



COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

April 10, 2013

Dear Prospective Offeror:

The Department of Medical Assistance Services (DMAS or the Department) is soliciting proposals from managed care plans (plans) to enter into risk-based contracts for the capitated model under the Medicare-Medicaid Financial Alignment Demonstration (also referred to as the Demonstration). The Center for Medicare and Medicaid Services' (CMS) authority for approving the Demonstration is set out in the Patient Protection and Affordable Care Act of 2010 and authorized under Section 1115A of the Social Security Act¹. Specific details about this procurement are in the enclosed Request for Proposals (RFP) 2013-05.

The Demonstration requires compliance with Title XIX of the Social Security Act and Medicaid regulations set forth in 42 CFR Chapter IV², Part C of Title XVIII³ and Medicare Advantage regulations set forth in 42 CFR part 422⁴, and Part D of Title XVIII⁵ and Medicare Part D regulations set forth in 42 CFR part 423⁶, except to the extent that waivers and variances are approved (any approved waivers and variances will be documented in the Memorandum of Understanding (MOU) between CMS and DMAS). Under the Demonstration, States, CMS, and participating plans will enter into three-way contracts through which the plans will receive a blended capitated rate for the full continuum of Medicare and Medicaid benefits provided to dual eligible individuals. Demonstrations will last three years, unless terminated earlier as provided for in section 1115A of the Social Security Act, the Memorandum of Understanding, and the three-way contract.

As outlined in this Request for Proposals 2013-05, pending final approval and execution of a MOU between CMS and DMAS, the participating plans shall deliver all covered services through a person-centered, integrated delivery system to individuals age 21 and over who are enrolled in Medicare Parts A, B, and D, and full-benefit Medicaid, including dual eligible individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities. The participating plans shall cover at a minimum, all services currently covered by Medicare, Medicaid wrap-

¹ http://www.ssa.gov/OP_Home/ssact/title11/1115A.htm.

² http://www.ssa.gov/OP_Home/ssact/title19/1900.htm.

³ http://www.ssa.gov/OP_Home/ssact/title18/1800.htm.

⁴ http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr422_main_02.tpl.

⁵ http://www.ssa.gov/OP_Home/ssact/title18/1800.htm.

⁶ http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr423_main_02.tpl.

around services, nursing facility services, home and community-based long-term services and supports provided under the Medicaid EDCD Waiver, and Medicaid-covered behavioral health services.

In addition to submitting a proposal through this RFP process, plans must also respond to and meet CMS requirements for participation in the Demonstration. CMS' Demonstration requirements and qualifications are outlined in the following CMS guidance documents:⁷

- The CMS January 25, 2012 memo, "Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans."⁸
- The March 29, 2012 CMS memo, "Additional Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans."⁹
- The January 9, 2013 CMS memo, "2014 Capitated Financial Alignment Demonstration Timeline."¹⁰
- The 2014 Capitated Financial Alignment Demonstration Application and other guidance materials.¹¹

Interested plans should be aware that in addition to responding to this RFP, plans must also submit information through the CMS Health Plan Management System (HPMS). To participate as a Demonstration plan in Virginia, plans must meet all CMS Demonstration requirements and be selected through the DMAS RFP process. CMS HPMS submissions will be evaluated as part of this RFP, including but not limited to, the medical provider and pharmacy networks. DMAS' review of information submitted through the HPMS will be distinct from, but informed by, CMS' review. Plans may also be required to respond to items in this RFP that mirror information that plans are required to submit through the HPMS, such as the Model of Care. Interested plans must provide consistent responses where applicable; however, state evaluation and scoring of the Model of Care will be based on the Model of Care submitted in response to this RFP.

The Department and CMS will implement the Medicare-Medicaid Financial Alignment Demonstration in Central Virginia, Northern Virginia, Roanoke, Tidewater and Western/Charlottesville regions, pending CMS approval. Implementation will be phased-in. Prospective plans may submit proposals for one or more Demonstration region(s). Prospective plans must cover all eligible individuals in all localities within the region(s) in which they intend to participate.¹² Plans do not need to submit a separate proposal for each region. However, proposals should clearly indicate which region(s) the plan wishes to participate in. Plans will be selected through both the DMAS and CMS plan selection processes. The Department anticipates that it will enter into three-way contracts with CMS and a minimum of two plans in each region. Selected plans are not required to participate with the Virginia Medicaid Medallion II or

⁷ The Memorandum of Understanding, CMS guidance documents, and/or legal/regulatory requirements, supersede the RFP if any areas of conflict exist.

⁸ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf>.

⁹ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf>.

¹⁰ http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_PlanGuidance01092013.pdf.

¹¹ https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_MMP_Application.pdf.

¹² The only exception to this statement is in the Tidewater region. Please see Appendix A for further information.

FAMIS programs in order to be eligible to contract under the Demonstration. **Proposals are due to the Department no later than 10:00 a.m. on May 15, 2013.** CMS is no longer accepting proposals from MCOs for this Demonstration.

Specific details about this RFP process are in the enclosed document, RFP 2013-05. DMAS will provide a data book containing fee-for-service expenditures for the eligible population, including data from calendar years 2009 and 2010. This data book will include Medicaid data and may include Medicare data. The data book is on track for distribution to Offerors in mid-April. Plans must check the DMAS web site at http://www.dmas.virginia.gov/Content_pgs/alte-enrl.aspx for any addenda, notices, or data. DMAS will also post the information on the eVA web site at <http://www.eva.virginia.gov> but the DMAS web site will serve as the official and controlling posting site. Please hold June 10 and 11 for proposal presentations on the vignettes included in this RFP. DMAS will reach out to Offerors within the next several weeks to schedule these one-hour presentations.

IMPORTANT NOTE: All of the specifications and terms in the RFP 2013-05 are based on the most current information available to the state at the time of publication and are subject to change and dependent on final approval and execution of a Memorandum of Understanding between DMAS and CMS. Specifications and terms will be finalized during the Memorandum of Understanding process and completion of the three-way contract between CMS, DMAS and participating plans.

Neither DMAS nor CMS shall pay any costs that any plan incurs in preparing a proposal. DMAS reserves the right to reject any and all proposals received.

All issues and **questions related to this RFP should be submitted in writing by April 19, 2013**, to the attention of Karen Kimsey, Deputy Director, Complex Care and Services, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that plans submit any questions or issues by email in MS Word format to DualIntegration@dmas.virginia.gov When submitting questions or comments to this mailbox please identify your inquiry as related to RFP 2013-05.

Thank you for your continued interest in Virginia's Demonstration. Please continue to check our website, http://www.dmas.virginia.gov/Content_pgs/alte-enrl.aspx, for any updates on the progress of the Demonstration.

Sincerely,

Christopher Banaszak
DMAS Contract Manager

Enclosure

**REQUEST FOR PROPOSALS
RFP 2013-05**

Issue Date: April 10, 2013

Title: Medicare-Medicaid Alignment Demonstration

Contract Period: An initial period of one (1) year from date of award, with provisions for two (2) additional one (1) year terms for a total of three (3) years.

All inquiries should be directed in writing via email in MS Word Format to DualIntegration@dmas.virginia.gov When submitting questions or comments to this mailbox please identify your inquiry as related to RFP 2013-05.

Karen Kimsey, Deputy Director, Complex Care and Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Deadline for submitting inquiries: 5:00 PM local time on April 19, 2013

Proposal Due Date: Proposals will be accepted until 10:00 AM local time on May 15, 2013.

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

“RFP 2013-05 Sealed Proposal”
Department of Medical Assistance Services
Attention: Christopher Banaszak
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Facsimile transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, §2.2-4343.1 (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-4343.1>) or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this RFP and pursuant to all conditions imposed herein or incorporated by reference, the undersigned proposes and agrees to furnish the services contained in its Proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone:	Date Signed
Fax Number:	E-Mail:
State Corporation Commission ID Number (Required) :(See Special Terms and Conditions)	SCC ID #:
Check Applicable Status: Corporation: _____ Partnership: _____ Proprietorship: _____ Individual: _____ Woman Owned: _____ Minority Owned: _____ Small Business: _____ If Department of Minority Business Enterprises (DMBE) certified, provide certification number: _____	

Submit this completed form with Proposal under Required Forms

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
REQUEST FOR PROPOSALS
FOR
THE MEDICARE-MEDICAID ALIGNMENT DEMONSTRATION
RFP 2013-05
ISSUED: April 10, 2013

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SECTION I: INTRODUCTION

1.1 Introduction

The Centers for Medicare & Medicaid Services (CMS) is the federal agency under the Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs under Titles XVIII (http://www.ssa.gov/OP_Home/ssact/title18/1800.htm) and XIX of the Social Security Act (http://www.ssa.gov/OP_Home/ssact/title19/1900.htm). The Department of Medical Assistance Services (DMAS) hereinafter referred to as the Department or DMAS, is the single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act. These programs are financed by both Federal and State funds and are administered by the State according to Federal guidelines.

DMAS is hereby soliciting proposals from managed care plans to enter into risk-based contracts for the Medicare-Medicaid Financial Alignment Demonstration to provide Medicare and Medicaid covered services through an integrated care delivery system to individuals age 21 and over who are enrolled in Medicare Parts A, B, and D, and are also receiving full-benefit Medicaid (“dual eligible individuals”), including dual eligible individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) home-and-community-based services waiver program and those residing in nursing facilities (NFs). The Demonstration will be implemented in Central Virginia, Northern Virginia, Roanoke, Tidewater and Western/Charlottesville (see Appendix A for Demonstration Regions and Localities). Implementation will be phased-in. Prospective plans may submit proposals for one or more Demonstration region(s). Plans do not need to submit a separate proposal for each region. However, proposals should clearly indicate in which region(s) the plan is wishing to participate. Prospective plans must submit proposals for all eligible individuals in all localities included in the region(s) in which they intend to participate. The Department and CMS anticipate contracting with at least two plans in each region. Following evaluation of the proposals received, the Department and CMS will enter into three-way contracts with the participating plans in each region.

