



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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DIRECTOR

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MEMORANDUM OF UNDERSTANDING

GENERAL CONDITIONS

THIS AGREEMENT is made as of the date below, by the Department of Medical Assistance Services (herein referred to as DMAS), with an office at East Broad Street, Suite 1300, Richmond, Virginia 23219 and the Virginia Department of Health (herein referred to as VDH), a Virginia State Agency with an office at P.O. Box 2448, Richmond, Virginia 23218-2448, 109 Governor Street, Richmond, Virginia 23219. These entities are jointly herein referred to as "Parties".

The Parties, as defined in 45 CFR 160.103, have entered into this 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 VDH's 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.

Each party 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:

- I. **Definitions.** As used in this agreement, the terms below will have the following meanings:
 - a) **Provider:** Any entity eligible to be enrolled and receive reimbursement through DMAS for any Medicaid-covered services.
 - b) **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.
 - c) **Protected Health Information (PHI)** has the meaning of individually identifiable health information as those terms are defined in 45 CFR 160.103.
 - d) **Breach** has the meaning as that term is defined at 45 CFR 164.402.
 - e) **Required by law** shall have the meaning as that term is defined at 45 CFR 160.103.
 - f) **Unsecured Protected Health Information** has the meaning as that term is defined at 45 CFR 164.40.
 - g) **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 VDH shall be sent via email or general mail to the DMAS Privacy Officer (with a copy to the DMAS contract administration) at:

DMAS Privacy Officer, Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
hipaaprivacy@dmass.virginia.gov

2. Other written notices to DMAS should be sent via email or general mail to DMAS contract administrator at:

Contact: Brian McCormick, DMAS Policy Division
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

III. Special Provisions to General Conditions

1. Uses and Disclosure of PHI by both Parties. Both Parties shall
 - a. Disseminate and use data in keeping with the provisions set out in the eHHR Memorandum of Understanding (E-MOU).
2. Accounting of Disclosures – Both Parties 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 name (member) address, if known.
 - iv. A description of the PHI disclosed, and the reason for the disclosure.
 - b. Provide this information to the DMAS to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.
3. Sanctions – Both Parties 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. Take steps to mitigate any harmful effect of any such violation of this Agreement.
4. Termination
 - a. Either party may immediately terminate this Agreement if it determines that the other party has violated a material term of the Agreement.
 - b. This Agreement shall remain in effect unless terminated for cause by either party 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 others under this Agreement before the effective date of termination.
5. 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, either party, by written notice of the other party, amend this Agreement in such manner as is necessary to comply with such law or regulation.

- b. If the other party disagrees with any such amendment, it shall so notify the other party in writing within thirty (30) days of the notice of change. 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.
6. This Agreement shall have a document ("Scope of Work"), 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 VDH, who shall be authorized to access DMAS's PHI.
 - c. A list of the specific data elements required by VDH in order to carry out the purposes of this Agreement.
 - d. The purposes for which such data is required.

VDH agrees to update the above noted information as needed in order to keep the information current. DMAS may request to review the above-referenced information at any time, included for audit purposes, during the term of this agreement.

7. This Agreement incorporates modification numbers 14 through 18, which are made a part hereof.

EACH PARTY has caused this Agreement to be properly executed on its behalf as of the date first above written.

For: Department of Medical Assistance Services

BY: Cindi B. Jones

Cindi B. Jones
Director, Department of Medical Assistance Services

DATE: 3/29/16

For: Virginia Department of Health

BY: Marissa J. Levine

Marissa J. Levine, M.D., M.P.H., F.A.A.F.P.
Commissioner, Virginia Department of Health

DATE: 4/25/16

Robert
3/29/16

SCOPE OF WORK

The Scope of Work provisions are identified and organized into the following sections:

Section I: Methods of Payment (Contract Administrator and Contract Monitors – DMAS: Reporting Manager, Fiscal and Purchases Division)

Section II: Long-Term Care Agreements (Contract Monitor – DMAS: Supervisor, Long Term Care Division)

- A. Nursing Facility Licensure and Certification
- B. Pre-Admission Screenings
- C. Developmental Disabilities (DD) Waiver Screening Assessments

Section III: Maternal and Child Health Collaborations (Contract Monitor – DMAS: Policy and Services Manager, Maternal and Child Health Division)

- A. Baby Care
- B. Children with Special Health Care Needs
- C. Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)
- D. Women Infants and Children (WIC)
- E. E. Plan First
- F. Maternal and Child Health Collaboration (Perinatal Health)

Section IV: MDS Automation Project (Contract Monitor – DMAS Office of Data Analytics)

Section V: Eligibility Information (Contract Monitor – DMAS Office of Data Analytics)

Section VI: Decedent Information (Contract Monitor – Program Operations Division Manager)

Section VII: Virginia Vaccines for Children (Contract Monitors – Maternal and Child Health Division Manager and Office of Epidemiology)

Section VIII: HIV AIDS Data Transfer (Contract Monitors – DMAS Office of Data Analytics and VDH Office of Epidemiology)

Section IX: STD and Hepatitis Data Transfer (Contract Monitors – DMAS Office of Data Analytics and VDH Office of Epidemiology)

Section X: Dental Data Exchange Project (Contract Monitors – DMAS Health Care Services, Program Administration and VDH Office of Family Health Services)

Section XI: Payment for Virginia Birth Records (Contract Monitors – DMAS Fiscal Division and Director VDH Division of Vital Records)

Section XII: Pandemic Relief/Anti-Viral Medication Tracking System (Contract Monitors – DMAS Information Technology Division and VDH Office of Emergency Preparedness)

Section XIII: Oral Health Outreach to Gloucester WIC Members

Section XIV: Fatality Review and Surveillance (Contract Monitors – DMAS Maternal and Child Health Division Manager and VDH Office of the Chief Medical Examiner)

Section XV: Virginia Medicaid Expedited Eligibility and Enrollment Reimbursement (Contract Monitors - VDH Office of Family Health Services)

Section XVI: Cost Sharing Agreement for ACA Special Projects

Definitions

As used in this attachment, the terms below will have the following meanings:

- a. ALF – Assisted Living Facility
- b. APA – Audit of Public Accounts
- c. BabyCare – Virginia Health program for education/counseling services for high risk pregnant women
- d. CCC - Care Connection for Children
- e. CDC - Centers for Disease Control and Prevention
- f. CFR – Code of Federal Regulations
- g. CMS – Centers for Medicare and Medicaid Services (formerly HCFA)
- h. COBRA - Consolidated Omnibus Budget Reconciliation Act
- i. CSECN - Children with Special Health Care Needs
- j. DD – Developmental Disabilities
- k. DD Waiver - Individual and Family Developmental Disabilities Support Waiver,
- l. DHHS – Department of Health and Human Services (Federal)
- m. DMAS – Department of Medical Assistance Services
- n. DOE – Department of Education
- o. DSS – Department of Social Services
- p. EBL - Elevated Blood Lead
- q. EPSDT – Early and Periodic Screenings, Diagnosis and Treatment Services
- r. FAMIS – Family Access to Medical Insurance Security
- s. FFP – Federal Financial Participation
- t. FIPS – Federal Information Processing Standards (codes)
- u. FQHC - Federally Qualified Health Center
- v. HIPAA – Health Insurance Portability and Accountability Act
- w. HMO – Health Maintenance Organization
- x. IAT – Interagency Transfer
- y. ICF/MR – Intermediate Care Facility for the Mentally Retarded
- z. IS - Information System
- aa. MDS – Minimum Data Set
- bb. MMIS – Medicaid Management Information System
- cc. Title V – Maternal and Child Health Services Block Grant of the Social Security Act
- dd. Title XIX – Medicaid provisions of the Social Security Act
- ee. Title XVIII – Medicare provisions of the Social Security Act
- ff. RAI - Resident Assessment Instrument
- gg. RAL - Regular Assisted Living
- hh. RHC - Rural Health Clinic
- ii. SCHIP – State Children’s Health Information Program
- jj. SME - Subject Matter Expert
- kk. SSA – Social Security Act
- ll. UAI – Uniform Assessment Instrument
- mm. VMAP – Virginia Medical Assistance Services Program / Medicaid
- nn. VAC – Virginia Administrative Code
- oo. VaMMIS – Virginia Medicaid Management Information Systems
- pp. Va. Code – Code of Virginia
- qq. VCHS – Virginia Center for Health Statistics
- rr. VDH – Virginia Department of Health
- ss. VHLS - Department of Health/Lead Safe Virginia
- tt. WIC – Special Supplemental Nutrition Program for Women, Infants and Children

Section I: Methods of Payment

DMAS Contact: – Reporting Manager, Fiscal and Purchases Division

VDH Contact: Deputy Commissioner for Administration

If monetary reimbursement is to be made for the performance of services described herein, DMAS will reimburse VDH by one of four methods identified below and defined in the Virginia Department of Accounts' memorandum of May 20, 1998, entitled "Procedures for Identifying and Accounting for Transactions between State Agencies and Institutions." The method of payment, if any, for each service covered by the Agreement is set forth in the relevant section.

VDH agrees to collect, record, and maintain documentation and an audit trail that supports expenses related to carrying out the provisions of this Agreement. VDH shall bill DMAS via Agency to Agency Transfer (ATA) for its monthly costs within forty-five (45) days of the close of each month. The ATA shall reflect the total expenditures incurred (i.e., both the General and Non-general funds), the project number assigned to each service, and the services performed. Sufficient documentation in the form of accounting or ledger reports shall be submitted with the ATA to support the draw of federal monies. Any indirect costs included in the billings shall be supported by a federally approved cost allocation plan and shall be separately identified on the billing. If sufficient documentation is not presented with the ATA, DMAS shall return the ATA to VDH. Once sufficient documentation has been presented, DMAS will use its best efforts to process the ATA. If the APA or other auditing agents question costs associated with billings by VDH, VDH shall be responsible for providing additional backup documentation and verification. VDH shall reimburse DMAS for any unsupported or disallowed costs. All requests for reimbursement shall be sent to:

Medicaid Grant Supervisor
Fiscal Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Method 1 – Pass Through Sub-recipient Transaction:

Under this method, DMAS, acting in its capacity as the single state agency, will transfer only federal matching funds to VDH to reimburse VDH for the costs of rendering services to the Medicaid and CHIP programs in accordance with the VDH Cost Allocation Plan. VDH, rather than DMAS, holds the state appropriations from the General Assembly for both the General and Non-General Funds. Under this method, VDH is DMAS' sub-recipient.

DMAS shall:

- Record the transactions using Fund 1000, Transaction Code 497, GLA 989, CFDA number 93.778 (93.767 for FAMIS) and a project number as defined in the applicable section of this Agreement.
- Report the pass through on the Schedule of Sub-recipient under VDH.
- Transfer funds from the Medicaid or SCHIP programs to VDH within thirty (30) days of receipt of the ATA.

VDH shall:

- Record expenditures using the appropriate sub-object codes using Fund 1000.
- Funds from DMAS should be coded with Transaction Code 116 using GLA 988 and Fund 1000.
- Report the expenditures on the Schedule of Pass through Funds Received from Other Agencies; and Report to the DMAS Grant Supervisor prior to July 15 each fiscal year the total amount of funds transferred through sub-recipient activity during the preceding fiscal year. If there are any unresolved discrepancies between DMAS and VDH calculations, the DMAS calculation shall be used for final filing of the Schedule of Federal Assistance.

In accordance with the provisions of 2 CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart D—Post Federal Award Requirements §200.330 Sub-recipient Monitoring and Management, this represents a sub-recipient relationship between VDH and DMAS.

Method 2 – Vendor Transaction:

Under this method, DMAS, acting in its capacity as the single state agency, will reimburse VDH for both the federal and state portions of qualifying expenditures related to services VDH has rendered to the Medicaid or CHIP programs. DMAS holds the appropriation from the General Assembly.

DMAS shall:

- Record the transactions using Funds 0100 and 1000, Transaction Code 380, CFDA number 93.778, the appropriate sub-object codes and a project number as defined in the applicable section of this Agreement.
- Process the ATA within thirty (30) days from the date of receipt of the ATA and supporting documentation.
- Report the vendor expenditure on the Schedule of Federal Assistance under the Medicaid Grant.

VDH shall:

- Record the amount received as revenue under Revenue Source Code 03007, Sale of Good, or Services to State Entities.

In accordance with the provisions of 2 CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart D—Post Federal Award Requirements §200.330 Sub-recipient Monitoring and Management, this represents a contractor relationship between VDH and DMAS.

Method 3 – Licensure and Certification:

As the designated State Survey Agency for Medicare/Medicaid by DHHS, VDH receives reimbursement directly from CMS for 75% of the total costs (FFP) of Medicaid survey and certification activities. The remaining 25%, (Medicaid State Match) is the responsibility of VDH.

In accordance with the provisions of 2 CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart D—Post Federal Award Requirements §200.330 Sub-recipient Monitoring and Management, this represents a contractor relationship between VDH and DMAS.

Method 4 – Federal Match Claims Processing:

Under this method, DMAS acting in its capacity as the single state agency, will reimburse VDH, the State Survey Agency, for the federal match portion of qualifying expenditures related to completion of pre-admission screening services which VDH has rendered to DMAS. DMAS holds the General Fund appropriation for the Medicaid State Match from the General Assembly.

DMAS shall:

- Execute claims processing of federal and general funds to reimburse VDH for the Medicaid pre-admission screenings submitted by each locality for processing.

VDH shall:

- Have localities submit completed pre-admission screening documentation for processing and adjudication by VaMMIS.
- Record DMAS' transfer of the Medicaid State Match amount (special fund revenue).

In accordance with the provisions of 2 CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart D—Post Federal Award Requirements §200.330 Sub-recipient Monitoring and Management, this represents a sub-recipient relationship between VDH and DMAS.

