallion", whether individually or collectively, shall be deemed to refer instead to the defined term "Medicaid Contract".

    - "Optima Family Care", "Optima Health Community Care", "Optima Community Complete" or any other specific Medicaid product offered by Plan, individually or collectively, shall be deemed instead to refer to generally the Medicaid products offered by SHP.

2. All Performance Management Bonus (PMB), Patient Management and Alignment Fees, or other incentive-based payments associated with prior Medicaid programs such as Medallion 4.0 are not part of the Cardinal Care Program and shall cease being paid on December 31, 2022.

3. The Medicaid Addendum attached to and made a part of the Provider Agreement shall be automatically replaced with the updated Medicaid Addendum below.

**UPDATED MEDICAID REGULATORY ADDENDUM**
***Effective January 1, 2023***

SHP and Provider, agree to abide by all applicable provisions of any Medicaid Contract. For purposes of this Medicaid Addendum: (a) the term "Medicaid Contract" shall include any Medicaid contract between Optima Health Plan and the Virginia Department of Medical Assistance Services; and (b) the term "Medicaid Member" shall include any Member who is entitled to receive coverage for certain health care services under the terms of any such Medicaid Contract. Sentara Health Plans, Inc. and Optima Health Plan shall be referred to collectively herein as "SHP." Provider compliance with a Medicaid Contract specifically includes, but is not limited to, the following requirements (to the extent applicable to Provider):

1. No terms of this Agreement are valid which terminate legal liability of SHP in any Medicaid Contract.

2. Provider shall meet SHP's standards for licensure, certification, and credentialing as described in the underlying Agreement and/or Provider Manual.

3. Provider agrees to participate in and contribute required data to SHP's quality improvement and other assurance programs as required in the Medicaid Contract.

4. Provider agrees to abide by the terms of the Medicaid Contract for the timely provision of emergency and urgent care. Where applicable, Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding ("Hospital/ Emergency MOUs") signed by SHP in accordance with the Medicaid Contract.

5. Any conflict in the interpretation of SHP's policies and the Agreement shall be resolved in accordance with federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and DMAS 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.

6. Provider agrees to submit SHP utilization data in the format specified by SHP, so SHP can meet the DMAS specifications required by the Medicaid Contract.

7. Provider agrees to comply with corrective action plans initiated by SHP.

8. Provider agrees to comply with all non-discrimination requirements in the Medicaid Contract, including, but not limited to, the requirement to provide services to Medicaid Members in the same manner as all non-Medicaid members.

9. Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in the Medicaid Contract.

10. Where applicable, Provider agrees to make every reasonable effort to screen pregnant women (or refer pregnant to an appropriate Participating Provider to screen) for maternal mental health concerns in accordance with the American College of Obstetricians and Gynecologists (ACOG) or American Academy of Pediatrics (AAP) standards. Provider shall follow SHP's referral process to refer to appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment for pregnant Medicaid Members who screen positive for mental health concerns.

11. Provider agrees to provide representatives of SHP, as well as duly authorized agents or representatives of DMAS, the U.S. Department of Health and Human Services, and the Virginia State Medicaid Fraud Unit access to its premises and its contracts and/or medical records in accordance with the Medicaid Contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with the Medicaid Contract.

12. Provider acknowledges that DMAS reserves the right to audit, formally and/or informally, for compliance with any term(s) of the Medicaid Contract and regulations of the Federal Government and the Commonwealth of Virginia, and for compliance in the implementation of any term(s) of this Agreement. Provider further acknowledges that if DMAS, CMS, or the DHHS Inspector General determine that there is reasonable possibility of fraud or similar risk, each may inspect, evaluate, and audit Provider at any time. Such right to audit will exist through ten (10) years after the final date of the contract period or from the date of completion of any audit, whichever is later.

13. Provider agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 C.F.R. § 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. Provider shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations.

14. Provider agrees to the requirements for maintenance and transfer of medical records stipulated in the Medicaid Contract. Provider shall make medical records available, or provide a copy of a Medicaid Member's medical records, to Medicaid Members and their authorized representatives within ten (10) business days of the record request. Provider shall ensure that each Medicaid Member's

medical record(s) include(s), as appropriate, the required elements pursuant to 42 C.F.R. §§ 456.111 and 456.211, including but not limited to: beneficiary ID, physician name, admission dates, and dates of application for and authorization of Medicaid benefits if application is made after admission, plan of care as required under 42 C.F.R. §§ 456.80 and 456.180, initial and subsequent continued stay review dates as required by 42 C.F.R. §§ 456.128, 456.133, 456.233, and 456.234 date of operating room (if applicable), justification of emergency admission (if applicable), reasons and plan for continued stay (if Provider believes continued stay is necessary), and other supporting material as necessary and appropriate.

15. Provider agrees to ensure confidentiality of family planning services in accordance with the Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

16. Provider agrees not to create barriers to access to care by imposing requirements on Medicaid Members that are inconsistent with the provision of Medically Necessary and Medicaid Covered Services.

17. Provider agrees to clearly specify referral approval requirements to its Practice Providers and in any sub-contracts. Additionally, Provider agrees to hold Medicaid Members harmless for charges for any Medicaid Covered Service. This includes those circumstances where Provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.