Each participating plan must have the legal capacity to enter into a contract with the Department and CMS, and have current certificates of authority to operate in the Commonwealth of Virginia, as determined by the Virginia Bureau of Insurance and the Virginia Department of Health.

Proposals should be thorough, concise and include sufficient detail to allow DMAS to properly evaluate the plan’s capacity, capability and relevant experience to perform the work contained within the Request for Proposals (RFP). Plans also must demonstrate the financial capacity and relevant expertise necessary to undertake the services required by this RFP. Participating plans shall assume full financial risk for developing and managing a care delivery system that will administer or arrange for the provision of covered Medicare and Medicaid benefits. In addition, each participating plan must demonstrate the capacity to provide person-centered care management that integrates medical and social models and that is appropriate to the needs of the enrolled population.

CMS and the State expect this model of integrated care and financing to, among other things, improve quality of care and reduce health disparities, meet both health and functional needs, and improve transitions among care settings. Meeting beneficiary needs, including the ability to self-direct care, be involved in one’s care, and live independently in the community, are central goals of this Demonstration. Successful plans will demonstrate the ability to consistently meet these objectives and will be evaluated, in part, by the degree to which the plan shows how it will achieve them. Participating plans shall comply with all applicable administrative rules and the Department’s and CMS’ written regulations, policies and procedures, as amended.

1.2 Background

Dual eligible individuals have some of the most complex care needs of any individuals who receive Medicaid or Medicare benefits, yet the current delivery system for this population strains, unevenly and inefficiently, to meet those needs. Nationally, dual-eligible beneficiaries comprise 21 percent of the Medicare population, but 31 percent of total Medicare costs, and 15 percent of the Medicaid population, accounting for 39 percent of total Medicaid costs (Jacobson et al. 2012; Young et al. 2012). The Demonstration seeks to make available comprehensive Medicare and Medicaid covered services which address individuals' full range of health and functional needs under one integrated system of service delivery. Participating plans will deliver the services in a setting of integrated care management through an interdisciplinary care team. Within this Model of Care, participating plans will have significant flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.

The Demonstration will employ a payment structure that aligns the incentives between Medicare and Medicaid. DMAS and CMS will combine Medicaid and Medicare funding using a blended global financial arrangement to provide integrated, comprehensive care for individuals enrolled in the Demonstration. Plans will employ or contract with primary care providers (PCPs) who work with Interdisciplinary Care Teams (ICTs) to arrange for care and services by specialists, hospitals, and providers of long-term services and supports (LTSS) and other community supports.

Integration of Medicare and Medicaid will, to the extent reasonably possible, extend to all administrative processes, including, but not limited to marketing, outreach and education functions, Demonstration oversight, customer service, quality, appeals and grievances, and financial accountability. DMAS and CMS will monitor plans' performance using a meaningful set of quality metrics. Enrollment in the Demonstration will be voluntary and will be supported by clear, useful and accessible information and facilitated by a neutral and impartial enrollment facilitator. Eligible members who do not express a preference regarding enrollment will be assigned by DMAS to a participating plan serving the locality in which the member resides. Enrollees will have the ability to change plans or opt out of the Demonstration at any time. DMAS wishes to preserve relationships between enrollees and eligible providers and where possible, will require that participating plans conduct outreach to current providers serving the target population and continually enroll new providers.

1.3 Federal Authority

CMS' authority for the Demonstration is set out in the Patient Protection and Affordable Care Act of 2010 and authorized under Section 1115A of the Social Security Act.¹³ The Department is seeking federal approval of the Demonstration from CMS via a §1932(a) State Plan Amendment and an amendment to the §1915(c) EDCD Waiver.

1.4 Plan Selection Process

Participating plans will be selected through DMAS and CMS plan selection processes. Plan selection will be based on CMS' and DMAS' review of information submitted via CMS's Health Plan Management System (HPMS) and DMAS' review of responses to this RFP. Plans chosen to participate must meet all CMS Demonstration requirements and be selected through this DMAS RFP process.

¹³ http://www.ssa.gov/OP_Home/ssact/title11/1115A.htm.

1.5 Plan Service Areas and Number of Contract Awards

The Department and CMS will implement the Demonstration in Tidewater, Central Virginia, Northern Virginia, Roanoke, and Western/Charlottesville regions beginning January 2014, pending CMS approval. It is anticipated a phased-in process will occur during the first year of the Demonstration; the dates for phasing in each region will be determined with CMS. The Department plans to select at least two plans for each region.

1.6 Volume and Participation

Adult full-benefit dual eligible individuals (age 21 and over), including full benefit dual eligible individuals in the EDCD Waiver and full-benefit dual eligible individuals residing in NFs, will be eligible to participate in the Demonstration. Table 1 below contains the estimated number of eligible enrollees as of Calendar Year (CY) 2011. These numbers represent the number of individuals who would have been eligible for the Demonstration had it been in effect during CY 2011. It is estimated that these numbers will increase by approximately one-third by January 2014.

Table 1: Estimated Number of Eligible Enrollees CY 2011

Region	Nursing Facility	EDCD Wavier	Community Non-waiver	Total
Central VA	4,430	3,762	16,135	24,327
Northern VA	1,935	1,766	12,952	16,653
Tidewater	3,031	2,492	12,575	18,098
Western/Charlottesville	1,477	842	4,427	6,747
Roanoke	2,833	1,355	8,583	12,771
Total	13,706	10,217	54,672	78,596

1.7 Contract Term, Amendments and Rates

CMS and DMAS intend to enter into a three-way contract with selected plans to provide covered services to enrollees for an initial one-year contract term effective January 1, 2014, with the possibility of two, one-year extensions. Any contract and/or rate amendments will be negotiated and released annually.

1.8 Implementation Schedule

The State is seeking plans that can implement services and tasks expeditiously and efficiently. The schedule below represents the State's and CMS' current timeframes for implementation of these services. This schedule is subject to change.

April 10, 2013	State Issues RFP
May 15, 2013	Deadline for Submission of Proposals
Summer 2013	Readiness Review Begins
September 2013	Three-Way Contract Signed
October 15 - December 7, 2013	Medicare Open Enrollment Period
January 1, 2014	Demonstration Implementation

SECTION II: BACKGROUND

2.1 Current Managed Care Delivery Model

The Virginia Medicaid program relies on both managed care plans and fee-for-service (FFS) arrangements to provide health care services to “non-dual” eligible individuals (including children, pregnant women, parents of children, and seniors and individuals with disabilities who are not enrolled in Medicare) enrolled in Medicaid, FAMIS, and FAMIS Plus. Although FAMIS is not a Medicaid program, it is provided through both the FFS and managed care delivery systems.

Under the current managed care program, the Department contracts with participating plans that have a current certificate of authority to operate in the Commonwealth of Virginia, as determined by the Virginia Bureau of Insurance and the Virginia Department of Health, and that meet all of DMAS’ Contract requirements. DMAS pays participating plans on a “per member per month” fee (capitated payment) through a full risk contract to manage the majority of acute health care services.

Participating plans assume the full risk for all Medicaid covered benefits and must also provide a number of additional services, including: providing or arranging access to covered medically necessary services; providing 24-hour member services and nurse advice lines; care management; maintaining an adequate provider network; processing provider claims, including assuring adequate and required reports and documentation of performance to the Department and CMS; and, participating in annual reviews conducted by the DMAS’ external quality review organization (EQRO).

2.2 Integrated Care Delivery Models

In 2006, the Governor of Virginia, with support from the 2006 General Assembly, set in motion a major reform of the Virginia Medicaid-funded long-term care (LTC) services program with a focus on care management and integration of acute and LTC services, through two delivery models; a community model and a regional model. The legislation (*Special Session I, 2006 Virginia Acts of Assembly, Chapter 3*) directed DMAS, in consultation with the appropriate stakeholders, to develop a long-range blueprint for the development and implementation of an integrated acute and LTC system. The blueprint can be found at: http://www.dmas.virginia.gov/Content_pgs/valtc.aspx. Finally, the legislation provided \$1.5 million in start-up funds for five Program of All-Inclusive Care for the Elderly (PACE) sites.

Virginia has successfully implemented a regional managed care model for primary and acute care services for low-income children and families and non-dual eligible individuals who are aged, blind or disabled; however, most dual eligible individuals continue to receive services through a patchwork of fragmented health and social programs that are not necessarily responsive to individuals’ needs. Medicare-covered acute care is often provided in a FFS environment with no chronic care management. Long-term care, also called long-term services and supports (LTSS), are provided by a variety of home and community-based care providers (with no overall care management) or a nursing facility. Further, dual eligible individuals must navigate between the Medicare and Medicaid systems with different and overlapping rules and requirements which further complicate access and the quality of the care they receive.

Community Model – Program of All Inclusive Care for the Elderly (PACE)

PACE provides coordinated care management to persons fifty-five years of age and older who meet NF criteria and choose to enroll in the PACE program as an alternative to NF care. All health and LTC services are provided in the community utilizing an adult day health care model with combined Medicaid and Medicare funding and a strong emphasis on Interdisciplinary Teams. There are currently twelve (12) PACE sites in the Commonwealth and plans are underway for five additional PACE sites. More than

1,000 beneficiaries are served through this integrated model.