VDH and DMAS shall undertake an annual review of the intent and provisions of the responsibilities described herein. Each agency shall designate a senior staff individual to serve as its principal contact on questions that arise on these subjects and/or for initiating amendments to this agreement when they are required.

Method 5 – DMAS Claims Processing:

Under this method, payment will be made to VDH health districts with provider billing agreements with DMAS and are authorized to render services at reimbursement rates established by DMAS. Reimbursement shall be made via the routine DMAS claims submission and payment process.

In accordance with the provisions of 2 CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart D—Post Federal Award Requirements §200.330 Sub-recipient Monitoring and Management, this represents a contractor relationship between VDH and DMAS.

Cardinal is the Commonwealth's new Financial Management System that launched statewide February 2016. DMAS and VDH agree to revisit impact of the payment methods after the statewide implementation of Cardinal.

Section II: Long-Term Care Agreements

A. Nursing Facility Licensure and Certification

DMAS Contact: Contract Monitor, Long Term Care Division Supervisor

VDH Contact: Deputy Commissioner for Public Health and Preparedness

State and Federal Code Reference:

Title 32.1, Chapter 10, of the Va. Code, 1950, as amended, and through agreement with the U.S. Secretary of the DHHS, to administer the Virginia State Plan for Medical Assistance Services and the provisions of Title XIX (Medicaid) of the SSA.

The VDH is the official State Survey Agency designated by agreement with the Secretary of DHHS, under statute 1864(a) of the Title XVIII of the SSA and § 32.1-137 of the Code of Virginia, 1950, amended.

State Code and Plan Reference:

VDH is the designated licensing agency responsible for carrying out provisions of Title 32.1, Chapter 5, Article 1 (Hospital and Nursing Home Licensure and Inspection), Article 2 (Rights and Responsibilities of Patients in Nursing Homes), Article 7 (Hospice Program Licensing) of the Va. Code, 1950, as amended, Article 7.1 (Home Care Organization Licensing) of the Va. Code, 1950, as amended, and the rules and regulations of the State Board of Health adopted from these statutes.

Purpose:

The purpose of this interagency agreement is to define the contractual responsibilities of the DMAS and the VDH, with respect to the execution of the federal survey and certification requirements, as well as clarify areas of collaboration related to state licensing requirements.

Description:

DMAS has contracted with VDH to execute the requirements relating to the on-site survey and certification of providers/suppliers participating in, or requesting participation in the Medicaid program. The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

The Department of Medical Assistance Services shall:

- Promptly provide copies to the VDH (the State Survey Agency) of all changes, revisions, and interpretations in the State Plan or federal regulations that affect the certification of providers/suppliers in the Title XIX, if possible thirty (30) days prior to the effective date of implementation;
- Promptly perform the functions required by federal statutes and regulations related to medical review, utilization review, and evaluation of the care of individual recipients for reimbursement purposes;
- Promptly forward to VDH correspondence relating to approval of Medicaid agreements for each certified provider; correspondence and reports relating to the evaluation of appropriateness of care, medical review, and utilization

- review visits; and all materials for investigations of complaints on actions by Medicare/Medicaid providers/suppliers that affect the healthcare or life safety of Medicare/Medicaid patients
- Participate in meetings, training sessions and joint on-site visits that are of mutual benefit to both agencies.
- Designate the Director, Long-Term Care and Quality Assurance Division, as the DMAS' liaison with VDH for all matters relating to patient care.
- Designate the Director, Program Operations Division, as the DMAS primary contact with VDH for all matters relating to provider agreements and enrollment status of Medicaid providers/suppliers of services.

VDH shall:

- Promptly forward to DMAS required survey documents for each provider/supplier in the Title XIX (Medicaid) program, surveyed or re-surveyed.
- Promptly forward to DMAS appropriate licensure and complaint information for Medicaid certified facilities.
- Participate in meetings, training sessions, and on-site visits that the VDH determines are of mutual benefit to both agencies.
- Designate the Director, Office of Licensure and Certification as liaison with DMAS for coordination of licensure and certification issues which affect both agencies.

Areas of Collaboration:

The Department of Medical Assistance Services and the Department of Health agree to:

- Confer regarding the status of nursing facilities and ICF/MR facilities that are out of compliance with Medicare/Medicaid certification requirements as often as necessary to assure timely communication.
- Furnish copies of nursing facility letters with attached survey reports, regarding the status of nursing facilities and ICF/MR facilities that are out of compliance with Medicare/Medicaid certification requirements.
- Work collaboratively to provide information to recipients and their families if a nursing facility or ICF/MR loses its Medicare and/or Medicaid certification. VDH will be available to explain the survey results as needed to recipients and their families.
- Collaborate on any issues or problems that may arise concerning the effectiveness of this process.

Reimbursement:

As the designated State Survey Agency for Medicare/Medicaid by DHHS, VDH receives reimbursement directly from CMS for 75% of the total costs (FFP) of Medicaid survey and certification activities. The remaining 25%, (Medicaid State Match) is the responsibility of VDH.

B. Pre-Admission Screenings

DMAS Contact: Manager Data and Quality, Division of Long Term Care

VDH Contact: Director of Process & Evaluation Oversight, Community Health Services

Federal Code Reference:

42 CFR § 441.302(c)(1) requires a screening of all individuals who, at the time of the request for admission to community-based care or an ICF/IID are eligible for medical assistance.

State Code and Plan Reference:

§ 32.1-330 of the Va. Code and the Virginia State Plan of Medical Assistance Services require DMAS to evaluate all individuals who will be eligible for institutional or community-based care services to determine their need for nursing facility services as defined in the State Plan.

DMAS has approved and VDH has agreed to carry out the directive of the Virginia General Assembly, Item 301 #11c QQQQ in final of the 2015-2016 Appropriations Act.

I. Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services are consistent with the statutory functions and the missions of the participating State departments. This Section outlines VDH's requirements to accept requests, and to conduct pre-admission screenings (PAS) within 30 days of initial request (unless VDH staff are engaged in a declared public health emergency) for all children up to the age of 18 and residing in the community and provide reports as necessary.

II. Period of Performance:

The effective date of this agreement is December 1, 2015 and this agreement shall remain in effect from the time both parties have executed the MOU until June 30, 2016 (SFY 16) with two one year extensions July 1, 2016 - June 30, 2017 (SFY 17) and July 1, 2017 - June 30, 2018 (SFY 18) and may be terminated or changed by mutual consent of both parties and confirmed in writing in an MOU Modification signed by the parties herein, or their official designee. The parties shall annually review this MOU to determine whether updates or clarification are required.

III. Description:

The pre-admission screening evaluation is done in order to determine if the individual requires long-term care services and, if so, whether the provision of community-based services or institutional services represents the most appropriate response to current needs. The request for screenings for children residing in the community, and are not inpatients, shall initiate from a parent of the child, the entity having legal custody of the child, or an emancipated child.

IV. Planning and Coordination:

The scope of services covered under the Department of Medical Assistance Services may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty may affect Medicaid provider service requirements and the cost of services. Each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

V. Responsibilities:

1. DMAS shall:

1. Require pursuant to the Va. Code, 1950, as amended, §32.1-330, a pre-admission screening of all individuals who, at the time request for admission to community-based care or a certified nursing facility as defined in Va. Code §32.1-123, are eligible for medical assistance or will become eligible within 180 days following admission;
2. Require local or district pre-admission screening committees to render decisions on applications for admission to nursing facilities or alternative community placements;
3. Prepare, maintain and provide regulations, policies and guidance to VDH regarding requirements for the PAS process;
4. Prepare, distribute and maintain a Medicaid Pre-Admission Screening Manual that describes current program procedures and criteria for conducting pre-admission screenings; and
5. Develop and provide automated training to ensure that all members of pre-admission screening committees are qualified to conduct the evaluations.
6. Support and enhance the DMAS designated automated system to the extent of funding and resources are available;
7. Collaborate with VDH and other stakeholders to identify enhancements that may be applicable to the current PAS process for children;
8. Provide technical assistance as needed and requested by VDH; and,
9. Submit to the Centers for Medicare and Medicaid Services (CMS) claims for the maximum federal reimbursement allowable for PAS activities.

2. VDH shall:

1. The requests for children's PAS shall be received by the local health department where the child resides.
2. Local health department shall only accept requests for PAS for a children residing in their jurisdiction parent of the child, the entity having legal custody of the child, or an emancipated child.
3. Screenings for children must be completed within 30 calendar days from the request date for the screening.
4. Follow requirements as defined in regulations and the Medicaid Pre-Admission Screening Manual;

5. Ensure that as a condition of payment for pre-admission screenings all local health department personnel who are assigned as members of pre-admission screening teams have been properly trained in the procedure for conducting such screenings;
6. Determine the necessity and authorize Medicaid reimbursement for institutional care or when more appropriate, alternate services which are available under one of the Medicaid community-based care waivers or the Program of All-Inclusive Care for the Elderly (PACE), in accordance with regulations and procedures and criteria specified by DMAS in the Medicaid Pre-Admission Screening Manual;
7. Submit required forms as required by the Medicaid Pre-admission Screening Provider Manual and the ePAS User Guide;
8. Inform the applicant, individual or family member in writing of the decision rendered for authorization of Medicaid services and of the appeal process that is available.
9. Utilize the DMAS designated automated system ePAS documents;
10. Provide management oversight and training that will be responsive for VDH PAS activities;
11. Conduct operational pilots in multiple jurisdictions between January 1, 2016 and March 30, 2016 for ePAS process for children. Fully implement ePAS for children statewide no later than June 30, 2016 utilizing results from pilots.
12. Provide fully trained and qualified individuals that will include, at a minimum, a registered nurse and a nurse practitioner or physician, to conduct PAS throughout the life of the MOU;
13. Provide technical assistance as needed and requested by DMAS;
14. Oversee performance for completing PAS consistent with existing regulatory and policy guidance as developed and approved by DMAS.
15. Using the ePAS system, complete and track all requests for children's PAS from request to completion of the PAS process;
16. Develop, and share with DMAS as requested, internal processes and protocols for managing requests, appointments, and outcomes (approval or denial) for each PAS;
17. Provide copies of all completed PAS required forms as required by DMAS to all appropriate parties in an appropriate timeframe; and,
18. As a part of the ePAS system, provide regular operational and corrective action reports to DMAS as described in this MOU or as may be requested.

3.0 General PAS Responsibilities

1. DMAS and VDH shall agree on the process for monthly review of ePAS data to ensure substantial compliance as measured by the statewide three month weighted/rolling average.
2. Key metrics to be monitored by VDH for each local health department on a monthly basis shall include:
 - a. Average days to complete PAS;
 - b. Percent of PAS completed within 30 calendar days or less;
 - c. Number of PAS completed;
 - d. Indication of each localities performance of completing PAS for children in 30 days or less.
3. VDH shall submit a monthly report to DMAS to include a summary of the monthly activities that include PAS results and corrective actions planned.
4. VDH shall submit an annual report to DMAS. The annual report shall include:
 - a. Summary of the quarterly activities that include PAS averages and trend analysis;
 - b. Challenges of completing PAS and activities; and,
 - c. Recommendations for enhancements to ePAS and other operational processes.
5. VDH shall respond to all customer or other inquiries about children's PAS.
6. Individuals and families will be contacting VDH either by phone or e-mail to request a screening, request information or technical assistance, or express concern. VDH shall submit monthly reports to DMAS on customer services activities. The report shall include:
 - a. A breakdown of types of contacts, the nature of the contact, and source of contacts that includes a separate reporting for provider contact and for individual or family contacts;
 - b. Percentages of the top five (5) most frequent reasons for the contact.
7. Collaborate on any issues or problems that may arise concerning the effectiveness of this process;
8. Collaborate on various initiatives involving the implementation of Olmstead recommendations and any other grants and initiatives concerning institutional or home and community-based services; and,
9. Collaborate to facilitate training as needed regarding new programs/services and existing programs available through the pre-admission screening process.

VI. Reimbursement:

With the implementation of the automated, pre-admission screening packages are now treated as completed claims once all edits for eligibility and service provision have been satisfied.

Pre-admission screenings (which may result in an individual being eligible for placement in a nursing facility, or a community-based care waiver program, or placement in an assisted living facility) shall be handled as claims transactions in accordance with procedures set forth in the basic agreement. A cost settlement will be conducted annually based on the VDH Cost Allocation Plan. The Cost Allocation Plan explains that annually VDH will determine the cost of pre-admission screenings and final payments will be reconciled to the federal share of the cost. Any additional payment (or recovery) of the federal share will be made using a pass through transaction.

VII. Fiscal and Administrative Accountability

VDH agrees the cost accounting policies and procedures are consistent with state laws; and are in accordance with applicable provisions of the Federal Social Security Act, Provision of 45 CFR, Part 205.150, Subpart E of the 45 CFR Part 95, and CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart E – Cost Principles §200.416 Cost allocation plans and indirect cost proposals.

DMAS agrees to reimburse the VDH the federal share of allowable costs in accordance with their CDA-submitted Cost Allocation Plan (CAP).

VIII. Payment and Responsibilities:

Upon approval of the Department of Planning and Budget (DPB), DMAS shall make available \$250,000 of General Funds via a budget execution adjustment (BEX) for FY16 and each subsequent year to provide general funds to support the activities identified in this MOU until such time as a permanent transfer of the funds is included as an amendment in the annual Appropriation Act. Any additional general fund support needed for this activity shall be the responsibility of VDH to identify, request and obtain.

This Section incorporates by reference the payment and responsibilities agreed to in the current interagency agreement Modification No. 4 to the Business Associate Agreement (BAA), which incorporates IAG No. 001, signed between the parties on September 1, 2005.

C. Developmental Disabilities (DD) Waiver Screening – Active until July 1, 2016 – At which time the Department of Behavioral Health and Developmental Services will assume the screening process. Unless the parties agree otherwise in writing, this section shall be null, void and of no force and effect on and after July 1, 2016

DMAS Contact: Contract Monitor - Long Term Care Division Supervisor

VDH Contact: CSHCN Program Supervisor, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:

42 CFR § 441.302(c)(1) requires a screening of all individuals who, at the time of application for admission to community-based care or an ICF/ID are eligible for medical assistance.