18. Provider agrees not to bill Medicaid Members for Medically Necessary services covered under the Medicaid Contract and provided during a Medicaid Member's period of SHP enrollment. This provision shall continue to be in effect even if SHP becomes insolvent. However, if a Medicaid Member agrees in advance of receiving the service and in writing to pay for a non-Medicaid Covered Service, then Provider can bill such non-Medicaid Covered Service.

19. Provider shall forward to SHP medical records, within ten (10) business days of SHP's request.

20. Provider shall promptly provide or arrange for the provision of all services required under the Agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if Provider becomes insolvent until such time as the Medicaid Members are withdrawn from assignment to the Provider.

21. Except in the case of death or illness, Provider agrees to notify SHP at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel Medicaid Members for up to thirty (30) day after such notification, until another Participating Provider is chosen or assigned.

22. If Provider is a primary care physician, Provider agrees to act as a PCP for a predetermined number of Medicaid Members, not to exceed the panel size limits set forth in the Medicaid Contract.

23. SHP shall follow prior authorization procedures pursuant to Virginia Code § 38.2-3407.15:2 and incorporate the requirements into its provider contracts. SHP must accept telephonic, facsimile, or electronic submissions of prior 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 prior authorization requests.

24. Notwithstanding any other provision to the contrary, the obligations of the Commonwealth of Virginia shall be limited to annual appropriations by its governing body for the purposes of the Agreement.

25. This Agreement is an agreement for the services of Provider and may not be subcontracted by Provider without prior written approval of SHP.

26. To the extent that any terms or provisions contained in this Exhibit C are inconsistent with or in conflict with the terms and provisions set forth in the Agreement, the terms and provisions set forth in this Exhibit shall control with respect to the subject matter contained herein. All other terms and provisions of the Agreement shall continue to apply.

27. Provider shall have a NPI.

28. 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 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.

29. Unless a longer time period is required by applicable statutes, regulations or the Agreement, Provider shall maintain records, including all medical, financial and administrative records related to Medicaid Covered Services, for the longer of: (a) ten (10) years from the termination of the Agreement; or (b) with regard to minors, at least six (6) years after a minor has reached 21 years of age.

30. Provider shall screen employees and contractors initially and on an ongoing monthly basis to determine whether any such employees or contractors has been excluded from participation in Medicare, Medicaid, SCHIP, any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act), or from certain procurement and non-procurement activities, and not employ or contract

with an individual or entity that has been excluded or debarred. Provider further understands that SHP is prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste, and abuse. Provider shall immediately report to SHP any exclusion information discovered, including its own termination from the Medicaid program for fraud, waste, and abuse. Provider acknowledges that civil monetary penalties may be imposed against any Participating Provider that employs or enters into contracts with excluded individuals or entities to provide items or services to Medicaid Members.

31. As a condition of payment, Provider shall identify to SHP any provider-preventable conditions or health care-acquired conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid Members for which Medicaid payment would otherwise be available. Provider further acknowledges that no payment will be made by SHP to Provider for provider-preventable conditions, as identified in the State plan and that under 42 CFR § 434.6(a)12(i), SHP is prohibited from making a payment to Provider for provider-preventable conditions outlined in 42 CFR § 447.26(b). SHP will comply with 42 C.F.R. § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition to payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. § 434.6(a)(12) and § 447.26. No reduction in payment for a provider-preventable condition shall be imposed on the Provider when the condition defined as a provider-preventable condition or that meets the definition of a health care-acquired condition for a particular Medicaid Member that existed prior to the initiation of treatment for that Medicaid Member by the Provider.

32. To the extent applicable, Provider shall comply with the CMS Home and Community-Based Services Settings Rule detailed at 42 C.F.R. § 441.301.

33. Provider shall comply with all applicable Affordable Care Act SHP policies and procedures, including but not limited to, reporting overpayments pursuant to state or federal law.

34. Provider shall accept SHP 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 a Medicaid Member's period of SHP enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid Member 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. Should an audit by SHP or an authorized state or federal official result in disallowance of amounts previously paid to Provider, Provider will reimburse SHP upon demand and shall not bill the Medicaid Member.

35. SHP shall pay nursing facilities, community Long Term Services and Supports (LTSS) providers, LTSS services when covered under the Early and Periodic Screening, Diagnosis, and Treatment Services (ESPDT) program, Community Mental Health Rehabilitation Services (CMHRS) and Behavioral Therapy, and Addiction and Recovery Treatment Services (ARTS) Participating Providers within fourteen (14) calendar days of receipt of a Clean Claim. Such claims shall be paid at no less than the current Medicaid FFS rate in effect on the date of service. For such services, Provider shall use the DMAS established billing codes. SHP shall pay all other Participating Providers within thirty (30) days of the receipt of a Clean Claim for Medicaid Covered Services rendered to a Medicaid Member.

36. Provider has the right to appeal adverse actions taken by SHP for services that have been rendered. However, Provider shall exhaust SHP's reconsideration process prior to filing an appeal with the DMAS Appeals Division.

37. SHP shall have the right to modify this Exhibit C from time to time, without the consent of Provider, to reflect changes to Medicaid Contracts, applicable law, and/or any requests or requirements of DMAS or any other Medicaid agency.