Regional Model

On September 1, 2007, DMAS achieved success in implementing the Acute and Long-Term Care (ALTC) program, a regional managed care model in which managed care plans provide all Medicaid-covered acute care services for non-dual eligible individuals who also receive LTSS. Under this program, enrollees remain in a participating plan for their primary and acute medical care services after approval for a home and community-based services (HCBS) waiver. Prior to this, individuals were disenrolled from managed care once they became eligible for HCBS.¹⁴ The HCBS waiver services for these individuals, including transportation to waived services, continue to be paid through the FFS program. As of October 2012, 2,892 individuals were being served through the ALTC program.

In 2011 and 2012, Governor McDonnell, with support from the Virginia General Assembly, set forth Medicaid reform initiatives (Item 297 MMMM.1 of the Virginia 2011 Appropriations Act and Item 307 RR of the 2012 Appropriations Act), which directed DMAS to expand principles of care management to all geographic areas, populations, and services under programs administered by the Department (see Appendix B). The language stipulates that the expansion should involve shared financial risk, performance benchmarks, and improve the value of care by measuring outcomes, enhancing quality, and monitoring expenditures. Items MMMM.1.g and RR.1.g specifically allow DMAS to develop and implement care management models for dual eligible individuals. Participation in the Demonstration will meet the terms of the language and will integrate Medicare and Medicaid funding and services under one risk-based contract.

2.3 Definitions

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

Activities of Daily Living (ADLs) - Personal care tasks that are generally performed on a daily basis (i.e., bathing, dressing, toileting, transferring, bowel/bladder control, and eating/feeding). An individual's degree of independence in performing these activities is a part of determining the appropriate level of care and services.

Acute Care - Preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

Adult Day Health Care Center (ADHC) - Agency provider that offers a community-based day program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of vulnerable adults at risk of placement in a nursing facility. The ADHC must be licensed by the Virginia Department of Social Services.

Adult Day Health Care Services - Services designed to prevent institutionalization by providing individuals with health, maintenance, and coordination of rehabilitation services in a congregate daytime setting.

Agency-Directed Services - Services provided by an agency provider who is responsible for directing and managing services in accordance with an individual's Plan of Care.

Agency Provider - A public or private organization/entity that holds a Medicaid provider contract and furnishes services to waiver participants using its own employees or subcontractors.

Appeal (Enrollee - Medicaid Only) - An enrollee's request for review of a participating plans coverage or payment determination, in accordance with 42 CFR 438.400 (<http://www.gpo.gov/fdsys/pkg/CFR->

¹⁴ ALTC excluded enrollees receiving Technology Assisted Waiver, nursing facility, and PACE services.

[2012-title42-vol4/pdf/CFR-2012-title42-vol4-part438.pdf](#)). The appeal process will be further explained in the Memorandum of Understanding between CMS and DMAS.

Appeal (Provider - Medicaid Only) – A provider’s request for review of a participating plan’s denial determination in accordance with the statutes and regulations governing the Virginia Medicaid appeal process and the Medicare-Medicaid Enrollee Alignment Demonstration. After a provider exhausts the plan’s appeal process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act (Virginia Code Section 2.2-4000 et seq.) and Virginia Medicaid’s provider appeal regulations (12 VAC 30-20-500 et seq.).

Assess - To evaluate an individual’s condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor’s observation of the individual.

Assessment - One or more processes that are used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status, and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of the Plan of Care.

Assisted Living Facility (ALF) - A congregate residential setting as defined in §63.2-100 of the *Code of Virginia*, as amended (<http://leg1.state.va.us/000/cod/63.2-100.HTM>).

Assistive Technology - Specialized medical equipment and supplies including those devices, controls, or appliances specified in the Plan of Care, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform ADLs and/or to perceive, control, or communicate with the environment in which they live or that are necessary for the proper functioning of the specialized equipment and are cost-effective and appropriate for the individual’s assessed needs.

Attendant - An individual who provides consumer-directed personal assistance services. This term is also used to describe persons who provide respite services through consumer-directed waiver services.

Atypical Provider Identification Number (API) – Atypical providers are individuals or organizations that are not defined as healthcare providers under the National Provider Identifier (NPI) Final Rule. Atypical providers may supply non-healthcare services such as non-emergency transportation or carpentry. DMAS assigns an API to providers who are not eligible to receive an NPI. Examples of Atypical providers are Adult Day Health Care, Non-Emergency Transportation, Assisted Living Personal Care, Case Management Respite Care, Family Caregiver Training, Treatment Foster Care, and Mental Retardation /Mental Health Services (non-health care).

Authorized Representative - A person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

Back-Up Plan – A plan to provide care for an individual when scheduled services (either agency or consumer-directed) do not occur as scheduled. This helps assure the health and safety of an individual. The back-up plan is a component of the EDCD Waiver and must be documented in the individual’s Plan of Care.

Behavioral Health Home – A team based services delivery model that provides comprehensive and continuous care to patients, including care management, with the goal of maximizing health outcomes. For this RFP, Health Homes do **not** need to meet the standards set forth in §2703 of the Patient Protection and Affordable Care Act.¹⁵

Behavioral Health Services - An array of therapeutic services provided in inpatient and outpatient psychiatric and community mental health settings. Services are designed to provide necessary support and address mental health and behavioral needs in order to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance use disorder.

Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Standard Time, except for state holidays and unless otherwise stated.

¹⁵ <https://www.federalregister.gov/articles/2012/11/26/2012-28428/patient-protection-and-affordable-care-act-health-insurance-market-rules-rate-review>.

Capitation Payment - A payment the Department makes periodically to a plan on behalf of each individual enrolled under a contract for the provision of services under the State Plan and waivers, regardless of whether the enrollee receives services during the period covered by the payment. Any and all costs incurred by the plan in excess of the capitation payment shall be borne in full by the plan.

Capitation Rate – The monthly amount, payable to the plan, per enrollee, for the provision of contract services as defined herein. The plans shall accept the annually established capitation rates paid each month by the Department and CMS as payment in full for all Medicaid and Medicare services to be provided pursuant to the three-way contract and all administrative costs associated therewith, pending final recoupment, reconciliation, sanctions or payment of quality withhold amounts.

Caregiver - A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers include relatives, friends, or others who volunteer to help. Paid caregivers provide services in exchange for payment for the services rendered.

Carved-Out Services - The subset of Medicaid and Medicare covered services for which the plan shall not be responsible under the program.

Care Management – Assessing and planning of services; linking the individual to services and supports identified in the Plan of Care; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family members involved with the individual; making collateral contacts to promote the implementation of the Plan of Care and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the Plan of Care (also see Targeted Case Management).

Centers for Medicare & Medicaid Services (CMS) – The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Titles XVIII, XIX, and Title XXI of the Social Security Act.

CFR – Code of Federal Regulations.

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

Client, Recipient, Enrollee, Member or Participant - Any individual having current Medicaid eligibility who shall be authorized by the Department and CMS to participate in the Demonstration.

Community Service Board (CSB) - A citizens' board established pursuant to Virginia Code §37.2-500 (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-500>) and §37.2-600

(<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-600>) that provides mental health, intellectual disabilities and substance abuse programs and services within the political subdivision or political subdivisions participating on the board. In all cases the term CSB also includes Behavioral Health Authority (BHA).

Complaint – A grievance.

Comprehensive Assessment - The person-centered process of gathering relevant social, psychological, medical and level of care information used by the care coordinator as a basis for the development of the Plan of Care.

Consumer-Directed (CD) Employee - A person who is employed by the individual receiving services through the consumer-directed model of care or their representative to provide approved services (e.g., personal care, companion and/or respite care), who is exempt in Virginia from Workers' Compensation.

Consumer-Directed Services – Home and community-based services for which the individual or their representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff.

Consumer-Directed (CD) Services Facilitator (SF) - The Medicaid enrolled provider who is responsible for supporting the individual or their representative, as appropriate, by ensuring the developing and monitoring of the Plan of Care, providing employee management training, and completing ongoing review activities as required by DMAS for individuals who are consumer-directing.

Contract - The signed and executed document resulting from this RFP, including all attachments or documents incorporated by reference.

Covered Services - The subset of services for which the PLAN shall be responsible for covering under the program.

Credentialing - The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility and to deliver covered services.

Department - The Virginia Department of Medical Assistance Services.

Disenrollment - The process of changing enrollment from one Demonstration plan to another Demonstration PLAN or returning from the Demonstration MCO to the fee-for-service system. This does not include ending eligibility in the Medicare or Medicaid programs.

Dual Eligible Individuals – A Medicare beneficiary who receives Medicare Part A, B, and D benefits and who also receives full Medicaid benefits. This term will be used throughout the RFP to reference individuals who are eligible for the Demonstration. Individuals who receive both Medicare and Medicaid coverage but who are NOT eligible for full Medicaid benefits (e.g., individuals who qualify as SLMB, QMB, QDWI, or QI) shall not be eligible for the Demonstration.

Durable Medical Equipment (DME) - Medical equipment, supplies, and appliances suitable for use in the home consistent with 42 CFR 440.70(b)(3) that treat a diagnosed condition or assist the individual with functional limitations.

Elderly Or Disabled With Consumer-Direction (EDCD) Waiver - The CMS-approved §1915(c) waiver that covers a range of community support services offered to individuals who are elderly or who have a disability and would otherwise require a nursing facility level of care.

Employer - The individual who directs their own care and receives consumer-directed services from an attendant who is hired, trained, and supervised by the individual or the individual's representative.

Encounter – Any covered or flexible service received by an enrollee through the plan or its subcontractor.

Encounter Data – Data collected by the managed care plans documenting all of the health care and related services provided to a member. These services include, but are not limited to, professional services, medical supplies or equipment and medications. Encounter data is collected on an individual member level and includes the person's Medicaid ID number. It is also specific in terms of the provider, the medical procedure, and the date the service was provided. DMAS and the Federal government require plans to collect and report this data. Encounter data is a critical element of measuring managed care plan's performance and holding them accountable to specific standards for health care quality, access, and administrative procedures.