State Code and Plan Reference:

12 VAC-30-120-700. Individual and Family Developmental Disabilities Support Waiver

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

The Individual and Family Developmental Disabilities Support Waiver, known as the "DD Waiver," is a Medicaid waiver that will provide home and community-based care services to Medicaid eligible individuals both children and adults, who

would otherwise be eligible for placement in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID). This waiver is effective July 1, 2000. Individuals six (6) years of age and older with a condition related to intellectual disability, but who do not have a diagnosis of intellectual disability, and who have been determined to require the level of care provided in an ICF/ID are eligible to receive services. Prior to becoming eligible, DMAS requires that a screening be conducted to determine if the individual meets the diagnostic and functional requirements for admission to the waiver.

Planning and Coordination

Virginia Medicaid may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

DMAS shall:

- Require a screening of all individuals who, at the time of application for admission to community-based care or an ICF/ID are eligible for medical assistance.
- Prepare, distribute, and maintain instructions and forms for waiver screenings.
- Provide training as required to ensure that individuals who conduct the screenings are qualified to conduct the evaluation.
- Provide an updated list of support coordinators.
- On a monthly basis, submit the names of individuals requesting to be screened for the DD Waiver to each clinic.
- Provide technical assistance to screening teams as issues arise.
- Inform the applicant, recipient or family member in writing of the decision rendered for authorization of Medicaid Services and of the appeal process that is available.

VDH shall:

- Ensure that as a condition of payment for all screenings conducted at a local health department or contracted available clinic, personnel who are assigned as members of the screening team have been properly trained in the procedure for conducting such screenings.
- Determine the necessity for institutional care or when more appropriate, alternate services which are available under the DD Waiver in accordance with procedures and criteria specified by DMAS in the Individual and Family Developmental Disabilities Support Waiver Screening Team Resource Guide.
- Refer the individual to DMAS when institutional care is determined to be the appropriate service and the individual chooses institutional care in lieu of home and community-based services through the DD Waiver.
- If the applicant meets the criteria for institutional care and chooses DD Waiver services, provide the applicant with a list of available support coordinators and allow the applicant to choose the coordinator of his/her choice. Once the applicant chooses the coordinator, forward screening materials to the support coordinator.
- Participate in the appeals process as needed if the applicant requesting the screening decides to appeal the screening decision.

Areas of Collaboration:

DMAS and VDH agree to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process.
- Provide training as needed regarding screening process and the DD Waiver.

Reimbursement:

VDH, Local Health Districts that conduct DD Waiver screenings shall bill DMAS in accordance with Method 2 Vendor Transactions as set forth by Section I of the Scope of Work Attachment. A Xerox Summary Report outlining the screenings performed that month shall support the billing. VDH contractors shall directly submit bills to and be reimbursed by DMAS at the stipulated rate of \$300 (\$350 in northern Virginia) for each screening performed.

Section III: Maternal and Child Health Collaborations

A. Baby Care

DMAS Contact: Contract Monitor, Maternal and Child Health Supervisor

VDH Contact: Contract Monitor, Division of Child and Family Services, Office of Family Health Services

Federal Code Reference:

Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative agreements with the State Health and Title V agencies. 42 CFR 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:

12 VAC30-50-410. Case management services for high-risk pregnant women and children.

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

BabyCare provides pregnant women with the support and services they need through targeted case management services as well as expanded prenatal care services. The program aims to improve birth outcomes by ensuring pregnant women and infants receive all the services they need. BabyCare services can include case management, nutritional counseling, substance abuse treatment, prenatal education, child development education, or home maker services. Such management is provided by a registered nurse or a social worker/family support worker with experience in health care and working with pregnant women and their families.

BabyCare targeted case management services encompass:

- Outreach or case finding and risk screening, which initiates the referral for services and identifies a woman and infant as needing care coordination. Outreach is conducted through medical clinics, physicians' offices, and hospitals. Plans are developed locally in conjunction with community partners.
- Assessments and Service Planning, which is a process that outlines services and resources needed to meet the needs of the client and provides assistance in accessing resources.
- Education and counseling including referral to expanded prenatal services which include classes on smoking cessation, preparation for parenting and childbirth, nutritional counseling, and homemaker services.
- Follow-up and monitoring to assess the ongoing progress and ensure that services are delivered through accurate record keeping.

Planning and Coordination:

The scope of services covered under the VMAP impacts other program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty can affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

DMAS and VDH shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process.
- Provide training as needed regarding new programs or services and existing programs.

Responsibilities:

The responsibility for the administration of the BabyCare program is a collaborative effort between the DMAS and VDH.

DMAS shall:

- Provide overall administration of the BabyCare Program.
- Collect data and evaluate the effectiveness of the BabyCare Program for pregnant women and children; maintain data for program evaluation and improvement.
- Monitor BabyCare providers in local health departments, private provider practices, Federally Qualified Health Centers and Rural Health Clinics.
- Work in conjunction with VDH to develop presentations to providers and other stakeholder groups on BabyCare as well as other maternal and child health issues that promote improved access to care.
- Maintain the BabyCare case management data tracking system.
- Maintain the BabyCare Provider Manual and other policies, procedures, forms and instructional materials developed in conjunction with the Virginia Department of Health in response to federal and state statutory or regulatory requirements.
- Maintain the VaMMIS subsystem files so that they remain sufficient to accomplish BabyCare claims processing, provider enrollment, and recipient enrollment.
- Authorize the VDH to apply to the federal Department of Health and Human Services for special grants or waivers or to any source of special funding as may be made available in the future for further development expansion of the Medicaid BabyCare program.
- Act as liaison between DMAS, VDH and the Medicaid Managed Care Organization.
- Participate in the VDH Home Visiting Consortium.

VDH shall:

- Provide BabyCare services in each health district where programs exist. This includes the identification of high-risk pregnant women, infants and children eligible to participate and to refer potential pregnant women and children to DSS for eligibility determination.
- Ensure that all Medicaid eligible high-risk pregnant women and children who are identified to health departments and are receptive to receive BabyCare services, receive prenatal care including support services such as appointment scheduling, transportation assistance, assessment of health needs, Behavioral Health Risk Screens, expanded prenatal services and tracking and care coordination to ensure initiation and continuation of treatment for identified problems.
- Provide maternal and child health expertise in the development of outreach and educational materials such as brochures and public relation campaigns.
- Work in conjunction with DMAS to develop presentations to professional and community groups on maternal and child health issues that promote improved access to care.
- Establish and maintain working relationships with local Medicaid participating providers of pediatric and obstetric services to BabyCare Program eligible recipients.
- Develop standards and procedures for quality assurance for maternal and child health providers in cooperation with DMAS.
- Assure that all local health department staff working with pregnant women and children are aware of participating Medicaid providers for maternal and child health services.
- Encourage local health departments to develop partnerships with private maternal and child health providers to facilitate access to care for pregnant women and children and to assist in identifying high-risk clients.
- Provide clinical consultation and technical assistance to local health department professional staff in the development of health care standards, guidelines, and administrative procedures for providers in the delivery of prenatal and postpartum services.
- Support the DMAS' efforts to obtain sufficient state appropriations to maintain provider reimbursement at a level that can assure that BabyCare services are as accessible to Medicaid recipients as they are to the general population;
- Designate a VDH BabyCare Program Manager who will provide program support and ascertain local health department BabyCare training needs as well as participate in any planning and implementation of training indicated.

- Communicate with DMAS and the Medicaid Managed Care Organizations issues that impact pregnant women and infants.

Areas of Collaboration:
DMAS and VDH shall:

- Develop materials to be included in the BabyCare Manual and other provider notices as may be required.
- Share data and participate in planning efforts to develop joint training to improve the delivery of services to high-risk pregnant women and children.
- Develop training and education programs for Medicaid providers, local professional staff, and recipients of BabyCare services.
- Keep each other apprised at all times of those services available to eligible individuals pursuant to federal law and state regulations and guidelines.
- Collaborate in the development of program objectives and outcome criteria including data needs in order to evaluate program effectiveness.
- Designate a liaison from their staff whose responsibilities shall include regular and periodic communication about programs and operations described in this agreement.

Reimbursement:

There shall be no reimbursement to VDH for services rendered in support of the administration of the BabyCare Program. Reimbursement for targeted case management services as well as expanded prenatal care services shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts that have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

VDH agrees to collect, record, and maintain services and claims billing documentation that supports expenses related to carrying out the provisions of this Agreement.

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

B. Children with Special Health Care Needs Program

DMAS Contact: (Contract Monitor -- Maternal and Child Health Supervisor

VDH Contact: Director, Children with Special Health Care Needs Program, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:

Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative agreements with the State Health and Title V agencies. 42 CFR 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:

Va. Code § 32.1-77 authorizes the Board of Health to prepare, amend, and submit to the appropriate federal authority, a state plan for maternal and child health services and children's specially services pursuant to Title V of the SSA and any amendments thereto. The State Health Commissioner is authorized to administer such plans and to receive and expend federal funds.

Va. Code § 32.1-89 authorizes the Board of Health to establish a program for the care and treatment of persons suffering from hemophilia and other related bleeding diseases.

Va. Code § 32.1-90 authorizes the Board of Health to provide health services for persons suffering from epilepsy and cystic fibrosis.

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

Special needs populations require more diverse and intense services than do individuals without special health care needs. This population includes children with special health care needs (CSHCN) who receive services through the health department's CSHCN Program funded by Title V of the SSA and state funds. CSHCN have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition(s) and who need health and related services of a type or amount over and above the usual for the child's age. The CSHCN Program administers the Care Connection for Children Program, Child Development Services Program, and the Virginia Bleeding Disorders Program that serve these children.

Planning and Coordination:

The scope of services covered under the VMAP impacts other program plans and budgets. Similarly, actions of the VDH to offer health care services to individuals living in poverty can affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

DMAS and VDH shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process.
- Provide training as needed regarding new programs or services and existing programs.

Responsibilities:

DMAS shall:

- Collaborate and coordinate on an ongoing basis with VDH on CSHCN issues, share resources, and disseminate information of mutual interest.
- Provide an upper management liaison between DMAS and the Care Connection for Children (CCC) Inter-Center Work Group to:
 - Serve as a point of contact for regular communication between DMAS and CCC.
 - Facilitate education so that CCC staff learns about Medicaid and FAMIS and DMAS staff learns about CCC.
 - Participate in problem solving with CCC about CSHCN issues.
 - Seek CCC input on DMAS policies related to CSHCN.
 - Attend the CCC Inter-Center Work Group meeting a minimum of once per year.
- Communicate with the Medicaid Managed Care Organizations issues that impact CSHCNs.

VDH shall:

- Provide feedback to DMAS on the impact of managed care on CSHCN, managed care contracts, identification of CSHCN, quality assurance and other issues that impact CSHCN.
- Collaborate and coordinate on an ongoing basis with DMAS on CSHCN issues, share resources, and disseminate information of mutual interest.

Reimbursement:

Reimbursement for services shall be made to the CSHCN Program in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts who have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process. For children who are enrolled in a Medicaid MCO, the CSHCN Program and local health departments must be a provider for the particular MCO the member is enrolled to be reimbursed for covered services.

VDH agrees to collect, record, and maintain services and billing documentation that supports expenses related to carrying out the provisions of this Agreement.

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

C. Early and Periodic Screenings, Diagnosis and Treatment Services (EPSDT)

DMAS Contact: Contract Monitor – Maternal and Child Health Supervisor

VDH Contact: Policy Analyst, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:

Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative agreements with the State health and Title V agencies. 42 CFR 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference: None

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

The Virginia EPSDT Program is a Medicaid Program that provides services for children as defined in 42 CFR §§ 440.40 (b) and 441, Subpart B. These preventive health services encompass:

- Screening and diagnostic services to determine physical or mental defects in recipients under age 21.
- Health care, treatment, and other necessary measures to correct or ameliorate any defects and chronic conditions discovered.

The administration of the EPSDT program is a collaborative effort among three state agencies: DMAS, VDH, and DSS.

Planning and Coordination:

The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

DMAS shall:

- Disseminate the EPSDT Supplement and other policies, procedures, forms, and instructional materials developed in conjunction with VDH in response to federal and state statutory or regulatory requirements.
- Maintain the VaMMIS EPSDT subsystem files so that they remain sufficient to accomplish EPSDT claims processing and report statistics required by the CMS and by other federal and state agencies.
- Authorize VDH to apply to the federal DHHS for special grants or waivers or to any other source of special funding as may be made available in the future for further development and expansion of the Medicaid EPSDT program.

VDH shall:

- Offer input to DMAS, regarding the current EPSDT program information brochures and other materials that are needed to communicate information about and promote EPSDT to the target population.
- Support DMAS' efforts to obtain sufficient State appropriations to maintain physician reimbursement at a level that can assure that services are available to Medicaid recipients at least to the extent that those services are available to the general population.
- Collaborate with DMAS and DSS in the development of screening standards and procedure guidelines for EPSDT providers.
- Assist with developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required.

Areas of Collaboration:

DMAS and VDH agree to:

- Collaborate in the development of screening standards and procedure guidelines for EPSDT providers.
- Collaborate with DSS, Head Start, Early Intervention, Department of Education (DOE), and other appropriate organizations to increase the annual number of screenings statewide.
- Provide or facilitate training and technical assistance on EPSDT policies/procedures to local public health department personnel on an as needed basis.
- Share data pursuant to a properly executed Scope of Work specified under this Agreement.

Reimbursement:

There shall be no reimbursement to VDH for services rendered in support of the administration of the EPSDT Program. Payment for medical services provided under the Medicaid and FAMIS Programs shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts that have provider agreements with DMAS and at rates established by DMAS. Reimbursement for these services shall be made via the DMAS claims submission and payment process.

