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Amendment to the *Virginia Health Maintenance Organization Medicaid Participation Attachment* to the *Blue Cross and Blue Shield Provider Agreement*

Beginning April 1, 2017, changes to your *Virginia Health Maintenance Organization (HMO) Medicaid Participation Attachment* to the *Blue Cross and Blue Shield Provider Agreement* take effect. These changes are required by the Virginia Department of Medical Assistance Services (DMAS) in support of the new Commonwealth Coordinated Care Plus (CCC Plus) program being implemented later this year for Managed Long-Term Services and Supports.

Article I: definitions

“CCC Plus” means the Commonwealth Coordinated Care Plus statewide Medicaid managed long term services and supports program. References to Medicaid and Medicaid Members herein also refer to CCC Plus and Medicaid Members receiving covered benefits from CCC Plus.

"Confinement" means any number of consecutive days that a Medicaid Member is confined to the Facility including leave days, if any.

"Medicaid Member" means a Member enrolled under any contract HMO may have with DMAS during the term of the Agreement. Medicaid Members include Members enrolled through Virginia's Medallion 3.0 program, Family Access to Medical Insurance Security ("FAMIS") plan, or FAMIS MOMS program or their successor programs as well as Members enrolled under any new programs for which HMO may contract with DMAS such as the Virginia Acute and Managed Long-Term Services and Supports Program, including CCC Plus.

“Medicaid Provider Manual" means the document or set of documents that sets forth certain operational and administrative rules, policies, programs and procedures established and implemented by HealthKeepers. HealthKeepers will make the Provider Manual(s) available through a commonly available web site **https://mediproviders.anthem.com/va/pages/manuals-directories-training.aspx** or upon request

Article II: services/obligations

2.12 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).

2.13 Consistent with Federal managed care regulations at 42 C.F.R. 438.3(u), the Facility shall maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years. In following with 12VAC30-120-1730, for Members who are children under age 21 and enrolled in the Tech program, the Facility 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.

2.14 Provider shall screen their employees and 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 or debarred. The provider shall be required to immediately report to HMO any exclusion information discovered. The provider shall be informed by the HMO 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.

2.15 Provider shall comply with Federal contracting requirements described in 42 CFR Part 438, 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.

2.16 Provider shall comply with the CMS HCBS Settings Rule detailed in 42 C.F.R § 441.301(c)(4)-(5).

2.17 Provider shall comply with corrective action plans initiated by HMO Contractor.

2.18 Provider shall comply with the Affordable Care Act Contractor policies and procedures, including but not limited to, reporting overpayments pursuant to state or federal law.

2.19 Provider shall have a National Provider Identifier ("NPI") number

2.20 Provider shall accept HMO payment as payment in full except for patient pay amounts and shall not bill or balance bill a Medicaid member for Medicaid covered medically necessary services provided during the member's period of HMO 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. Should an audit by the HMO or an authorized state or federal official result in disallowance of amounts previously paid to the provider, the provider will reimburse the HMO upon demand.

Article III: compensation and audit

3.1.1 Provider agrees to provide to HMO, unless otherwise instructed, at no cost to HMO or the Medicaid Member, all information necessary for HMO to determine its payment

liability. Such information includes, without limitation, accurate and Clean Claims for Medicaid Covered Services. Once HMO determines it has any payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's Health Benefit Plan, the PCS, Regulatory Requirements, and the provider manual(s). Notwithstanding the foregoing, HMO shall make best efforts to pay Provider within thirty (30) days of the receipt of a Clean Claim for Medicaid Covered Services rendered to a Medicaid Member. Claims for LTSS Services (including when LTSS services are covered under ESPDT), community behavior health and early intervention services will be processed within fourteen (14) days of receipt of the clean claim for Members enrolled in CCC Plus. If HMO does not reimburse Provider within this thirty (30) day period, HMO will pay interest to Provider pursuant to Code of Virginia § 38.2-4306.1.

Article VII: general provisions

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, or the Provider Manual, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect. Notwithstanding the foregoing, any conflict in the interpretation of HMO's policies and this Agreement 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.

These changes are made in accordance with *Paragraph 7.1 — Regulatory Amendment* of your *Virginia HMO Medicaid Participation Attachment* to the *Blue Cross and Blue Shield Provider Agreemen*t that states: "Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments."

Note, no action is required by you. If you are currently participating in the Anthem HealthKeepers Plus network, your Medicaid attachment is automatically being updated to include provisions for new CCC Plus members. If you are not participating in the Anthem HealthKeepers Plus network and would like to participate, please contact your network manager.