Enrollee/Member - A person eligible for Medicaid who is enrolled in a plan to receive services under the provisions of the resulting three-way contract.

Enrollment (Managed Care) - The completion of approved enrollment forms by or on behalf of an eligible person and assignment of an individual to a plan by the Department in accordance with the terms of this contract. This does not include attaining eligibility for the Medicare or Medicaid programs.

Enrollment (Waiver) - The process whereby an individual has been determined to meet the eligibility requirements (financial and functional) for a program or service and the approving entity has verified the availability of services for that individual. It is used to define the entry of an individual into a home and community-based services waiver program. This does not include attaining eligibility for the Medicare or Medicaid programs.

Enrollment Facilitator - An independent entity that enrolls individuals in the plan and who is responsible for the operation and documentation of a toll-free helpline. The responsibilities of the Enrollment Facilitator include, but are not limited to: education and enrollment, assistance with and tracking of individuals' grievance resolutions, and may include marketing and outreach. The Enrollment Facilitator will provide services that are similar to the services that the "Enrollment Broker" provides for the current Medicaid managed care program.

Enrollment Period – The time that an individual is enrolled in a participating plan.

Environmental Modifications - Physical adaptations to a house, place of residence, primary vehicle or work site (when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the individual's health and safety or enable

functioning with greater independence. The adaptation may not be used to bring a substandard dwelling up to minimum habitation standards and must be of direct medical or remedial benefit to the individual.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354 and performs external quality review, and other EQR related activities as set forth in 42 CFR§ 438.358.

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

Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 CFR § 405.2401(b), as amended.

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

Fiscal/Employer Agent (F/EA) - An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 which has a separate Federal Employer Identification Number used for the sole purpose of filing federal employment tax forms and payments on behalf of program individuals who are receiving CD services.

Flexible Benefits - Benefits Demonstration Plans may choose to offer outside of the required Covered Services. Flexible Benefits will not be considered in the development of the capitation rate.

Formulary – A list of drugs that the plan has approved. Prescribing some of the drugs may require service authorization.

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

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

Health Plan Management System (HPMS) - A web based system used to upload information to CMS.

Home and-Community-Based Services (HCBS) Waiver - A variety of home and community-based services paid for by DMAS as authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutional (nursing facility) placement.

Home Health Aide - A person who, under the supervision of a home health agency, assists persons who are elderly, ill, or a person with a disability, with household chores, bathing, personal care, and other daily needs.

Home Health Services - The provision of part-time or intermittent nursing care and home health aide services and other services as determined by the State, that are provided to beneficiaries in their place of residence. Home health services must be ordered by a physician as part of the individual’s Plan of Care.

Hospital - A facility that meets the requirements of 42 CFR § 482, as amended.

Instrumental Activities of Daily Living (IADLs) - Activities such as meal preparation, shopping, housekeeping, laundry, and money management. The extent to which an individual requires assistance in performing these activities is assessed in conjunction with the evaluation of level of care and service needs.

Intensive Behavioral Health Outpatient Services – Services shall include the major psychiatric, psychological and psycho-educational modalities to include: individual and group counseling; family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social

functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Intensive outpatient services for individuals are provided in a nonresidential setting.

Interdisciplinary Care Team (ICT) - A team of professionals that collaborate, either in person or through other means, to develop and implement a person-centered Plan of Care built on the individual's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity and meets the medical, behavioral, LTC and social needs of enrollees. ICTs may include physicians, physician assistants, LTC providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the individual's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

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

Level of Care (LOC) - The specification of the minimum amount of assistance that an individual requires in order to receive services in an institutional setting under the State Plan.

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

Managed Care Plan - An organization which offers managed care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in Va. Code § 38.2-3407 or preferred provider subscription contracts as defined in Va. Code § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this RFP, and in accordance with 42 CFR § 438.2, means an entity that has qualified to provide the services covered under this Contract to qualifying Demonstration enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other individuals within the area served, and meets the solvency standards of 42 CFR § 438.116.

Medicaid Covered Services - Services reimbursed by DMAS as defined in the Virginia State Plan for Medical Assistance or State regulations.

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

Medicaid Recipient or Enrollee - Any individual enrolled in the Virginia Medicaid program.

Medicaid Works Program - A voluntary Medicaid plan option that enables workers with disabilities to earn higher income and retain more in savings, or resources, than is usually allowed by Medicaid.

Medication Monitoring - An electronic device that is only available in conjunction with Personal Emergency Response Systems (PERS) that enables individuals at risk of institutionalization to be reminded to take their medications at the correct dosages and times.

Medication Therapy Management Program - The MMA 2003 established the requirement that each Medicare Part D plan sponsor offer a Medication Therapy Management program to targeted beneficiaries beginning in 2006. At a minimum, targeted beneficiaries include those members with multiple chronic conditions, taking multiple Part D drugs, and likely to incur annual costs for covered Part D drugs that exceed a predetermined level.

Medicare Advantage - (Medicare “Part C”) - Sometimes referred to as “MA Plans,” Medicare Advantage plans provide all of an individual’s Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

Medicare Part A - Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

Medicare Part B – Insurance that helps cover medically-necessary services like doctors’ services, outpatient care, durable medical equipment (DME), home health services, and other medical services. Part B also covers some preventive services.

Medicare Part D – Medicare prescription drug coverage.

The Minimum Data Set (MDS) - Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals’ current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual’s condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings. Beginning October 1, 2010, all Medicare and Medicaid certified nursing facilities were required to use the MDS 3.0.

Model of Care – A comprehensive plan that describes the plan’s population, identifies measurable goals for providing high quality care and improving the health of the enrolled population, describes the plan’s staff structure and care management roles, describes the interdisciplinary care team, system of disseminating the Model to plan staff and network providers and other information designed to ensure that the plans provide services that meet the needs of enrollees.

Money Follows the Person (MFP) - Demonstration project designed to create a system of long-term services and supports that better enable individuals to transition from certain LTC institutions into the community. To participate in MFP, individuals must: 1) have lived for at least 90 consecutive days in a nursing facility, an intermediate care facility for persons with mental retardation, a long-stay hospital licensed in Virginia, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF), or a combination thereof; and 2) move to a qualified community-based residence. Individuals may participate in MFP for up to twelve (12) months. Individuals enrolled in MFP will be excluded from the Demonstration.

Monitoring - The ongoing oversight of the provision of waiver and/or other services to determine that services are furnished according to the individual’s Plan of Care and effectively meet his or her needs, including assuring health and welfare. Monitoring activities may include, but are not limited to, telephone contact, observation, interviewing the individual and/or the individual’s family, as appropriate, and in person or by telephone, and/or interviewing service providers.

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

Network Provider - The health care entity or health care professional who is either employed by or has executed a contract with the plan or its subcontractor to render covered services to enrollees as defined in this RFP.

Nursing Facility (NF) – "Certified nursing facility" - Any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing facility, whether freestanding or a

portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and the *Code of Virginia*, §32.1-137.

Open Enrollment – Time frame defined by CMS between October 15th and December 7th of each year during which Medicare beneficiaries can make changes to their Medicare Advantage or Medicare prescription drug coverage for the following year. The Demonstration will adhere to CMS' timeframe.

Opt-Out Option - The option for eligible beneficiaries to choose to not enroll in a plan prior to the program start date or to disenroll from the Demonstration at any time.

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

Participating Plan - A managed care plan selected to participate in Virginia's Medicare-Medicaid Alignment Demonstration and a party to the three-way contract with CMS and DMAS.

Patient Pay - When an individual's income exceeds an allowable amount, he or she must contribute toward the cost of their LTC services. This contribution, known as the *patient pay amount*, is required for individuals residing in a NF and for those receiving EDCD Waiver services. Patient pay is required to be calculated for every individual receiving NF or waiver services, although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be outlined in the three-way contract.

Personal Care Provider –Provider that renders services to prevent or reduce more costly institutional care by providing eligible individuals with personal care services.

Personal Care Services - Long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter a NF. Personal care services are provided to individuals in the areas of activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires assistance with activities of daily living, and where specified in the Plan of Care, such supportive services may include assistance with instrumental activities of daily living. Services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

Person-Centered Planning - A process, directed by an individual or his/her family/caregiver, as appropriate, intended to identify the needs, strengths, capacities, preferences, expectations, and desired outcomes of the individual.

Personal Emergency Response System (PERS) - An electronic device and monitoring service that enable certain individuals at risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

PERS Provider - An entity that meets the standards and requirements set forth by DMAS to provide PERS equipment, direct services, and PERS monitoring. PERS providers may also provide medication monitoring.

Plan Of Care (POC) – A comprehensive written document specifying an individual's services and supports (both formal and informal). The Plan of Care is developed through a person-centered planning process that incorporates the individual's strengths, skills, needs, and preferences. The Plan of Care is updated with the individual yearly or whenever an individual's needs change. The Plan of Care includes all aspects of an individual's care needs including, but not limited to, medical, behavioral, social, and long-term services and supports, as appropriate.

Pre-Admission Screening (PAS) - The process to: (i) evaluate the functional, nursing, and social supports of individuals referred for long-term services and supports; (ii) assist individuals in determining needed services; (iii) evaluate whether community services are available to meet the individuals' needs; and (iv) refer individuals to the appropriate provider for Medicaid-funded facility or home and community-based care.

Pre-Admission Screening (PAS) Team - The entity contracted with DMAS that is responsible for performing pre-admission screening pursuant to the *Code of Virginia* § 32.1-330.

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

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

Primary Caregiver - The primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.

Quality Management Review – An on-site visit of the plan conducted by DMAS to assure the health and safety of the EDCD Waiver participants and compliance with the CMS §1915(c) Waiver assurances.