VDH agrees to collect record and maintain services and billing documentation that supports expenses related to carrying out the provisions of this Agreement. For children who are enrolled in a Medicaid MCO, local health departments must be a provider for the particular MCO the member is enrolled to be reimbursed for covered services.

D. Women, Infants and Children (WIC)

DMAS Contact: Contract Monitor – Maternal and Child Health Supervisor

VDH Contact: Contract Monitors: Director and Systems Manager/EDI Coordinator, Division of Community Nutrition, Office of Family Health Services

Federal Code Reference:

The federal grants administration procedures detailed in Title 43 CFR, Part 74 and the provisions of 42 CFR § 431.300

State Code Reference:

12 VAC 30-10-770. Required coordination between the Medicaid and WIC Programs.

State Plan Reference:

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with §1902(a)(53) of the Act.

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources, more effective service delivery, and improved and documented outcomes by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State agencies.

Description:

The Omnibus Budget Reconciliation Act of 1989 mandated the coordination and referral of services with the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Program and other maternal and child health programs. Through the EPSDT program administered by DMAS, children from birth through 20 years of age may receive medically necessary services identified through screening exams conducted by a medical professional. The WIC program provides low income pregnant, postpartum, and breastfeeding women, infants and children up to their fifth birthday with nutritious supplemental food, infant formula, and nutrition education.

Scope of Services:

The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to low income individuals may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:**DMAS shall:**

- Keep abreast of federal regulations, policies, or directives that may affect the program.
- Designate a staff member to serve as DMAS' liaison for the WIC program.
- Work with VDH to review overall participation of Medicaid recipients in WIC to include unserved potentially eligible recipients. This will be done annually.
- Reimburse VDH for the state share and federal match of the cost of exempt infant formula and medical foods for infants and children enrolled in Virginia Medicaid via claims submitted electronically by VDH. Claims submitted correctly will be paid within thirty (30) calendar days of receipt of the claim.
- Update MMIS system as needed if new formula codes are available.
- Keep VDH/WIC informed of any claims or billing problems that would affect their process.
- Pay claims for exempt formula and medical foods for the WIC amount and any medically necessary amount over the WIC limit.
- Ensure the VDH is conducting appropriate monitoring of the providers of exempt formula and medical foods.

VDH shall:

- Keep abreast of federal regulations, policies, or directives that may affect the program.
- Designate a staff member to serve as VDH's liaison for the WIC program. Ensure that qualified staffs are recruited as necessary to meet program needs.
- Provide program consultation and technical assistance to the program sites.
- Monitor and evaluate the program through site visits, reports, and statistical reviews and provide a copy of the evaluation to DMAS. The evaluation should include comparative statistics that show the impact of the program.

- Maintain personnel, expenditure, and other fiscal records necessary to document the use of funds and its performance of responsibilities under the agreement, and make such records available to federal officials or DMAS staff on request.
- Provide quantities of exempt formula and medical foods in excess of that allowable for WIC and will submit a claim to DMAS for the full amount issued.
- Use the same policy, monitoring and review processes with Medicaid participants as with non-Medicaid WIC participants with the exception of providing ready to feed exempt formula when concentrate is not available to premature infants who receive Medicaid.
- Provide DMAS with information on reviews including the number of reviews conducted and any adverse actions that were taken as result of such reviews.

E. Plan First

DMAS Contact: Maternal and Child Health Supervisor

VDH Contact: Family Planning Program Supervisor, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:

Title V of the Social Security Act

Title XIX of the Social Security Act

State Code and Plan Reference:

Va. Code § 32.1-77 authorizes the Board of Health to prepare, amend, and submit to the appropriate federal authority, a state plan for maternal and child health services and children's specialty services pursuant to Title V of the SSA and any amendments thereto. The State Health Commissioner is authorized to administer such plans and to receive and expend federal funds.

Va. Code § 32.1-325 authorizes the Board of Medical Assistance Services to prepare, amend, and submit to the Secretary of the United States DHHS a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto.

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance. For this project DMAS will provide to VDH certain data in order to evaluate Plan First enrollment and services provided under the Plan First, the Medicaid State Plan option for family planning (hereinafter, "Plan First"). This data in this project will also be used to provide outreach for enrollment as well as provider training.

The assignment of responsibilities as stated herein is intended to result in improved use of State resources and provide more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Type and Format of the Data to be exchanged:

- VDH is authorized to use eligibility data provided by DMAS pursuant to Section V of this Agreement for the purposes of this subsection.
- DMAS shall provide a monthly file of Medicaid (fee-for-service and managed care) enrollment data of pregnant women getting ready to lose coverage postpartum to VDH for targeted enrollment to Plan First.

The file shall contain the following data elements:

- Member Medicaid ID
- Member first name
- Member middle initial

- Member last name
 - Member FIPS
 - Member address (street, city, state, zip)
 - Member telephone number
 - Member aid category
 - Member Estimated Date of Delivery
 - Member race
- DMAS shall provide a monthly file to VDH with contact information of practitioner based prenatal care providers of Medicaid (fee-for-service and managed care) pregnant women for targeted outreach of Plan First.

The file shall contain the following data elements:

- Service provider name (Agency name, first name, last name)
 - Provider type
 - Provider servicing address (street, city, state, zip and FIPS)
 - Provider telephone and fax numbers
 - Provider email addresses
 - National Provider Identifier
- DMAS shall provide to VDH a monthly data file of members with a claim paid or denied under Plan First at any point in time during the reporting period. The file shall contain the following data elements:
 - Medicaid Member ID
 - Member FIPS
 - Member address (street, city, state, zip)
 - Member race, age
 - Service provider name (Agency name, first name, last name)
 - Provider NPI
 - Provider type
 - Provider servicing address (street, city, state, zip)
 - Procedure code and description
 - Drug code and drug name
 - Amount billed
 - Claim status
 - Total paid
 - Denial reason
 - DMAS shall provide to VDH a monthly data file of localities where there are high rates of no enrollment in Medicaid for women postpartum. The file shall contain the following data elements:
 - FIPS of Member when enrolled in pregnancy coverage

Security and Confidentiality:

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

Responsibilities:

DMAS shall:

- Provide training and consultation about Plan First services to family planning providers and case managers.
- Develop and make available printed information about Plan First services for active and potential members, and make these resources available to VDH family planning clinics and other maternal and child health service providers.
- Track and analyze enrollment and claims data on monthly, quarterly and annual basis.

- Notify VDH of any changes to Plan First application or other marketing material.

VDH shall:

- Provide additional analysis of Plan First enrollment and claims data as mutually agreed upon by DMAS and VDH to evaluate system performance and to develop a systematic plan for additional public and/or provider outreach and education.
- Except for disclosures required by law, VDH shall consult with DMAS prior to use of any of the exchanged data in a manner that could result in the disclosure of individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act (HIPAA). VDH understands and agrees to abide by the confidentiality provisions included in HIPAA and other relevant federal and state laws, including, but not limited to, the limitation on the publication and disclosure of data as described in 45 C.F.R. § 164.514.

Areas of Collaboration:

- DMAS and VDH agree to collaborate on needs assessment, planning, analysis of enrollment and claims data, and evaluation of Plan First to help increase enrollment and utilization in Plan First. DMAS and VDH agree to encourage local health departments to collaborate with their local departments of social services regarding Plan First applications and enrollment process. DMAS and VDH agree to provide training and consultation about Plan First services to family planning providers and case managers.

Reimbursement:

There shall be no reimbursement to the VDH for services rendered in support of the administration of Plan First. Reimbursement for family planning services shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts that have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

F. Maternal and Child Health Collaboration (Perinatal Health)

DMAS Contact: Maternal and Child Health Services Manager

**VDH Contact: Policy Analyst (MCH Lead), Division of Policy and Evaluation, Office of Family Health Services
State Registrar – Division of Vital Records**

Federal Code Reference:

Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative arrangements with State Health and Title V agencies. 42 CFR § 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:

Va. Code § 32.1-77 authorizes the Board of Health to prepare, amend, and submit to the appropriate federal authority, a state plan for maternal and child health services and children's specialty services pursuant to Title V of the SSA and any amendments thereto. The State Health Commissioner is authorized to administer such plans and to receive and expend federal funds.

Va. Code § 32.1-325 authorizes the Board of Medical Assistance Services to prepare, amend, and submit to the Secretary of the United States DHHS a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto.

Va. Code § 32.1-351 authorizes the DMAS to develop and submit to the federal Secretary of Health and Human Services a Title XXI plan for the Family Access to Medical Insurance Security Plan (FAMIS) and revise such plan as may be necessary.

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance (Medicaid) and the Family Access to Medical Security Plan (FAMIS). For this project DMAS will provide VDH data in order to evaluate perinatal health outcomes for services provided under Medicaid and FAMIS, including FAMIS MOMS.

The assignments of responsibilities as stated herein are intended to result in improved use of State resources and provide more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

A subcomponent of the data exchange is a requirement from the Centers for Medicare and Medicaid Services (CMS) Strong Start Initiative grant to test the effectiveness of the Centering Pregnancy prenatal care model in reducing preterm birth. CMS aims to test and evaluate this prenatal care model for women enrolled in Medicaid or FAMIS who are at risk for having a preterm birth. The goal of the initiative is to determine if these approaches to care can reduce the rate of preterm births, improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy, delivery and over the first year of life for children born to mothers in Medicaid or FAMIS. Virginia Commonwealth University (VCU) is a recipient of the CMS Strong Start Initiative grant. VCU is tasked to monitor and evaluate the effectiveness of Centering Pregnancy prenatal care model in reducing poor birth outcomes. The grant requires the utilization of linked birth registry-claims data to evaluate the Initiative.

Type and Format of the Data to be exchanged:

- VDH is authorized to use eligibility data provided by DMAS pursuant to Section V of this Agreement for the purposes of this subsection.
- DMAS shall provide to VDH an annual data file of females of reproductive age who were enrolled Medicaid or FAMIS at any point of time during the calendar year. The file shall contain the following data elements:
 - Recipient ID
 - Social Security Number
 - Recipient first name
 - Recipient middle initial
 - Recipient last name
 - Date of birth
 - All eligibility/aid categories for enrollment periods active during the reporting year and previous year, with begin and cancel dates.
 - All managed care enrollment spans active during the reporting year and previous year, with begin and end dates.
- DMAS shall provide Medicaid fee-for-service and encounter claims data for services provided to pregnant women and newborns as needed for special projects agreed to by VDH and DMAS to support the purpose of this section.
- VDH shall provide to DMAS or to a contractor of DMAS or VDH a data file with vital records data pursuant to the provisions set out in the eHHR Enhanced Memorandum of Understanding (E-MOU).
- VDH shall provide VCU linked vital records and DMAS data in an aggregate form to evaluate the effectiveness of the Strong Start Initiative in Virginia. This data shall be provided to VCU annually through the life of the project 2013-2016. De-identified aggregate data shall be reported to CMS.

Security and Confidentiality:

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

Responsibilities:

DMAS shall:

- DMAS shall provide to VDH an annual data file as needed of females of reproductive age who were enrolled into Medicaid or FAMIS at any point of time during the calendar year. The file shall contain the following data elements:
 - Recipient ID
 - Social Security Number
 - Recipient first name
 - Recipient middle name
 - Recipient last name
 - Date of birth
 - All eligibility/ aid categories for enrollment periods active during the reporting year and previous year, with begin and cancel dates.
 - All managed care enrollment spans active during the reporting year and previous year, with begin and end dates.
- DMAS shall provide to VDH Medicaid fee-for-service and encounter claims data for services provided to pregnant women and newborns as needed for special projects agreed to by VDH and DMAS to support the purpose of this section.
- Provide training and consultation about Medicaid, FAMIS, and FAMIS MOMS eligibility and services to local health department providers and case managers.
- Develop printed information for active and potential recipients, and make these resources available to VDH clinics and other maternal and child health service providers.
- Permit VDH to review and approve the representation (in written and oral form) of the linked data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA), laws governing vital records, and other pertinent federal and state laws.

VDH shall:

- VDH is authorized to use eligibility data provided by DMAS pursuant to Section V of this agreement for the purposes of this subsection.
- VDH shall provide to DMAS or to a contractor of DMAS or VDH a data file with vital records data linked to or including identifiers needed for linkage to DMAS data for projects that are mutually agreed to by DMAS and VDH to support the purpose of this section.
 - As the Strong Start grant recipient, VDH shall provide linked vital records and DMAS data or vital records data capable of linkage with DMAS data to evaluate the effectiveness of the Strong Start Initiative in Virginia. This data shall be provided to VCU annually through the life of the project 2013-2016. Only de-identified aggregate data shall be reported to CMS.
- Provide other analysis for the purposes of this subsection as mutually agreed upon by DMAS and VDH, such as:
 - Link DMAS data to birth record data, natural fetal death record data, and VDH program data based on identifying information of the mother.
 - Provide to DMAS the number of births and natural fetal deaths to Medicaid and FAMIS enrollees by eligibility/aid category and coverage plan.
 - Provide to DMAS the number of low weight and very low weight births to Medicaid and FAMIS enrollees.
 - Provide to DMAS data on pregnancy risk factors for Medicaid and FAMIS enrollees.
- Permit DMAS to review and approve the representation (in written and oral form) of the exchanged data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA) and other pertinent federal and state laws.

Provide de-identified linked vital registry and DMAS data to VCU. Data will flag Centering Pregnancy (Strong Start) recipients.

Areas of Collaboration:

DMAS and VDH agree to collaborate on outreach, needs assessment, planning, and evaluation of services for pregnant women and infants eligible for Medicaid, FAMIS, and FAMIS MOMS coverage.

Reimbursement:

There shall be no reimbursement to VDH for services rendered in support of the administration of the Medicaid, FAMIS, or FAMIS MOMS programs. Reimbursement for perinatal health services shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts that have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

Section IV. MDS Automation Project – Resident Assessment Instrument (RAI) Data System

DMAS Contact: Contract Monitor – Office of Data Analytics

VDH Contact: Director, Office of Licensure and Certification

Purpose:

The purpose is to improve utilization of Agency resources through targeting potential problem facilities and by focusing onsite survey activities on specific problem areas within a facility. Provide data for use in support of State Medicaid functions to include the Medicaid payment system, utilization review, service placement and improvement in the State's ability to monitor and evaluate the cost effectiveness and quality of care and services provided.

Description:

Operation and management of the RAI data system used for survey and certification of nursing home providers suppliers participating or requesting to participate in Medicaid programs. Certification includes on site visitation and evaluation. CMS requires the use of "Resident Assessment Instrument (RAI) in federally certified long-term care facilities to assess the clinical characteristics and care needs of long term care residents." Resident records of care and treatment provisions are reviewed. The RAI's purpose is to better utilize survey agency resources by targeting potential problem facilities and focusing on site survey activities on specific problem areas within a facility. An objective of RAI system use is to provide data to support the Medicaid payment system, utilization review, service placement and improving the process of monitoring and evaluating the cost effectiveness, services provided and quality of care under the Medicaid program.

Federal Code Reference:

§§ 1864 and 1874, Title XVIII, SSA; Health Standards and Quality

State Code & State Plan Reference:

Title 32.1 Chapter 10, Code of Virginia

Planning & Coordination:

VDH and DMAS will take appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by nursing home providers and to follow requirements and procedures governing the confidentiality of patient data.

VDH and DMAS will develop options made available by CMS to state regarding the Minimum Data Set portion of the RAI including part S of the MDS data record.

Responsibilities:

VDH agrees to the following:

- Installation of the RAI system provided by CMS or CMS contractors in VDH's premises.
- VDH shall perform day to day operations of the system to include receipt and validation of RAI records. CMS must be provided access to the RAI data systems.
- VDH shall provide DMAS with a fully exportable file / data set containing all MDS data collected from nursing facilities and processed through the CMS edits.

- VDH shall designate the optional version of Resource Utilization Groups (RUG) III 1997 update as the quarterly assessment instrument to be completed by nursing facilities for support of the Medicaid payment system.
- VDH shall process information from the MDS portion of the RAI for all residents in long term Medicare and / or Medicaid certified long term care facilities.
- VDH shall absorb all costs associated with the daily operation of the RAI system to include staff, space, utilities, equipment, maintenance and facility submission support.

DMAS agrees to the following:

- DMAS shall absorb all costs related to the development and operation of the DMAS case-mix based reimbursement system.
- If DMAS requests any special work or work products from VDH, DMAS shall incur the cost. Prior to initiation of such work, DMAS and VDH shall agree upon the cost of the special request.
- DMAS shall establish and operate computing hardware and software for the purpose of receiving and storing MDS data retrieved by DMAS from records maintained on the CMS supplied MDS portion of the RAI data systems.

Areas of Collaboration:

VDH is the Federal agent and designee of CMS, assigned the duty to receive, possess, maintain, implement, use and control the RAI data system on behalf of CMS.

Section V. Eligibility Information

DMAS Contact: Office of Data Analytics

VDH Contact: Director/CIO, Office of Information Management and Health IT

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources by providing for the sharing of official enrollment and eligibility data between the VDH and DMAS.

Background:

Staff of the DMAS Division of Cost Settlement and Reimbursement provided VDH with an analysis of total denied claims from VDH operating units by specific reasons of denial for SFY 2000 and SFY 2001. This analysis was provided in order to furnish VDH with specific information that could lead to improvements in the billing processes thereby producing a cost savings to DMAS. The volume of VDH claims denied for payment from DMAS based on reasons related to accurate eligibility, led to the initiation of a basic efficiency and productivity survey of VDH operating units. The results of this survey document that: 1) VDH operating units devote considerable staff time to the acquisition of eligibility information that can only be garnered through a telephonic queuing process; 2) Mistakes are made in the billing process due to the lack of or inaccurate eligibility information; and 3) The VDH WebVision system, used by VDH operating units for billing purposes, can be easily modified to provide electronic on-line DMAS eligibility information.

Federal Code Reference:

None

State Code & State Plan Reference:

Va. Code § 32.1-127.1:04 requires the agencies of the Secretary of Health and Human Resources to establish a secure system for sharing PHI that may be necessary for the coordination of prevention and control of disease, injury or disability.

Responsibilities:

DMAS shall:

- Provide a key contact within DMAS whose responsibility will be to ensure a secure data transfer process and proper data use safeguards.
- Provide VDH representative with selected Eligibility File data on a biweekly basis.
The data provided will be in a mutually agreed upon format using a mutually agreed upon procedure that complies with all applicable HIPAA and VITA requirements.
- The data will include all active Medicaid enrollees and contain the following data fields:
 - Recipient ID number
 - Recipient name
 - Social Security Number
 - Sex
 - Date of birth
 - Medicaid program enrolled in
 - Beginning and end dates for current and previous two enrollment periods
 - Third party payor to include type of insurance and policy number
 - Policy effective begin and end dates
 - HMO provider ID
 - Lock-In program provider and effective dates

VDH shall:

- Provide a procedure and primary contact within VDH for the secure data transfer through a means compliant with Commonwealth Security Standards for the transfer of sensitive data. VDH will have a dedicated data owner whose responsibilities include the transfer, management, and storage of the data. Use the data only for the purpose of eligibility verification.

Section VI. Decedent Information

**DMAS Contact: Contract Monitor: Program Operations Division
Working Job Title: Sr. Systems Analyst**

VDH Contact: Director, Division of Vital Records and Health Statistics, Office of Information Management

Purpose:

The assignments as stated herein are intended to result in improved use of state government resources by providing for the sharing of official decedent data between VDH and DMAS, in order to assist DMAS from removing deceased individuals from its roles and preventing fraud and abuse against the Commonwealth.

Description:

In 1997 an audit test conducted by the DMAS Division of Internal Audit & Contract Evaluation determined that, because of untimely notice of recipient mortality, the Medicaid program was paying approximately \$100,000.00 per annum in claims and capitation payment (primarily for pharmacy claims and to HMOs) for recipients who were deceased. Such payments require DMAS staff to attempt recoupment upon eventual DMAS receipt of official notice of death from the VDH. The recoupment of such monies can be difficult because recoupment sometimes starts many months after the original payment.

Federal Code Reference:

None

State Code & State Plan Reference:

Va. Code § 32.1-272 entitled "Certified copies of vital records; other copies" reads in part: D. Other federal, state and local, public or private agencies in the conduct of their official duties may, upon request and payment of a reasonable fee, be furnished copies or other data from the system of vital records for statistical or administrative purposes upon such terms or

conditions as may be prescribed by the Board. Such copies or other data shall not be used for purposes other than those for which they were requested unless so authorized by the State Registrar.

Responsibilities:

DMAS shall:

- Provide a key contact within DMAS whose responsibility will be to ensure a secure data transfer process and establish proper data use safeguards.
- Use data only for the purpose of verification of a recipients' status on the Eligibility File and to check for payments made on behalf of deceased recipients either through error or as the result of fraudulent activities. Upon receipt of such data, DMAS will acknowledge the receipt of the information to VDH by e-mail.
- Retain this information in a secure environment with controlled access to its contents during the duration of its usefulness, and ensure that DMAS employee and those that work under contract, who have access to this data, strictly adhere to the applicable privacy and confidentiality requirements of state and federal law.
- Dispose of these files in a manner consistent with the applicable requirements of state and federal privacy and confidentiality laws.
- Coordinate any use of this data for publishing statistical reports with Virginia Center for Health Statistics (VCHS) analytical staff to insure consistency between the agencies' publications.
- DMAS will work with VCHS to identify areas where information contained in the MMIS and other appropriate systems may be extracted for population-based analyses of key indicators important in public health assessment.
- The results of such studies will be made available to both DMAS and VDH.
- Individually identifiable data will not be published or disclosed.

VDH shall:

- Provide a key contact within VDH, Division of Vital Records, whose responsibility will be to ensure a secure data transfer process and proper data use safeguards pursuant to the provisions set out in the eHHR Enhanced Memorandum of Understanding (E-MOU).

Section VII. Virginia Vaccines for Children Program (VVFC)

DMAS Contact: Maternal and Child Health Division Manager

VDH Contact: Director, Division of Immunization (DOI), Office of Epidemiology

Federal Code Reference: Title XIX, Sections 1902 (42 USC 1396(a) and (42 USC 1396(s)) of the Social Security Act

State Code and Plan Reference: 12VAC30-10-50. Pediatric immunization program

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

VDH, Division of Immunization (DOI) is responsible for promoting and protecting the health of Virginians by ensuring that an adequate and viable inventory of vaccines are available to district health departments and private physicians participating in the Vaccines for Children (VFC) program. The Division also conducts quality assurance site visits, oversees the investigation of suspected cases of vaccine preventable disease and assesses immunization coverage statewide.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to the underserved may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans

to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

To be eligible for free vaccine from the VVFC program, children must be under 19 years of age and meet at least one of the following criteria:

-
- Medicaid enrolled, including Medicaid MCOs
 - Uninsured (those without health insurance)
 - Native American or Native Alaskans (no proof required) and
 - Underinsured (those whose insurance does not cover immunizations) (only at FQHCs or RHCs).

Responsibilities:

DMAS shall:

- Provide VDH with the name, address and Medicaid provider number of new Medicaid providers quarterly.
- Provide link to VVFC website on DMAS website.
- Annually provide Medicaid enrollment data in a template provided by VVFC.
- Authorize VVFC to implement the "Opt Out Policy" and issue exemption letters on behalf of VVFC and DMAS.

VDH shall:

- Make available on the VDH website the VVFC policies, program guidelines and forms at: <http://www.vdh.virginia.gov/epidemiology/immunization/vfc/index.htm>.
- Distribute VVFC enrollment information to new Medicaid providers.
- Provide a link to the DMAS website on the VVFC enrollment page website.
- Provide information on vaccine pricing and new vaccines as needed.
- Provide template for the annual reporting of Medicaid enrollment.
- Write letters on behalf of VVFC and DMAS to VVFC providers who have been approved for exemption from VVFC within 30 days of identification and forward DMAS Program Integrity staff person a copy of the letter.

Areas of Collaboration:

DMAS and VDH agree to:

- Provide training and technical assistance on policies, procedures, and services on an as needed basis.
- Participate in workgroups to address programmatic challenges and issues as needed.
- Resolve problems or issues as they arise.

Vaccines for Children's Program Opt Out Policy:

As part of the Medicaid provider agreement, Medicaid doctors that wish to enroll in Medicaid also must enroll and participate in the Commonwealth of Virginia's Vaccines for Children (VVFC) Program. The VVFC program is designed to keep the client at the medical home to receive immunizations.

There are providers enrolled in Medicaid who do not participate with VVFC. Providers enrolled in Medicaid must meet the following criteria to opt-out of VVFC participation:

- Provider's Medicaid panel has less than 10 VVFC eligible children under the age of three (3) years old.

If the provider does meet the criteria, they may request exemption from the VVFC participation requirement. The request must contain the following:

- Where they are referring the patients.
- Justification for referring the patients.
- How plans for retrieving the immunization record from the other facility, including clearance from the immunizing facility to agree to provide feedback.

This documentation will be kept on file by VVFC for reference purposes. If the provider does not meet the criteria, then they are required to enroll in VVFC. VVFC will contact them in one year to follow up on their membership.

Reimbursement:

There shall be no reimbursement to either agency for services rendered in support of the administration of the VVFC Program and the Medallion program. Payments for medical services provided under the Medicaid and FAMIS Programs shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the scope of work attachment to local health districts that have provider agreements with DMAS at rates established by DMAS. Reimbursement for these services shall be made via the DMAS claims submission and payment process.

Section VIII. HIV AIDS Data Transfer

DMAS Contact: Office of Data Analytics

VDH Contact: Director, HIV Surveillance, Division of Disease Prevention, Office of Epidemiology

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance. For this project DMAS will work collaboratively with VDH to identify overlap and improve the delivery of medical services to the Medicaid population with HIV infection. DMAS will supply VDH with patient-related data that VDH will use for the purpose of meeting federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act grant requirements including identifying how many people in their service area know they are HIV-positive but are not receiving regular I-HIV-related primary medical care. VDH has a responsibility to support this process by assessing service needs and barriers in order to improve access to care. DMAS will use the findings of this VDH assessment and the assurance processes to improve the delivery of medical services to the Medicaid population.

Federal Code Reference:

The Ryan White CARE Act, Public Law 106-345, re-authorized the amendments of 2000, and contains multiple provisions focused on enhancing access to primary care for persons living with HIV disease who are not in care. These provisions also include enhancements to needs assessment requirements, directing the development of epidemiologic measures "for establishing the number of individuals living with HIV disease who are not receiving HIV-related health services".

State Code Reference:

Va. Code § 32.1-36 requires physicians and laboratories to report any patient in Commonwealth who tests positive for exposure to human immunodeficiency virus (HIV) to VDH. Furthermore, § 32.1-36 allows for the voluntary reporting of additional information at the request of VDH for special surveillance or other epidemiological studies. The patients' and the providers' identities and disease state shall be confidential as provided in §§ 32.1-36.1 and 32.1-41. Any unauthorized disclosure of reports made pursuant to this section shall be subject to the penalties of § 32.1-27.

Type and Format of the Data to be exchanged:

DMAS shall provide to VDH client-level information of Medicaid recipients with HIV infection in a format and type to be determined by VDH. DMAS shall provide this data to VDH in hardcopy or electronic form via removable media or secure data transfer.