Reevaluation - The periodic, but at least annual, review of an individual’s condition and service needs to determine whether the individual continues to need a level of care specified in the waiver.

Respite Care - Short term personal care services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of unpaid caregivers who normally provide the care.

Respite Care Provider - Agency provider that renders services designed to provide periodic or routine relief for unpaid primary caregivers under the EDCD Waiver program.

Rural Health Clinic - A facility as defined in 42 CFR §491.2, as amended.

Service Authorization/Prior Authorization Request – A managed care enrollee’s request for the provision of a service.

Service Facilitator - Entity responsible for supporting the individual, individual’s family/caregiver or Employer of Record, as appropriate, by ensuring the development and monitoring of the CD services Plans of Care, providing employee management training, and completing ongoing review activities as required by the Department for CD personal care and respite services.

Significant Change - is a decline or improvement in a resident’s status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not “self-limiting” (for declines only); 2. Impacts more than one area of the resident’s health status; and 3. Requires interdisciplinary review and/or revision of the care plan.

Spend down –When a Medicaid applicant meets all Medicaid eligibility requirements other than income, Medicaid eligibility staff conduct a “medically needy” calculation which compares the individual’s income to a medically needy income limit for a specific period of time referred to as the “budget period” (not to exceed 6 months). When a Medicaid applicant’s incurred medical expenses are equal to the spend down amount, the individual is eligible for full benefit Medicaid for the remainder of the spend down budget period. Individuals with a spend down are not eligible to participate in the Demonstration.

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

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

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

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

Temporary Detention Order (TDO) - An emergency custody order by sworn petition to any magistrate to take into custody an individual believed to be mentally ill and in need of hospitalization and transported to a location to be evaluated pursuant to 42 CFR § 441.150 and Code of Virginia, 16.1- 335 et. seq. and 37.1-67.1 et seq.

Targeted Case Management (TCM) - Medicaid-funded State Plan case management service provided by private providers for individuals with substance use disorders or developmental disabilities and by Community Services Boards/Behavioral Health Authorities for individuals with behavioral health disorders or intellectual disabilities. TCM encompasses both referral/transition management and clinical services such as monitoring, self-management support, medication review and adjustment. In circumstances where individuals receive TCM services through the Medicaid State Plan, care management provided by the plan and TCM provider shall be collaborative with clearly delineated responsibilities and methods of sharing important information between the plan and the TCM provider. TCM is separate from "care management" as defined in this RFP; however, the two programs shall work in concert for individuals receiving both services. Regulations for TCM can be found in the *Virginia Administrative Code* at: 12VAC30-50-420 - Case management services for seriously mentally ill adults and emotionally disturbed children; 12VAC30-50-440 - Case management services for individuals with mental retardation; 12VAC30-50-450 - Case management services for individuals with mental retardation and related conditions who are participants in the Home and Community-Based Care waivers for such individuals; 12VAC30-50-470 - Case management for recipients of auxiliary grants; 12VAC30-50-490 - Case management for individuals with developmental disabilities, including autism; and 12VAC30-50-491 - Case management services for individuals who have an Axis I substance related disorder.

Third-Party Liability (TPL) - Any entity (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Transition Coordination - Plan staff member or other contracted provider responsible for supporting the individual and his/her designated representative, as appropriate, with the activities associated with transitioning from an institution to the community. Transition coordination services include, but are not limited to, the development of a transition plan; the provision of information about services that may be needed, in accordance with the timeframe specified in federal law, prior to the discharge date, during and after transition; the coordination of community-based services with the case manager, if case management is available; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation; and the provision of ongoing support for up to 12 months after discharge date. Individuals enrolled in and receiving Transition Coordination that is provided for an individual in the Money Follows the Person Program shall be excluded from the Demonstration.

Transition Services - Services that are set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. For the purposes of transition services, an institution means a NF, or a

specialized care facility/hospital as defined at 42 CFR § 435.1009. Transition services do not apply to an acute care admission to a hospital.

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

Virginia Administrative Code (VAC) – Contains regulations of all of the Virginia State Agencies.

Virginia Uniform Assessment Instrument (UAI) - The standardized multidimensional questionnaire that is completed by a Preadmission Screening Team or a hospital discharge planner for individuals residing in a hospital setting that assesses an individual’s psychosocial, physical health, mental health, and functional abilities to determine if an individual meets level of care criteria for long-term services and supports funded through Medicaid.

SECTION III: TECHNICAL REQUIREMENTS

This section contains the technical requirements for the RFP that an Offeror must meet. The Offeror shall provide all applicable documentation requested in this section. It must also indicate its understanding and ability to perform tasks specified and provide detailed evidence to demonstrate compliance with the requirements listed in this section. The Offeror shall provide a detailed narrative of how it will define and perform each of the required tasks listed in this section and cross-reference the proposal response to each RFP requirement. The description shall correspond to the order of the tasks described herein. The narrative shall demonstrate that the Offeror has considered all the requirements and developed a specific approach to meeting them that will support a successful project. It is not sufficient to state that the requirements will be met. The Offeror may perform all of these processes internally or involve subcontractors for any portion. Subcontractors shall be identified by name and by a description of the services/functions they will be performing. The plan shall be wholly responsible for the performance of the resulting three-way contract whether or not subcontractors are used. The successful Offeror will also provide functionality that will place Virginia at the leading edge of innovation. Offerors are encouraged to be creative in how these tasks are accomplished. Offerors may add additional tasks in their proposal or suggest an alternate task to replace a task described below and how the alternate task will meet the same objective as appropriate (and as approved by the Department). DMAS encourages Offerors to bring new ideas and innovations and propose enhancements that will help DMAS more effectively implement the Demonstration.

3.1 Past Performance

DMAS will not approve proposals from organizations that are, or whose parent or a sibling legal entities are, as of the RFP due date, under sanction as enumerated in 42 CFR § 422.750 and 42 CFR § 423.750. This policy is in line with that effectuated by CMS: per the March 29, 2012, CMS Guidance entitled “Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in Interested States.” CMS will not consider an organization eligible to offer a Demonstration plan if it is under a Medicare enrollment and/or marketing sanction. Poor past performance as a Medicaid or Medicare plan may serve as the basis for non-selection.

- For Offerors that have Medicare experience within the last three (3) years: If an Offeror’s Medicare plan or its parent organization has been designated by CMS as a past performance outlier or “consistently low performing” in the previous **three (3) years**, then the offeror must identify the reasons CMS designated the plan as an outlier/low performer and describe actions taken or being taken to remedy poor performance. Offerors should also include the actions taken by the plan to correct the deficiencies and prevent a recurrence. These factors will be used to rank plans and are grounds for non-selection. All else equal, DMAS will rank higher those legal entities that are not

considered to be past performance outliers or consistently low-performing as determined by its organizational performance. If the state determines that the CMS deficiencies have not been resolved or that corrective actions are inadequate, DMAS may use the information as grounds for non-selection.

- For Offerors that have Medicaid experience within the last three (3) years: Offerors that have Medicaid experience within the last three (3) years must indicate any Medicaid sanctions imposed on the Offeror during the **past three (3) years** or any areas in which a corrective action plan was required in any state in which the offeror operates a Medicaid managed care plan. Offerors should also include the actions taken by the plan to correct the deficiencies and prevent a recurrence. These factors will be used to rank plans. If the state determines that deficiencies have not been resolved or that corrective actions are inadequate, DMAS may use the information as grounds for non-selection.

3.2 Provider Network Composition and Access to Care Standards

3.2.1 Provider Network Composition

Participating plans shall be required to establish and maintain a network of providers, either directly or through sub-contractual arrangements that ensure access to all Medicare and Medicaid services and is capable of meeting the needs of the individuals enrolled in the Demonstration. Participating plans will be required to establish and maintain provider networks that at least meet State Medicaid access standards for LTSS, community behavioral health and other services for which Medicaid is the historical primary payer. Medicare standards shall be utilized for medical and pharmacy benefits and for other services for which Medicare is the historical primary payer. Home health and DME requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be at least as beneficiary-friendly as Medicare standards. For any covered service for which Medicare requires a more rigorous network adequacy standard than the Medicaid standards, (including time, distance, and/or minimum number of providers or facilities), participating plans must meet the Medicare requirements.

Offerors must submit their preliminary networks for Medicare Parts A, B and D services through the CMS HPMS system, based on the timeline established by CMS. Offerors may also be required to submit their preliminary provider networks for historically Medicaid-covered services through the CMS HPMS system. Information on this process will be forthcoming from CMS. **In response to this RFP, however, Offerors must submit preliminary provider networks for historically Medicaid-covered services. Only providers with which Offerors have signed letters of intent may be included. Offerors must also submit the hospitals with which they have signed letters of intent. Final networks, including signed provider contracts will be evaluated prior to implementation during the readiness review process.**

For services for which Medicaid is the historical primary payer, plans must submit an electronic listing using Microsoft Excel of all providers and potential providers within their networks as part of their Proposal and a mapped version of their preliminary network. Plans must also submit the hospitals for which they have signed letters of intent.