DMAS shall provide on a quarterly basis to VDH data fields that include but are not limited to the following, as available:

Infections:

Acquired Immunodeficiency Syndrome (AIDS)
Human Immunodeficiency Virus (HIV)

Data Variables:

Last Name

First Name
Middle Name
Social Security Number
Street Address
City
State
ZIP Code
Race
Sex
Date of Birth
Date of Death or Cancellation Reason 001
Date of HIV Diagnosis
Date of AIDS Diagnosis
Date of Most Recent Viral Load
Results of Most Recent Viral Load
Date of Most Recent CD4 Count
Results of Most Recent CD4 Count
Date of the Most Recent Antiretroviral Therapy Rx
Date of the Most Recent Medical Visit
Provider Name
Healthcare Facility Name
Provider Phone
Provider Street Address
Provider City
Provider State
Provider Zip Code

VDH shall provide to DMAS the Diagnosis and Procedure Codes necessary to generate the requested data fields.

Security and Confidentiality:

All data provided by DMAS to VDH is subject to all applicable security and confidentiality limitations described in the Business Associate Agreement signed by the parties on September 1, 2005. In addition, VDH will abide by supplemental guidelines that describe data release protocols in place for appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of HIV records.

Responsibilities:

DMAS and VDH agree to:

- VDH shall primarily use the information from the exchanged data to fulfill annual grant application requirements. Aggregate data without client identifiers may also be included in applicable reports and publications prepared by VDH. VDH will provide a copy of aggregate data analyses used for these purposes to DMAS.
- DMAS shall be permitted to review and approve any additional representation (in written and oral form) of the exchanged data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA) and other pertinent federal and state laws.

Reimbursement: N/A

Section IX. STD and Hepatitis C Data Transfer

DMAS Contact: Office of Data Analytics

VDH Contact: Director, STD Surveillance, Operations and Data Administration, Division of Disease Prevention, Office of Epidemiology

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance. For this project DMAS will work collaboratively with VDH to identify overlap and improve the delivery of medical services to the Medicaid population with STD and Hepatitis C infections. DMAS will supply VDH with patient-related data that VDH will use for the purpose of assessing state mandated reporting requirements, as well as federal "Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies (AAPPS)" grant requirements, including identifying how many people in Virginia are 1) diagnosed with STDs and Hepatitis C; 2) known to have been linked to primary medical care (especially for HIV-co-infected persons); and 3) receiving appropriate treatment services to limit antimicrobial resistance. VDH has a responsibility to support this process by assessing service needs and barriers in order to improve STD and Hepatitis C prevention and access to care activities. DMAS will use the findings of VDH assessment and assurance processes to improve the delivery of medical services to the Medicaid population.

Federal Code Reference:

See Section VII

State Code Reference:

Code of Virginia §32.1-36 requires every physician practicing in the Commonwealth of Virginia who diagnoses or reasonably suspects any patient to have any disease required by the Board of Health to be reported and every director of any laboratory doing business in the Commonwealth of Virginia that performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by Board of Health Regulations (Regulations for Disease Reporting and Control, March 2011). Furthermore, § 32.1-36 allows for the voluntary reporting of additional information at the request of VDH for special surveillance or other epidemiological studies. The patient's and provider's identity and disease state shall be confidential as provided in § 32.1-36, § 32.1-36.1 and §32.1-41. Any unauthorized disclosure of reports made pursuant to this section shall be subject to the penalties of § 32.1-27.

Type and Format of the Data to be exchanged:

DMAS shall provide to VDH client-level information of Medicaid recipients with STD and hepatitis infections in a format and type to be determined by VDH. DMAS shall provide this data to VDH in hardcopy or electronic form via removable media or secure data transfer.

DMAS shall provide on a quarterly basis to VDH data fields that include but are not limited to the following, as available:

Infections:

Acquired Immunodeficiency Syndrome (AIDS)
Cancroid
Chlamydia trachomatis infection
Gonorrhea
Granuloma inguinal
Hepatitis C
Human immunodeficiency virus (HIV)
Lymphogranuloma venereum
Syphilis (all stages)

Data Variables:

Last Name First Name Middle Name
Social Security Number
Street Address
City
State
ZIP Code
Race

Sex
Date of Birth
Date of Death or Cancellation Reason 001
Diagnosis
Diagnosis Date
Treatment Received
Treatment Date
Date of Most Recent Medical Visit
Provider Name
Healthcare Facility Name
Provider Phone
Provider Street Address
Provider City
Provider State
Provider Zip Code

VDH shall provide to DMAS the Diagnosis and Procedure Codes necessary to generate the requested data fields.

In addition, DMAS will provide to VDH the chlamydia HEDIS measure, the percentage of women 16-24 years of age enrolled in Medicaid who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

The numerator for this measure is the number of sexually active females 16-24 years of age enrolled in Medicaid that were tested at least once for chlamydia during the measurement period. The denominator for this measure is the number of sexually active females 16-24 enrolled in Medicaid. This measure should be provided quarterly if possible, and annually at a minimum.

Security and Confidentiality:

All data provided by DMAS to VDH is subject to all applicable security and confidentiality limitations described in the Business Associate Agreement signed by the parties on September 1, 2005. In addition, VDH will abide by supplemental guidelines that describe data release protocols in place for appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of STD and Hepatitis records.

Responsibilities:

DMAS and VDH agree to the following:

- VDH shall primarily use the information from the exchanged data to fulfill annual grant application requirements. Aggregate data without client identifiers may also be included in applicable reports and publications prepared by VDH. VDH will provide a copy of aggregate data analyses used for these purposes to DMAS.
- DMAS shall be permitted to review and approve any additional representation (in written and oral form) of the exchanged data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA) and other pertinent federal and state laws.

Section X. Dental Data Exchange Project

DMAS Contact: DMAS Dental Contract Monitor, Health Care Services Division, Program Administration

VDH Contact: Maternal and Early Child Oral Health Coordinator and Dental Health Program Manager, Division of Child and Family Services, Office of Family Health Services

Purpose:

The purpose of this section is to provide for data exchanges between DMAS and VDH. Both agencies require the electronic exchange of data for purposes directly related to the administration of the State Plan for Medical Assistance. This section

provides for such data exchange regarding the provision of dental services to enrollees. VDH will use an IS application to plot the dental provider locations in Virginia (provider names will not be used). VDH will use the member and provider data to help identify provider shortage areas and to assist in the establishment of a dental home. In addition, the parties shall also exchange claims data submitted by non-dental providers for the treatment of fluoride varnish on Medicaid children under age 3. They use this information to help increase the number of non-dental providers who are trained to apply fluoride varnish.

Responsibilities:

DMAS shall provide to VDH Medicaid dental reimbursement data, to include the following:

Medicaid Provider NPI Number
Dentist License Number
Medicaid Location ID
Full Location Street Address [Street, City, Zip]
Physician First Name
Physician Middle Initial (if available)
Physician Last Name
Medicaid Member Count per Provider
Member First Name
Member Last Name
Member Age
Member Claim Count per Provider
Total Medicaid Dental Payments per Provider
All the locations where the Provider practices
EIN
Dental FTE per site
Total Medicaid FTE for each Dentist's Practice Location

Reimbursement:

N/A

Section XI. Payment for Virginia Birth Records

DMAS Contact: Analyst, Fiscal Division

VDH Contact: Director, Division of Vital Records, Office of Information Management

Federal Code Reference:

Title XIX, Sections 1902 (42 USC 1396a) and 1928 (42 USC 1396s) of the Social Security Act

State Code Reference:

12VAC30-40

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that current recipients and future applicants born in Virginia can be shown to have United States citizenship per §6036 of the Deficit Reduction Act of 2005 (DRA) through an allowed data match process.

Description:

To assist in the process of eligibility determination for Medicaid applicants/recipients, VDH, Division of Vital Records will perform searches for Virginia birth records upon a proper request from authorized Medicaid eligibility workers. Verification will be provided back to the requestor for those searches producing a valid Virginia birth record.

Planning and Coordination:

Each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

DMAS shall:

- Provide Medicaid reimbursement to the Business Associate for birth record verifications related to §6036 of the Deficit Reduction Act of 2005 (DRA). Reimbursement shall be monthly, or at an interval mutually agreed upon, and shall be determined on a fee schedule as follows:
 - For birth verifications where the authorized Medicaid eligibility worker provides the required information on the approved request form *with* a copy of a Virginia birth certificate or birth certificate number, DMAS will reimburse a fee of \$3.00 per search by the VDH Division of Vital Records.
 - For birth verifications where the authorized Medicaid eligibility worker provides the required information on the approved request form *without* a copy of a Virginia birth certificate or birth certificate number, DMAS will reimburse a fee of \$6.00 per search by the VDH Division of Vital Records.

VDH shall:

- Initiate the payment process through the electronic submission of reports to DMAS detailing the number of searched per month by type (described above).
- Maintain detailed records regarding requests for and execution of searches intended to provide birth verification for purposes of the determination of Medicaid eligibility.
- Allow DMAS or its agent access to detailed records (i.e. fax verification requests/responses) that verify and describe the birth verification searches performed by the Business Associate under this agreement.

Areas of Collaboration:

DMAS and VDH agree to:

- Provide technical assistance on policies, procedures, and services and their coordination on an as-needed basis.
- Participate in a workgroup to address challenges and issues faced in this area.
- Resolve any problems or issues that may arise concerning the effectiveness of this process.

Reimbursement:

DMAS shall reimburse VDH for services rendered as described above under "Responsibilities," in accordance with Method 2 Vendor Transactions as set forth by Section I of the Scope of Work Attachment.

Section XII. Pandemic Relief/ Anti-Viral Medication Tracking System

DMAS Contact: Information Technology Division Director

VDH Contact: Director of Pharmacy – Division of Pharmacy Services, Office of Epidemiology

Purpose:

The purpose of this section is to ensure the maintenance of an anti-viral medication dispensing tracking system in the DMAS Medicaid Management Information System (MMIS) for use in the event of a pandemic flu outbreak and to provide technical support for this system to users via an Interactive Voice Recorded (IVR)/operator call support center.

Responsibilities:

The Department of Medical Assistance Services created a program (the original specifications of the modifications to the MMIS that resulted in the development of this system are described in Information Service Request 2009-152-001-M) within the MMIS with the capacity to track the dispensing of anti-viral medications and to allow for reimbursement by VDH for the provision of said medications. If the system is put into effect, DMAS will send VDH monthly reports documenting medications dispensed, and VDH will reimburse DMAS for the cost of all claims processed. DMAS, acting in a liaison role, shall facilitate the maintenance of an IVR/operator technical call support center for users of this application. VDH will bear the responsibility for determining the scope of services provided and for any compensation due to the vendor for services rendered in association with this technical call support center.

The specifications for the IVR/operator technical call support center are attached. (See ATTACHMENT 1)

Reimbursement:

If the system is put into effect VDH will reimburse DMAS for the cost of all claims processed by DMAS for VDH at the per claim cost for pharmacy point of sale claims in effect at the time under DMAS' contract for MMIS fiscal agent services as

well as the cost of the claim if paid by DMAS on behalf of VDH. VDH will compensate the contracted vendor for all cost associated with the operation of an IVR/operator technical call support center for the anti-viral dispensing tracking system.

Section XIII. Oral Health Outreach to Gloucester WIC Members

DMAS Contact: Dental Contract Monitor

DentaQuest Contact: Member Outreach Coordinator

VDH Contact: Gloucester WIC Coordinator, Three Rivers WIC Coordinator – Community Health Services

Purpose:

The Medicaid Dental Benefit Administrator, (Dentaquest), staff will initiate a pilot project in the Gloucester WIC office to increase the proportion of children enrolled in Medicaid or CHIP who receive a preventive dental service who are also WIC participants in the pilot area. Increasing utilization of preventive dental services is a goal DMAS has established as a participant in the CMS Oral Health Learning Initiative.

Scope of Work:

DentaQuest will be looking at preventive service utilization rates in the pilot project area from Oct 2013-Oct 2014 to establish baseline information and then again from October 1, 2014 to October 30, 2015 to determine if outreach efforts and member education had a positive impact on the proportion of children who are enrolled in Medicaid and WIC.

DentaQuest will receive a list of Gloucester WIC members who participate in Medicaid and were enrolled from October 1, 2013 through October 30, 2014 and then another list of enrolled members from October 1, 2014 through October 30, 2015. Only the Medicaid members who participated in WIC in this area during both years will be a part of the pilot project and their claims data will be reviewed to determine if their oral health utilization rates/preventive services treatment increased as a result of targeted outreach by WIC and DentaQuest staff. WIC staff will be given oral health outreach materials and received training from Jackie Wake regarding the importance of oral health and the establishment of a dental home. Then WIC staff will distribute oral health materials and distribute an oral health survey to WIC participants. Consent to utilize participant's information will be a part of the survey. Jackie Wake will attend one WIC clinic per month to meet directly with WIC members. Jackie will also distribute oral health information directly to a limited number of members who are in attendance that clinic day and Jackie will also distribute the survey and get the signed consent. WIC participants Medicaid number, date of service, service treatment information (claims), dental provider's names and addresses will be reviewed to determine if oral health education by DentaQuest and WIC staff increased the targeted participant's utilization of dental services available through the Medicaid Smiles for Children dental program.

Duration:

The Period of Performance began March 1, 2014 and will continue through October 30, 2015 for the pilot project.

Responsibilities:

The Virginia Department of Medical Assistance Services/DentaQuest shall:

- Provide Oral Health Outreach Materials to WIC Clinic staff and WIC participants.
- Staff training regarding the importance of Oral Health and the establishment of a Dental Home.
- Provide Annual Report of Outreach Results.

The Gloucester WIC Clinic shall:

- Distribute Oral Health Outreach Materials to WIC participants.
- Distribute Oral Health Survey to WIC participants.
- Give DMAS/DentaQuest Gloucester WIC participants information from October 2013-October 2014 to establish baseline information and then again from October 1, 2014 to October 30, 2015.

Areas of Collaboration:

- WIC staff will assist DMAS/DentaQuest by distributing Oral Health Information and Oral Health Survey to WIC participants.
- DentaQuest Staff will train Gloucester WIC Staff Members and WIC Members on the importance of oral health and the establishment of a Dental Home.
- DentaQuest pilot project results will be shared with Gloucester WIC management staff.

Security and Confidentiality:

Any data provided by DMAS/DentaQuest to Gloucester WIC personnel pursuant to this agreement is subject to all applicable security and confidentiality limitations under federal and state laws and regulations.

Reimbursement:

N/A

Section XIV. Fatality Review and Surveillance

DMAS Contact: Maternal and Child Health Division Manager

VDH Contact: Program Manager, Fatality Review and Surveillance, Office of the Chief Medical Examiner

Purpose:

The purpose of this section is to assist in data collection and case review for fatality review and surveillance projects in the Office of the Chief Medical Examiner (OCME) of VDH:

- The State Child Fatality Review Team, established pursuant to § 32.1-283.1.
- Family and Intimate Partner Homicide Surveillance, established pursuant to § 32.1-283.3.
- The Maternal Death Surveillance and Maternal Mortality Review Team, conducted pursuant to § 32.1-40.
- The Virginia Violent Death Reporting System.
- The Adult Fatality Review Team, established pursuant to § 32.1-283.5.

The purpose of these projects is to generate public health information about decedents' injuries, diseases, and contacts with social service agencies that is more detailed and timely than is currently available. In return the OCME shall provide to DMAS results from maternal mortality surveillance reflecting the number of women who died who were recipients of services paid for by funds administered through.

Responsibilities:

The Virginia Department of Medical Assistance Services agrees to provide service and claims information including the names of agencies and providers of service for all persons receiving care on either a Fee for Service (FFS) or through a Medicaid Managed Care Organization (MCO). It is agreed that individual case information will be provided upon request, including Medicaid/FAMIS/FAMIS MOMS enrollment including dates of enrollment and FFS vs. MCO, claims information including DOS and provider contact leading up to date of death.

OCME will provide upon request from the results from maternal mortality surveillance reflecting the number of women who died who were recipients of services paid for by funds administered through DMAS.

Reimbursement:

N/A

Section XV. Virginia Medicaid Expedited Eligibility and Enrollment (E&E)

**DMAS Contacts: Information Technology Division, eHHR Program Director
Budget and Contracts Manager**

VDH Contacts: Director/CIO, Office of Information Management and Health IT

Purpose:

The purpose of this section is to set out the terms whereby DMAS can reimburse VDH for the costs incurred in successfully meeting the goals of the Virginia Medicaid Expedited Eligibility and Enrollment (E&E) version 2, Implementation - Advance Planning Document (I-APD) in:

- Establishing interfaces for eligibility and enrollment system workflow automation to the Enterprise environments such as Birth Reporting Interface (BRI), Death Reporting Interface (DRI), Immunization Registry Interface (IRI), and Rhapsody Connectivity (RC) Interfaces.
- Upgrading the existing VDH services/interfaces as necessary to national standards/implementation guides approved by HITSAC.
- Supporting a Publish/Subscribe model for automatic enrollment and disenrollment and electronic notifications of birth and date, respectively.

Description:

The timeline and the technical requirements VDH shall meet to develop these interfaces are described in Section 8: MITA Care Management Business Area Services - MITA Interfaces and Legacy Interfaces/Meaningful Use of the Virginia Medicaid Expedited Implementation Advanced Planning Document (I-APD) for Eligibility and Enrollment, which is incorporated by reference into this Agreement and made a part hereof.

These projects are a joint effort between DMAS and VDH and will be staffed with members from both agencies. DMAS will provide SOA enterprise staff and VDH will provide staff knowledgeable of current VDH systems for birth, death, and immunization systems. The project teams will jointly produce the following Software Development Life-Cycle documents: requirements, design, test plans/scenarios, test results, and implementation guide(s).

The costs shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS)-approved Implementation Advanced Planning Document (I-APD) for Eligibility and Enrollment.

Under this Agreement, VDH will function in a vendor relationship. VDH will provide time and effort, and materials and information to DMAS and report any staff/contract time and materials charged. Travel costs are non-reimbursable; all other costs including staff and contractor costs, equipment, supplies, materials, and training will be reimbursed from Section 8 - MITA Care Management Business Area Services of DMAS' CMS approved I-APD for Eligibility and Enrollment for a total amount not to exceed \$1,696,960 as broken down in the table below:

| VDH Budget - Care Management Business Area Services (Oct 1, 2012 - Mar 31, 2016) | | | |
|--|--|-------------|--------------------|
| # | E&E I-APD Funded Projects | Fund Source | Program Cost |
| | | | TOTAL |
| 1 | Section 8. MTA Care Management Business Area Services - MTA Interfaces - Death Reporting Interface (DRI) | E&E/CHIP | \$286,520 |
| 2 | Section 8. MTA Care Management Business Area Services - Birth Reporting Interface (BRI) | E&E/CHIP | \$288,520 |
| 1 | Section 8. MTA Care Management Business Area Services - Interfaces/ Meaningful use - Immunization Registry Interface (IRI) | E&E/CHIP | \$499,920 |
| | Section 8. MTA Care Management Business Area Services - Logic Interfaces/ Meaningful use - Rhapsody Connectivity (RC) | E&E/CHIP | \$624,000 |
| Total Program Costs | | | \$1,698,960 |

DMAS will hire or utilize existing full-time, classified as well as non-classified positions in order to meet the goals described above within the budget approved by CMS. Some of these personnel include an Agency Project Technical Lead and an Agency Project Business SME. The salaries of these personnel will be allocated based on the percentage of time spent on the Care Management business area services described above.

Responsibilities:

DMAS agrees to the following:

- DMAS will assume responsibility for creating all full-time, classified and non-classified positions for the Enterprise Development and Implementation.
- DMAS will assume responsibility for the supervising, monitoring and evaluating of these personnel.

VDH agrees to the following:

- VDH shall assume responsibility for creating all full-time, classified and non-classified, positions for any changes in existing VDH systems.
- VDH shall provide DMAS with monthly and annual updates on financial expenditures as it relates to position funding.

Reimbursement:

- Payments shall be made in accordance with Method 2 Vendor Transactions as set forth by Section I of the Scope of Work Attachment and to the following:
- VDH shall submit invoices monthly to DMAS via Interagency Transfer (IAT) Form directed to:

Dave Mix
 eHHR Program Manager
 Department of Medical Assistance Services
 600 East Broad Street, Suite 1300
 Richmond, Virginia 23219

- DMAS agrees to reimburse VDH for the costs incurred in establishing the Death Reporting Interface (DRI), Birth Reporting Interface (BRI), Immunization Registry Interface (IRI), and the Rhapsody Connectivity Interface (RC) to the enterprise environments, from Section 8 of DMAS' CMS-approved I-APD for Eligibility and Enrollment, for the period from October 1, 2012 to March 31, 2016.

DMAS has authority under this Agreement to withhold payment of any invoice for work which DMAS determines fails to comply with the requirements of Section 8 of the I-APD.

- All invoices submitted by VDH should be broken down by the projects worked upon in the description field of the Miscellaneous Services Invoice Detail Report such as:

E&E VDH Death Reporting Interface (DRJ)
E&E VDH Birth Reporting Interface (BRI)
E&E VDH Immunization Registry Interface (IRI)
E&E VDH Rhapsody Connectivity Interface (RC)

- All invoices submitted by VDH shall include adequate supporting documentation to support confirmation of goods purchased or services provided.
- Payment date will be 30 days after receipt of a DMAS-approved invoice. DMAS will process an expenditure IAT comprised of total expenditures, including both general funds and federal funds, in accordance with the Department of Accounts' Commonwealth Accounting Policies and Procedures (CAPP) Topic No. 20405 using the CFDA Number of #93.778 for Medicaid and #93.767 for CHIP. DMAS will seek federal reimbursement from the Centers for Medicare and Medicaid Services (CMS) based on Section 8 of DMAS' CMS-approved I-APD for Eligibility and Enrollment.
- VDH shall collect, record, and maintain documentation, and an audit trail that supports expenses related to carrying out the provision of the amendment. VDH shall maintain cost documentation for three years. If auditing agents (e.g. Auditor of Public Accounts or Centers for Medicare and Medicaid) question costs associated with this activity, then they will need to contact VDH directly for additional backup and verification. VDH must provide supporting documentation and verification upon request.

Section XVI. Cost Sharing Agreement for ACA Special Projects (IAG #001-05, Project# 70069)

DMAS Contact: Special Projects Director, Contracts Manager

VDH Contact: Business Manager - Office of the Commissioner

Purpose

The purpose of this section is to set out the terms whereby DMAS will reimburse VDH the salary and fringe amounts that exceed \$20,000 that relate to Jodi Manz's serving as Special Projects Manager for both the Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance and Increase of outreach and education regarding the ACA's health insurance coverage opportunities through the expansion of in-person assistance resources Section 1311 of the Affordable Care Act Health Insurance Exchange Grants.

Scope of Work:

Special Projects Manager tasks include:

- Drafting of internal, State and Federal documents to align and implement Administration enrollment priorities with Affordable Care Act directives and goals.
- Communicating with stakeholder and contractor agencies regarding Federal guidance, data, Administration priorities, events, reports, and other information that filters between and among governmental (Federal, Virginia, and other States) and non-governmental agencies.
- Communicating enrollment activity and data to Secretary and Administration and aligning policy priorities with Federal grant guidelines.
- Serving as a liaison for development, creation, and movement of paid marketing campaign for Cover Virginia during Federal Marketplace open enrollment period.
- Strategically planning for future enrollment activities and resources in Virginia, including but not limited to marketing, stakeholder management, assister activity, sustainability, and potential changes to the Federal Marketplace and Virginia's status as a Federally Facilitated Marketplace (FFM) State, per Administration direction.
- Coordinating with Medicaid/Family Access to Medical Insurance Security (FAMIS) programs for Cover Virginia activities and functions, social media, application alignment and

data, and local enrollment activity through the Federal Marketplace as it relates to local Department of Social Services workers.

Reimbursement:

- In accordance with the provisions of 2 CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart D—Post Federal Award Requirements §200.330 Subrecipient Monitoring and Management, this represents a contractor relationship between DMAS and VDH.
- VDH shall submit electronic invoices monthly to DMAS via Interagency Transfer (IAT) Form to:

Budget & Contacts Management Division
BCMInvoices@dmavirginia.gov

- All invoices submitted by VDH shall include notation of Project #70069.
- All invoices submitted by VDH shall include adequate supporting documentation to support confirmation of goods purchased or services provided. If sufficient documentation does not accompany the invoice(s), DMAS will return the invoice(s).
- DMAS agrees to reimburse VDH the salary and fringe amounts that exceed \$20,000 that relate to Jodi Manz, Special Projects Manager – Governor's Office.
- DMAS will process the invoice in accordance with the relationship established in accordance with the provisions of 2 CFR Title 2, Subtitle A, Chapter II, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) including Subpart D—Post Federal Award Requirements §200.330 Subrecipient Monitoring and Management; and the Department of Accounts' Commonwealth Accounting Policies and Procedures (CAPP) Manual - Cardinal Topic No. 20405 using the CFDA Number of #93.525 for the following grants:
 - Section 1311 of the Affordable Care Act, Health Insurance Exchange Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance
 - Section 1311 of the Affordable Care Act, Health Insurance Exchange, Increase of outreach and education regarding the ACA's health insurance coverage opportunities through the expansion of in-person assistance resources

DMAS will seek federal reimbursement from the Centers for Medicare and Medicaid Services (CMS) based on IAT's and supporting documentation.

- Payment date will be 30 days after receipt of a DMAS-approved invoice. DMAS will record the transaction using cost center 074 and 076, and Project #70069.
- VDH shall collect, record, and maintain documentation, and an audit trail that supports expenses related to carrying out the provision of the amendment. VDH shall maintain cost documentation for three years. If auditing agents (e.g. Auditor of Public Accounts or Centers for Medicare and Medicaid) question costs associated with this activity, then they will need to contact VDH directly for additional backup and verification. VDH must provide supporting documentation and verification upon request.

ATTACHMENT 1:

**VDH/DMAS Interagency Agreement
Section XII. Pandemic Relief/Anti-Viral Medication Tracking System
IVR/Operator Technical Support Call Center Specifications**

SCOPE OF WORK:

- 1) Establish a dedicated toll free phone number for the Pandemic Antiviral Program.
 - a) Establish human call scripts to address the 5 claims issues defined below.
 - b) Establish and implement Interactive Voice Response (IVR) call scripts to address the 5 claims issues defined below.
 - c) Implement an IVR to allow automated call response. The message will include the Virginia Department of Health Toll Free phone number should the caller wish to contact.
 - d) Validate all Member and NDC codes are resident in the Virginia MMIS and are configured properly.
 - e) Establish reports from the call switch to provide the number of calls weekly and the average response time.
 - f) Develop training materials to be used to train staff initially to support the 24 hours per day x7 days per week operation.
- 2) In the event the call center is enacted, the Contractor will perform the following task:
 - a) Train up to 12 call center staff representing different work shifts to ensure 24 hours per day x7 days per week coverage. It is expected that refresher training will be required at the time of a pandemic.
- 3) The Contractor will advise callers on the following claims issues:
 - a) Pandemic-specific recipient ID numbers to be used.
 - b) Antiviral NDC codes to be used.
 - c) Medication quantity limits.
 - d) Medication days' supply limits.
 - e) Appropriate BIN number to be used for claims submission.
- 4) All calls will be received by the Interactive Voice Response (IVR) unit.
 - a) The callers may opt to speak to a live operator once the IVR answers the call.
 - b) The callers will be presented the OEpi Toll Free number for issues or questions not requiring technical claims submission assistance.
- 5) The Contractor will provide call tracking reports weekly to document the number of calls and the average response time (time to answer).
- 6) The Contractor will establish a training program to be used to initially train up to 12 operators representing different work shifts. The same training program will be kept "on the shelf" and retraining will occur as necessary once a pandemic episode begins.
- 7) The OEpi Antiviral call center will be operational 24 hours a day, 7 days a week including holidays.
- 8) The OEpi Antiviral call center will be operational within 48 hours of being notified by OEpi to activate the call center.
- 9) In the event of a large call volume dictated by a pandemic that requires additional call center support, the Contractor reserves the right to distribute calls across call centers located in the United States to ensure contractual needs are met.