Excel: For the purposes of this proposal, plans shall submit letters of intent as well as any existing members of their provider network which the plan believes will participate in the Demonstration. The listing of providers must be unduplicated. If a provider has more than one physical office location, each location may be submitted. If a provider has more than one provider type and/or provider specialty and one location, add the additional provider types and/or specialties to the file as needed. Submissions not meeting these requirements will be rejected and returned. To be evaluated, a corrected file must be

returned within 10 days; otherwise, the network requirements will be rated unsatisfactory. Format the electronic submission using the following column headings:

1. Provider First name
2. Provider Last name
3. Provider type1, example: Personal Care, Adult Day Health Care, etc. (if internal company abbreviations are used, supply a cross reference)
4. Provider type2
5. Provider type3
6. Provider specialty1
7. Provider specialty2
8. Provider specialty3
10. Address – this should be the physical office location, NOT a billing/payment location
11. City
12. State
13. Zip
14. Geographic area served (can use City/County codes as defined in Appendix A)
15. Office telephone number
16. Tax ID number
17. National Provider Identifier (NPI) or Administrative Provider Identifier (API), if applicable
18. Additional language abilities (other than English)
19. Status of contract (letter of intent or signed contract)

Mapped: In addition to the Excel submission, plans shall also submit a separate mapped version of their proposed network by region (using network mapping software) for the following services:

- personal care
- respite care
- adult day health care
- nursing facility
- crisis intervention
- crisis stabilization
- day treatment/partial hospitalization services
- hospital (historically covered by Medicare)
- intensive community treatment
- mental health support services
- opioid treatment
- psychosocial rehabilitation
- residential substance abuse treatment for pregnant and post partum women
- substance abuse targeted case management
- substance abuse crisis intervention
- substance abuse day treatment
- substance abuse day treatment for pregnant and post partum women
- substance abuse intensive outpatient treatment
- temporary detention order

3.2.2 Long-Term Service and Support Provider Requirements

The participating plans shall enter into provider contracts for the provision or administration of NF and EDCD Waiver covered services. Provider qualification requirements for these services may be found at the following regulatory and DMAS manual cites:

Adult Day Health Care - Regulation: (12 VAC 30-120-940(B)); (12 VAC 30-120-940(C)) and 12 VAC 40-60-10 et seq (Licensing regulations) <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-940>

EDCD Waiver Manual: (Chapter II, Pages 11-17)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Agency Directed Personal Care - Regulation: (12 VAC 30-120-950(D))

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-950>

EDCD Waiver Manual: (Chapter II, Pages 8-11)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Agency Directed Respite Care - Regulation: (12 VAC 30-120-960(D)) <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-960>

EDCD Waiver Manual: (Chapter II, Pages 8-11)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Personal Emergency Response System (PERS) - Regulation: (12 VAC 30-120-970(D)) and (12 VAC 30-120-970(E))

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-970>

EDCD Waiver Manual: (Chapter II, Pages 17-19)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Consumer Directed Services (Service Facilitation) - Regulation: (12 VAC 30-120-980(D))

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-980>

EDCD Waiver Manual: (Chapter II, Pages 19-21)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Consumer Directed Services (Personal Care Aide) - Regulation: (12 VAC 30-120-980(D))(10)

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-980>

EDCD Waiver Manual: (Chapter II, Pages 21-22)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Nursing Facility- Regulation: (12 VAC 30-60-300)

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-60-300>

Nursing Facility Manual: (Chapter II)

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

The plan shall be required to ensure the completion of criminal records checks as outlined in state regulations for the following positions:

1. Personal Assistants – 12 VAC 30-120-950(D)(2)
2. Respite Care Assistants – 12 VAC 30-120-960(D)(2)
3. Adult Day Health Care Workers – 22 VAC 40-90-40 through 22 VAC 40-90-60
4. Registered Nurse – 12 VAC 30-120-950(D)(2)
5. Licensed Practical Nurse - 12VAC30-120-950(D)(2)

The scope of the investigation includes a Virginia State Police Criminal History Records Check. All agency providers licensed by the Virginia Department of Health must demonstrate that criminal records checks have been completed as a part of the annual licensing process. All agency providers exempt from licensing pursuant to Va. Code § 32.1-162.8 must demonstrate that criminal records checks have been completed as a part of the Quality Management Review process conducted by DMAS. All agency providers must also demonstrate the completion of criminal records checks as a part of the enrollment

process with the participating plan. For consumer-directed services, the participating plan shall be responsible for conducting criminal records checks.

Participating plans shall request the criminal background checks to the Virginia State Police prior to the start of employment with additional supervision provided to the employee until the records check results are received, typically within 30 days.

3.2.3 Behavioral Health Networks

Participating plans shall be required to have an adequate network of behavioral health and substance abuse providers to meet the needs of the dual eligible population, including their community mental health rehabilitative service needs (see Appendix C). Examples of these types of providers include, but are not limited to, psychiatrists, clinical psychologists, licensed clinical social workers, outpatient substance abuse treatment providers, and residential substance abuse treatment providers for pregnant women, etc. Community mental health rehabilitative services providers must meet DMAS' qualifications as outlined in the most current DMAS community mental health rehabilitative services provider manual found at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

3.2.4 Access to Care Standards

The participating plans shall be solely responsible for arranging and administering covered services to enrolled individuals and shall ensure that its delivery system shall provide available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services.

In accordance with this RFP, enrolled individuals in the EDCD Waiver must have a choice of a minimum of two (2) providers of each type of EDCD Waiver service within the time and distance standards specified in Section 3.2.5 below. Furthermore, enrolled individuals must have a choice of a minimum of two (2) Medicaid primary paid community mental health and rehabilitative service providers within the time and distance standards specified in Section 3.2.5 below.

Plans shall consider the following when establishing and maintaining their networks:

1. The anticipated Demonstration enrollment;
2. The expected utilization of services, taking into consideration the characteristics and health, behavioral health, and long-term service and support needs of the anticipated population to be served;
3. The numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;
4. The numbers of network providers not accepting new patients;
5. The geographic location of providers and enrollees, considering distance, travel time, and the means of transportation ordinarily used by enrollees; and,
6. Whether the location provides physical access for enrollees with disabilities, including items such as exam tables that accommodate individuals who have mobility limitations.

3.2.5 Travel Time and Distance

Travel Time Standard - Participating plans shall meet CMS requirements for travel time for providers of services for which Medicare is the traditional primary payer. For services for which Medicaid is the traditional primary payer, the participating plan shall ensure that each enrollee shall have a choice of at least two (2) providers of each service type located within no more than thirty (30) minutes travel time from any enrollee in urban areas unless the plan has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during

commuting hours). The participating plan shall ensure that each enrollee shall have a choice of at least two (2) providers of each service type located within no more than sixty (60) minutes travel time from any enrollee in rural areas unless the plan has a Department-approved alternative time standard.

Travel Distance Standard - Participating plans shall meet CMS requirements for travel distance for providers of services for which Medicare is the traditional primary payer. For services for which Medicaid is the traditional primary payer the participating plan shall ensure that each enrollee shall have a choice of at least two (2) providers per service type located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the participating plan has a Department-approved alternative distance standard.

3.3 Network Provider Licensing and Certification Standards

Each participating plan must have the ability to determine whether providers are licensed by the State and have received proper certification or training to perform the services agreed to under the contract. The participating plan's standards for licensure and certification shall be included in its participating provider network contracts with its network providers which must be secured by current subcontracts or employment contracts.

3.4 Credentialing/Recredentialing Policies and Procedures

Participating plans shall implement written policies and procedures that comply with the credentialing/recredentialing policies and procedures that will be outlined in the three-way contract.

3.5 Eligibility and Enrollment

3.5.1 Eligible Populations

Individuals age 21 and over at the time of enrollment who are eligible for full Medicaid benefits and who are enrolled in Medicare Parts A and B and eligible for Medicare Part D, are eligible to enroll in the Demonstration (except for individuals who are excluded from participation as outlined below).

More specifically, the following individuals are eligible to enroll in the Demonstration:

1. Existing and newly enrolled dual eligibles: individuals enrolled in Medicare and eligible for full Medicaid coverage. These individuals are included in the Virginia Administrative Code as "Qualified Medicare Beneficiaries (QMB) Plus."
2. Existing dual eligibles enrolled in the EDCD Waiver and dual eligibles who become eligible for the EDCD Waiver. This CMS-approved §1915(c) waiver covers a range of community support services offered to individuals who are elderly and/or who have a disability and would otherwise require a NF level of care.
3. Dual eligible individuals residing in NFs.

3.5.2 Excluded Populations

Individuals who meet at least one of the exclusion criteria listed below shall be excluded from the Demonstration:

1. Dual eligible individuals in the Demonstration areas under age 21.
2. Dual eligible individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements.
3. Dual eligible individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including dual eligible individuals such as:

- a. Qualified Medicare Beneficiaries (QMBs);
- b. Special Low Income Medicare Beneficiaries (SLMBs);
- c. Qualified Disabled Working Individuals (QDWIs); or,
- d. Qualified Individuals (QIs).

These individuals may receive Medicaid coverage for the following: Medicare monthly premiums for Part A, Part B, or both (carved-out payment); coinsurance, copayment, and deductible for Medicare-allowed services; Medicaid-covered services, including those that are not covered by Medicare.

4. Dual eligible individuals who are inpatients in State mental hospitals, including but not limited to those listed below:
 - Catawba Hospital,
 - Central State Hospital,
 - Eastern State Hospital,
 - HW Davis Medical Center,
 - Northern Virginia Mental Health Institution,
 - Piedmont Geriatric Hospital,
 - Southern Virginia Mental Health Institution,
 - Southwestern State HM&S,
 - Southwestern VA Mental Health Institution
 - Western State HM&S, and
 - Western State Hospital
5. Dual eligible individuals who are institutionalized (State Hospitals; ICF/MR facilities; Residential Treatment Facilities; long stay hospitals). Note that dual eligible individuals residing in NFs will be enrolled in the Demonstration.
6. Dual eligible individuals who are participating in federal waiver programs for home and-community-based Medicaid coverage other than the EDCD Waiver (e.g., Individual and Family Developmental Disability Support, Intellectual Disabilities, Day Support, Technology Assisted Waiver, and Alzheimer's Assisted Living waivers).
7. Dual eligible individuals who are enrolled in a hospice program. If an individual enters a hospice program while enrolled in the Demonstration, he/she will be disenrolled from the Demonstration. However, plans shall refer these individuals to the EDCD Waiver pre-admission screening team for additional LTSS.
8. Dual eligible individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the Demonstration. However, an individual who starts receiving the ESRD Medicare benefit while enrolled in the Demonstration will remain in the Demonstration, unless he/she opts out. If he/she opts out, the individual cannot opt back into the Demonstration.
9. Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare; insurance provided to military dependents; and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).
10. Dual eligible individuals who have a Medicaid eligibility period that is less than three months
11. Dual eligible individuals who have an eligibility period that is only retroactive.
12. Individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.
13. Dual eligible individuals who are enrolled in the Money Follows the Person (MFP) Program.
14. Dual eligible individuals residing outside of the Demonstration areas.
15. Dual eligible individuals enrolled in the Program of All-inclusive Care for the Elderly (PACE). However, PACE participants may enroll in the Demonstration if they choose to disenroll from their PACE provider.
16. Individuals participating in the CMS Independence at Home (IAH) demonstration.

Individuals enrolled in a plan who are subsequently determined to meet one or more of these criteria shall be excluded as appropriate. Individuals excluded from the Demonstration shall receive services under the current FFS system (unless enrolled in PACE). When enrollees no longer meet the criteria for exclusion, they will be passively re-enrolled into the Demonstration with the option of opting out at any time. The Department and CMS shall, upon new State or Federal regulations or Department policy, exclude other individuals as appropriate.

3.5.3 Determination of Eligibility for the Demonstration

The Department, as the single state Medicaid agency, has the authority and responsibility for determining eligibility for Medicaid, and CMS has the sole authority and responsibility for determining eligibility for Medicare. Together, the Department and CMS have the sole authority and responsibility for determining enrollment into the Demonstration, into the participating plan, and for excluding individuals from participation. Such determinations shall be final and are not subject to review or appeal by the participating plans. Nothing prevents the participating plan from providing the Department or CMS with information that the participating plan believes indicates that an enrollee's eligibility was incorrectly determined or has changed so that enrollment with the participating plan is no longer appropriate.

3.5.4 Enrollment

Participating plans shall adhere to the Demonstration enrollment and disenrollment processes and procedures that will be outlined in the three-way contract.

3.6 Model of Care

All covered services will be provided through a fully integrated delivery system. Participating plans must implement a Model of Care (MOC) using evidence-based practices as applicable. Using the 11 Special Needs Plan (SNP) Model of Care elements listed below and outlined in CMS guidance dated March 29, 2012 (*Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013*), plans shall provide a description of the Model of Care the plan will use if selected for this Demonstration. Plans must include a detailed description and multiple examples of how it will address each MOC element and demonstrate how it will address the needs of the Demonstration population. Examples should be varied to address the needs of the "Plan Specific Target Population" included in Element 1. Each element must be responsive to beneficiary needs and preferences, and take into account the health, safety and welfare of enrollees. **Note that the Virginia Specific Elements included in the Model of Care outlined below include more specific requirements than previous versions the state provided to interested plans and the plan should be cognizant of these new requirements when developing its response to the Model of Care.** Plans should also reference the "Model of Care Assessment and Plan of Care Expectations" chart included in this section for further guidance on assessment, reassessment, and Plan of Care development timelines. The National Committee for Quality Assurance (NCQA) score of the Model of Care will be incorporated into the total score for this section. Offerors must also submit their Model of Care for review and approval by CMS via the HPMS. The MOC must include the following elements:

Required Elements of the Model of Care

- 1. Description of the Plan-specific Target Population;*
- 2. Measurable Goals;*
- 3. Staff Structure and Care Management Goals;*
- 4. Interdisciplinary Care Team;*
- 5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;*

6. *MOC Training for Personnel and Provider Network;*
7. *Health Risk Assessment;*
8. *Individualized Plan of Care;*
9. *Integrated Communication Network;*
10. *Care Management for the Most Vulnerable Subpopulations; and*
11. *Performance and Health Outcomes Measurement.*

The Model of Care will be scored by CMS or its contractor based on the federal standards described in the *Guidance* referenced above. In addition to submitting the MOC through the HPMS, offerors must submit, as part of the response to this RFP, their Models of Care as submitted to or approved by CMS and include the additional State-specific MOC requirements described below. Offerors must clearly identify the state-specific sections that were added to the MOC consistent with the State requirements below. Plans may submit for review any tools or flow charts that illustrate the proposed processes.

Further, as part of the state’s MOC evaluation process, Offerors must also respond to each of the vignettes included in Appendix D. The RFP evaluation process will also include an in-person presentation by the Offeror on a minimum of two of the vignettes. Further details regarding the presentation will be provided to respondents, but the presentation should demonstrate the Offeror’s structural capability and ability to excel at meeting the needs of the enrolled population. The standards outlined in the following sections will be used to evaluate the respondent’s MOC structure and capabilities.

The Model of Care shall be person-centered. Plans shall demonstrate in their responses that they have staff experienced in person-centered practices and how they will provide ongoing staff training on these principles. In addition, Offerors will demonstrate that they have the infrastructure and systems in place to monitor the delivery of person-centered care management.

Model of Care Elements
<p>1. Description of the plan-specific Target Population (based on target population of full duals as defined by the State)</p> <p>The plan’s response to Element #1 (Description of the Plan-specific Target Population) must include all Virginia-specific sub-populations of dual eligibles as follows:</p> <ol style="list-style-type: none"> a. Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver; b. Individuals with intellectual/developmental disabilities; c. Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury); d. Individuals with physical or sensory disabilities; e. Individuals residing in nursing facilities; f. Individuals with serious and persistent mental illnesses; g. Individuals with end stage renal disease, h. Individuals with complex or multiple chronic conditions; and i. Individuals who have no reported medical, behavioral health, or long-term service and support (LTSS) needs but may have needs in the future. <p>Responses to the Model of Care section should take into account the fact that many enrolled individuals will have co-occurring conditions and could be included in more than one sub-population. Populations identified in items a – h are also included as “Vulnerable Subpopulations” in Element #10.</p>

2. Measurable Goals

- a. Describe the specific goals including:
 1. Improving access to essential services such as medical, mental health, and social services
 2. Improving access to affordable care
 3. Improving coordination of care through an identified point of contact (e.g., gatekeeper)
 4. Improving seamless transitions of care across healthcare settings, providers, and health services
 5. Improving access to preventive health services
 6. Assuring appropriate utilization of services
 7. Improving beneficiary health outcomes (specify organization selected health outcome measures)
- b. Describe the goals as measurable outcomes and indicate how the organization will know when goals are met
- c. Discuss actions the organization will take if goals are not met in the expected time frame

The state has no further requirements beyond those listed above in **Element # 2.**

3. Staff Structure and Care Management Roles

- a. Identify the specific employed or contracted staff to perform **administrative** functions (e.g., process enrollments, verify eligibility, process claims, etc.)
- b. Identify the specific employed or contracted staff to perform **clinical** functions (e.g., coordinate care management, provide clinical care, educate beneficiaries on self-management techniques, consult on pharmacy issues, counsel on drug dependence rehab strategies, etc.)
- c. Identify the specific employed or contracted staff to perform **administrative and clinical oversight** functions (e.g., verifies licensing and competency, reviews encounter data for appropriateness and timeliness of services, reviews pharmacy claims and utilization data for appropriateness, assures provider use of clinical practice guidelines, etc.)

The state has no further requirements beyond those listed above in **Element # 3.**

4. Interdisciplinary Care Team (ICT)

- a. Describe the composition of the ICT and how the organization determined the membership
- b. Describe how the organization will facilitate the participation of the beneficiary whenever feasible
- c. Describe how the ICT will operate and communicate (e.g., frequency of meetings, documentation of proceedings and retention of records, notification about ICT meetings, dissemination of ICT reports to all stakeholders, etc.)

In addition to the elements described in **Element #4** above, additional state expectations include the following:

- d. If an enrollee is receiving Medicaid State Plan Targeted Case Management services, it is expected that the plan's ICT will include the targeted case manager as a member of the ICT. Describe how the plan will include the targeted case manager in the ICT.

5. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols

- a. Describe the specialized expertise in the organization's provider network that corresponds to the target population including facilities and providers (e.g., medical specialists, mental health specialists, dialysis facilities, specialty outpatient clinics, etc.)
- b. Describe how the organization determined that its network facilities and providers were actively licensed and competent

- c. Describe who determines which services beneficiaries will receive (e.g., is there a gatekeeper, and if not, how is the beneficiary connected to the appropriate service provider, etc.)
- d. Describe how the provider network coordinates with the ICT and the beneficiary to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the beneficiary in a timely and quality way, how reports on services delivered are shared with the plan and ICT for maintenance of a complete beneficiary record and incorporation into the care plan, how services are delivered across care settings and providers, etc.)
- e. Describe how the organization assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols (e.g., review of medical records, pharmacy records, medical specialist reports, audio/video-conferencing to discuss protocols and clinical guidelines, written protocols providers send to the organization's Medical Director for review, etc.)

The state has no further requirements beyond those listed above in **Element # 5**.

6. Model of Care Training for Personnel and Provider Network

- a. Describe how the organization conducted initial and annual model of care training including training strategies and content (e.g., printed instructional materials, face-to-face training, web-based instruction, audio/video-conferencing, etc.)
- b. Describe how the organization assures and documents completion of training by the employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, electronic training record, etc.)
- c. Describe who the organization identified as personnel responsible for oversight of the model of care training
- d. Describe what actions the organization will take when the required model of care training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion, etc.)

The state has no further requirements beyond those listed above in **Element # 6**. However, state staff may attend plan staff Model of Care trainings.