ATTACHMENT 2:

**eHHR Enhanced Memorandum
of Understanding (E-MOU)**

Version Date: April 2, 2014

List of Appendices and Attachments

- Appendix 1** **Procedures for Adding a New Partner, Suspending a Partner and Termination of a Partner**
- Appendix 2** **Process to Amend the eHHR Enhanced MOU**
- Appendix 3** **Change Process for Data Exchange Services**
- Appendix 4** **Procedures for Breach Notification**
- Appendix 5** **Requirements for Data Exchange Services**
- Appendix 6** **New Partner Testing and Validation Requirements**

1 **eHHR Enhanced Memorandum of Understanding (E-MOU)**

2
3 **WITNESSETH:**

4
5 WHEREAS, the Secretaries of Health and Human Resources, Technology, and Transportation desire
6 to establish the eHHR Enhanced Memorandum of Understanding ("E-MOU") with the goal of enhancing the
7 security of data maintained and exchanged by the participating agencies for the benefit of the
8 Commonwealth of Virginia and individuals participating in programs operated by agencies under these
9 Secretariats;

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11
12 WHEREAS, the participating agencies desire to securely exchange data as permitted or required by
13 applicable law in order to increase the efficiency and effectiveness of programs operated by the agencies for
14 the benefit of the Commonwealth of Virginia and individuals participating in such programs;

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16 WHEREAS, the participating agencies agree to comply with this E-MOU and its supporting
17 appendices adopted with the goal of promoting and supporting the secure exchange of data. This E-MOU is
18 not intended to preempt in any manner or presume any statutory duties or authority granted to the
19 participating agencies. Rather, the participating agencies enter into this E-MOU to enable their voluntary
20 participation in the Data Exchange, as set forth below;

21
22 WHEREAS, as a condition of participating in the Data Exchange, each participating agency voluntarily
23 agrees to sign this E-MOU; comply with all applicable law and the policies, standards, and guidelines of the
24 Partners and the Coordinating Committee; and either abide by the decisions of the Coordinating Committee
25 or chose to unilaterally and voluntarily terminate their participation in the Data Exchange;

26
27 NOW, THEREFORE, for and in consideration of the mutual covenants herein contained, the
28 participating agencies hereto mutually agree to the provisions set forth in this E-MOU.

29
30 1. **Definitions.** For the purposes of this E-MOU, the following terms shall have the meaning ascribed to
31 them below. All defined terms are capitalized throughout this E-MOU.

32
33 a. **Applicable Law** shall mean all applicable federal and state laws and regulations.

34
35 b. **Applicant** shall mean potential Partner new to the Data Exchange. On-boarding new
36 partners shall be in accordance with Appendix 1, Section 1 of this E-MOU.

37
38 c. **Authorization** shall have the meaning and include the requirements set forth at 45 CFR
39 § 164.508 and include any similar but additional requirements under Applicable Law,
40 including Virginia Code § 32.1-127.1:03(G). Authorization shall be confirmed by
41 execution of the Uniform Authorization to Exchange Information form or some other
42 written authorization that meets the requirements of Applicable Law that applies to the
43 Agency providing the data.

44
45 d. **Breach** shall mean all known incidents that threaten the security of the
46 Commonwealth's databases and data communications resulting in exposure of data
47 protected by federal or state laws, or other incidents compromising the security of the
48 Commonwealth's information technology systems with the potential to cause major
49 disruption to normal agency activities.

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51 e. **Changes** shall mean Developmental Changes and Compliance Changes. Changes shall be
52 managed in accordance with Appendix 3 of this E-MOU.

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- f. **Citizen** shall mean an individual whose personal information is maintained by a participating agency and subject to exchange with participating agencies.
- g. **Common Partner Resources** shall mean software, utilities and automated tools made available for use in connection with the exchange of Data pursuant to this E-MOU and which have been designated as "Common Partner Resources" by the Coordinating Committee. Partners that make resources available to be shared are responsible for ensuring compliance with Applicable Laws and Vendor licensing requirements.
- h. **Commonwealth Authentication Service** shall mean the enterprise solution developed by the Virginia Department of Motor Vehicles for the purpose of validating a Citizen's identity and assigning credentials based on the Citizen's validated identity.
- i. **Data** shall have the same meaning as "personal information" set forth in Virginia Code § 2.2-3801 when dealing with information about a Citizen.
- j. **Data Exchange Service** shall mean software programs that serve to securely and safely share data between approved Partners. Requirements for Data Exchange Services are defined in Appendix 5 of this E-MOU.
- k. **Data Request** shall mean a request for data made by one Partner to another and defined by an approved E-MOU Specification.
- l. **Data, Test** shall mean Data created by a Partner in accordance with the Validation Plan and used by the Partner, or by other Partners, for Testing purposes in a Test environment. Test Data in a Test environment shall not contain personally identifying information.
- m. **Data Transmittal** shall mean an electronic exchange of Data between Partners using agreed upon Specifications.
- n. **Digital Credentials** shall mean a mechanism, such as a public-key infrastructure, that enables Partners to electronically prove their identity and their authority to conduct data transmittal with other Partners.
- o. **Discloser** shall mean a Partner that discloses Data to another Partner through a transmittal in any format.
- p. **Dispute or Disputed Matter** shall mean any controversy, dispute, or disagreement arising out of or relating to this E-MOU.
- q. **Effective Date** shall mean the date of execution of this E-MOU, as recorded by the Coordinating Committee.
- r. **Emergent Specifications** shall mean the technical specifications that existing and/or potential Partners are prepared to implement to test the feasibility of the Specifications, to identify whether the Specifications reflect an appropriate capability for the Partners,

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and assess whether the Specifications are sufficient to add as a production capability available to the Partners.

- s. **Information Technology Service Provider or ITSP** shall mean a company or other organization that will support one or more Partners by providing them with operational, technical, or information technology services.
- t. **Notice or Notification** shall mean a written communication, unless otherwise specified in this E-MOU, sent to the appropriate Partner's representative, at the address listed with the Coordinating Committee, in accordance with the other policies and procedures attached to this E-MOU.
- u. **Operational Measures or Operational Data** shall mean information pertaining to the volume and performance of Data Transmittals pursuant to this E-MOU; such as activity counts, performance measures, uptime metrics, error rates, connection metrics and other indicators of activity. It does not include citizen specific data.
- v. **Partner** shall mean any agency that is a signatory to this E-MOU.
- w. **Partner Access and Disclosure Policies** shall mean those policies and procedures of a Partner that govern a User's ability to access, exchange, and transmit Data using the Partner's System, including privacy and security policies.
- x. **User** shall mean any person who has been authorized to conduct Data Transmittal through the respective Partner's System in accordance with the Partner's Access and Disclosure Policies and Applicable Law.
- y. **Recipient** shall mean the Receiving Partner(s) that receives Data through a Data Transmittal from a Discloser.
- z. **Specifications** shall mean the Specifications established by Applicable Law or adopted by the Coordinating Committee that prescribe the Data content, technical, and security requirements needed to enable the Partners to Transmit Data. Specifications may include, but are not limited to, specific standards, services, and policies applicable to Data Transmittal pursuant to this E-MOU. The specification requirements are attached hereto as Appendix 5, and may be amended in accordance with Appendix 3. This E-MOU shall not be deemed to supersede any Partner's obligations (if any) to comply with Specifications promulgated or established by the Secretary of Technology and the Commonwealth's Chief Information Officer pursuant to § 2.2-225 and § 2.2-2007 of the *Code of Virginia*.
- aa. **System** shall mean the software, portal, platform, or other electronic medium controlled by a Partner through which the Partner conducts its Data Transmittal related activities. For purposes of this definition, it shall not matter whether the Partner controls the software, portal, platform, or medium through ownership, lease, license, or otherwise.
- bb. **Testing** shall mean the tests and demonstrations of a Partner's System and processes used for interoperable Data Transmittal to assess conformity with the Specifications and Validation Plan.

151 **cc. Transmit, Transmittal or Transmitting** shall mean, in varying tenses, to disclose Data
152 electronically using the Specifications.
153

154 **dd. Validation Plan** shall mean the framework for Testing and demonstrations for parties
155 seeking to become Partners. The Validation Plan is attached hereto as part of Appendix
156 6, and as amended in accordance with Appendix 3.
157

158 2. **Coordinating Committee.**
159

160 **a. Formation of the Coordinating Committee.** To support secure Data Transmittal, the
161 Partners agree to establish a Coordinating Committee, which shall develop the
162 Specifications, including Emergent Specifications, with which the Partners shall comply
163 in Transmitting Data pursuant to this E-MOU.
164

165 **b. Composition of the Coordinating Committee.** The Coordinating Committee shall be
166 composed of Agency Heads or their designees from each of the Partner agencies. A
167 majority of voting Committee members shall select a Committee Chairman from among
168 the voting members of the Committee to serve an annual term coinciding with the
169 Effective Date of this E-MOU. A Committee Chairman can serve successive terms.
170

171 **c. Staff Support for Coordinating Committee.** The Partners agree to designate support
172 staff from their own agencies as required to provide a sufficient degree of support
173 needed to carry out the activities of the Coordinating Committee as described in Section
174 3 and throughout this E-MOU.
175

176 **d. Recorder - Role.** The Recorder shall serve the Coordinating Committee by facilitating
177 and archiving requests made by the Partners. For example: administering on-boarding
178 requests from new Partners to join the Data Exchange; distributing Suspension or
179 Termination notifications to Partners; coordinating requests to amend this E-MOU and
180 administering requests to change Data Exchange Services. Unless otherwise noted in
181 this E-MOU, the Recorder shall be the primary point of contact for the Coordinating
182 Committee; receiving and sending communications on behalf of the body.
183

184 **e. Recorder - Selection and Term.** A majority of the voting Committee members shall
185 select the Recorder from among the voting members of the Committee. The duties of the
186 role may be delegated to a staff member of the elected Partner. The Recorder serves a
187 term of one year and can serve successive terms.
188

189 **f. Subcommittees.** The Chairman of the Coordinating Committee shall be authorized to
190 form subcommittees to support Data Transmittal pursuant to this E-MOU.
191 Subcommittees shall consist of one (1) representative from each of the Partner
192 agencies, as designated by the Agency Head. Subcommittee members may include the
193 agency Chief Information Officers (CIO), Information Security Officers (ISO) or other
194 designee, as determined by the Agency Head.
195

196 **g. Auditor of Public Accounts Representative.** The Auditor of Public Accounts may
197 appoint an ex-officio, non-voting representative to serve on the Coordinating
198 Committee.
199

- 200 3. **Coordinating Committee Responsibilities.** The Partners agree that the Coordinating
201 Committee will conduct the following activities:
202
- 203 a. Maintaining a list of all E-MOU Partners, their designated representative(s) and their
204 preferred contact information where they can be reached. Such contact information
205 shall be made accessible by the Coordinating Committee to all E-MOU Partners by
206 posting on a website. The Coordinating Committee shall request that VITA maintain a
207 website that is accessible to all E-MOU Partners, Members of the Coordinating
208 Committee, and any other stakeholders that the Coordinating Committee determines
209 shall have access. Initially, this information will be deployed under the eHHR site at
210 <https://dssshare.virginia.gov/sites/eHHRprogram>;
211
 - 212 b. Receiving reports of Breaches, notifying Partners of Breaches, receiving confirmation
213 from Partners when the security of their Systems have been restored after Breaches,
214 and notifying Partners when all issues leading to a Breach have been resolved.
215 Notification of a Breach to the Coordinating Committee does not relieve the Partner of
216 its responsibilities under Applicable Law, including required notifications that a Breach
217 has occurred;
218
 - 219 c. Suspending or terminating Partners in accordance with Appendix 1 of this E-MOU;
220
 - 221 d. Resolving Disputes between Partners in accordance with this E-MOU;
222
 - 223 e. Managing the amendment of this E-MOU in accordance with Appendix 2 of this E-MOU;
224
 - 225 f. Developing, evaluating, prioritizing, and adopting Specifications, including Emergent
226 Specifications, changes to such Specifications and the artifacts required by the
227 Validation Plan in accordance with Appendix 5 and Appendix 6 of this E-MOU. Any
228 Specifications developed shall be consistent with Applicable Law, any data or technical
229 standards for information technology adopted by VITA Data Governance, the Secretary
230 of Technology, and any policies, procedures, and standards developed by the
231 Commonwealth's Chief Information Officer for the protection of Data;
232
 - 233 g. Maintaining a process for managing versions of the Specifications, including migration
234 planning;
235
 - 236 h. Evaluating requests for the Introduction of Emergent Specifications into the Production
237 environment used by the Partners to Transmit Data;
238
 - 239 i. Coordinating with VITA Data Governance, the Secretary of Technology and
240 Commonwealth's Chief Information Officer to ensure the interoperability of the
241 Specifications with other Health and Human Resources initiatives regarding data
242 exchange including, but not limited to, providing input into Information Technology
243 Resource Management policies, standards and guidelines;
244
 - 245 j. Performing impartial review of Partners compliance with the Specifications as defined
246 in Appendix 5 of this E-MOU; and
247
 - 248 k. Fulfilling all other responsibilities delegated by the Partners to the Coordinating
249 Committee as set forth in this E-MOU.