7. Health Risk Assessment

- a. Describe the health risk assessment tool the organization uses to identify the specialized needs of its beneficiaries (e.g., identifies medical, psychosocial, functional, and cognitive needs, medical and mental health history, etc.)
- b. Describe when and how the initial health risk assessment and annual reassessment is conducted for each beneficiary (e.g., initial assessment upon enrollment, annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, written form completed by beneficiary, etc.)
- c. Describe the personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, psychologist, etc.)
- d. Describe the communication mechanism the organization institutes to notify the ICT, provider network, beneficiaries, etc. about the health risk assessment and stratification results (e.g., written notification, secure electronic record, etc.)

In addition to the elements described in **Element #7** above, additional state expectations include the

following.

- e. Describe how the organization will ensure that initial HRAs for those individuals who are enrolled in the program at the time of program launch¹⁶ are conducted for individuals who meet the criteria of a “**Vulnerable Subpopulation**” (as outlined in Element #10(a)) within 60 days of enrollment and for all other enrollees, within 90 days of enrollment.
- f. Describe how the organization will ensure that HRAs for new enrollees who enter the Demonstration *after* the program’s launch¹⁷ are conducted within 30 days of enrollment for EDCD Waiver participants; within 60 days of enrollment for “**Vulnerable Subpopulation**” (as outlined in Element #10(a)) (excluding EDCD Waiver participants); and, within 60 days of enrollment for all other enrollees.
- g. Describe how the organization will ensure that Level of Care (LOC) annual reassessments are conducted timely for EDCD Waiver participants (minimum within 365 days of the last annual reassessment). For EDCD Waiver participants, describe how the organization will conduct annual face-to-face assessments (functional) for continued eligibility for the EDCD Waiver. The LOC annual reassessment must include all the elements on the DMAS 99-C LOC Review Instrument for individuals who are in the EDCD Waiver who have a change in status (available at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>). LOC annual reassessments for EDCD Waiver participants must be performed by providers with the following qualifications: (i) a registered nurse licensed in Virginia with at least one year of experience as an RN; or (ii) an individual who holds at least a bachelor's degree in a health or human services field and has at least two years of experience working with individuals who are elderly and/or have disabilities.
- h. Describe how the organization will ensure that Level of Care (LOC) annual reassessments are conducted timely (minimum within one year of the last assessment) for nursing facility residents and how the organization will work with nursing facilities to conduct these annual assessments (functional) for continued nursing facility placement.
- i. Describe how the organization will communicate annual LOC reassessment data for EDCD Waiver participants and nursing facility residents to DMAS in a timely manner.

8. Individualized Care Plan

- a. Describe which personnel develops the individualized plan of care and how the beneficiary is involved in its development as feasible
- b. Describe the essential elements incorporated in the plan of care (e.g., results of health risk assessment, goals/objectives, specific services and benefits, outcome measures, preferences for care, add-on benefits and services for vulnerable beneficiaries such as disabled or those near the end-of-life, etc.)
- c. Describe the personnel who review the care plan and how frequently the plan of care is reviewed and revised (e.g., developed by the interdisciplinary care team (ICT), beneficiary whenever feasible, and other pertinent specialists required by the beneficiary’s health needs; reviewed and revised annually and as a change in health status is identified, etc.)
- d. Describe how the plan of care is documented and where the documentation is maintained (e.g., accessible to interdisciplinary team, provider network, and beneficiary either in original form or

¹⁶ “At the time of program launch” includes the opt-in enrollment period and the passive enrollment period. All days are calendar days. The “clock” begins on the plan effective date.

¹⁷ “After the program’s launch” means ongoing enrollment. This starts in year 1 of the Demonstration, the month directly following the month that the plan receives members through passive enrollment.

copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality, etc.)

- e. Describe how the plan of care and any care plan revisions are communicated to the beneficiary, ICT, organization, and pertinent network providers.

In addition to the elements described in **Element # 8** above, additional state expectations include the following.

- f. Describe how the organization will ensure that plans of care for all individuals who are enrolled in the program at the time of the program's launch are conducted within 90 days of enrollment. Participating Plans must honor all existing plans of care and prior authorizations (PAs) until the authorizations ends or 180 days from enrollment, whichever is sooner. For EDCD Waiver participants, the plan of care must be developed and implemented by the Participating Plan no later than the end date of any existing PA.
- g. Describe how the organization will ensure that plans of care for new enrollees who enter the Demonstration *after* the program's launch are conducted within the following timeframes:
 - Within 30 days of enrollment for EDCD Waiver participants;
 - Within 60 days of enrollment for "Vulnerable Subpopulations" (as outlined in Element #10(a)) (excluding EDCD Waiver participants); and,
 - Within 90 days of enrollment for all other enrollees.
- h. The plan shall develop a POC for each individual enrolled in the plan. The POC will be tailored to individual needs, based on the plans method of stratification. The POC shall be updated and agreed to by the individual annually or upon reassessment resulting from a health status change.
 - 1. Describe the method of stratification, the person-centered and culturally competent POC development process, and how its POC development process will incorporate and not duplicate Targeted Case Management.
 - 2. Describe how information from the Uniform Assessment Instrument and LOC will be incorporated into the plan of care for individuals in the EDCD Waiver.¹⁸
 - 3. Describe the organization's process for obtaining nursing facility MDS data and how it will be incorporated into the POC.
 - 4. Describe how the organization will ensure that individuals in nursing facilities who wish to move to the community will be referred to the Money Follows the Person Program.
 - 5. Describe how the POC will address health, safety (including minimizing risk), and welfare of the participant.
- i. In addition to SNP Model of Care Element 8(b) listed above, describe the process the organization will use to include the following elements in the POC:
 - 1. Prioritized list of concerns, needs, and strengths;
 - 2. Attainable goals and outcome measures with target dates selected by the individual and/or caregiver;

¹⁸ The UAI may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/forms/032-02-0168-01-eng.pdf and the UAI User's Manual may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/manuals/uai/manual.pdf. Pre-admission screening criteria is available in the Preadmission Screening manual at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

3. Strategies and actions, including interventions and services to be implemented and the person(s)/providers responsible for specific interventions/services and their frequency;
4. Progress noting success, barriers or obstacles;
5. Enrollee’s informal support network and services;
6. Back up plans as appropriate (for EDCD Waiver participants using personal care and respite services) in the event that the scheduled provider(s) is unable to provide services;
7. Determined need and plan to access community resources and non-covered services;
8. Enrollee choice of services (including consumer-direction) and service providers; and
9. Elements included in the DMAS-97AB form, (which can be downloaded from <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>) for individuals enrolled in the EDCD Waiver.

- j. Describe how the organization will ensure that reassessments and plan of care reviews are conducted:
- By the plan of care anniversary for “Vulnerable Subpopulations” (as outlined in Element #10(a)) (excluding EDCD Waiver participants and nursing facility residents) and all other enrollees;
 - By plan of care anniversary, not to exceed 365 days for EDCD Waiver participants; and,
 - Participating Plans must follow MDS guidelines/timeframes for quarterly and annual plan of care development for nursing facility residents.

k. Describe how the organization will ensure that plans of care are revised based on triggering events, such as hospitalizations or significant changes in health or functional status.

9. Communication Network

- a. Describe the organization’s structure for a communication network (e.g., web-based network, audio-conferencing, face-to-face meetings, etc.)
- b. Describe how the communication network connects the plan, providers, beneficiaries, public, and regulatory agencies
- c. Describe how the organization preserves aspects of communication as evidence of care (e.g., recordings, written minutes, newsletters, interactive web sites, etc.)
- d. Describe the personnel having oversight responsibility for monitoring and evaluating communication effectiveness

In addition to the elements described in **Element #9(a)** above:

- e. The plan shall include how its communication structure will accommodate the needs of individuals with communication impairments (e.g., hearing and vision limitations) and individuals with limited English proficiency.

10. Care Management for the Most Vulnerable Subpopulations

- a. Describe how the organization identifies its most vulnerable beneficiaries
- b. Describe the add-on services and benefits the organization delivers to its most vulnerable beneficiaries

For Element 10(a) “**Vulnerable Subpopulations**” shall include, at a minimum:

- a. Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver;
- b. Individuals with intellectual/developmental disabilities;
- c. Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury);
- d. Individuals with physical or sensory disabilities;
- e. Individuals residing in nursing facilities;

- f. Individuals with serious and persistent mental illnesses;
- g. Individuals with end stage renal disease; and
- h. Individuals with complex or multiple chronic conditions.

11. Performance and Health Outcome Measurement

- a. Describe how the organization will collect, analyze, report, and act on to evaluate the model of care (e.g., specific data sources, specific performance and outcome measures, etc.)
- b. Describe who will collect, analyze, report, and act on data to evaluate the model of care (e.g., internal quality specialists, contracted consultants, etc.)
- c. Describe how the organization will use the analyzed results of the performance measures to improve the model of care (e.g., internal committee, other structured mechanism, etc.)
- d. Describe how the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care (e.g., electronic or print copies of its evaluation process, etc.)
- e. Describe the personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness (e.g., quality assurance specialist, consultant with quality expertise, etc.)
- f. Describe how the organization will communicate improvements in the model of care to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.)

In addition to the elements described in **Element #11** above, additional state expectations include the following.

- g. The plan needs to acknowledge its understanding that additional quality measures and evaluation, including but not limited to those identified below, will be required.

Quality Measurement and Evaluation

Participating plans will be required to report on quality indicators to allow an evaluation of the impact on quality of care for enrollees. The CMS-required Core Quality Performance Measures (as determined) and the EDCD Waiver Performance Measures. Plans must also adhere to Medicaid managed care regulatory standards in 42 CFR 438.240. **All performance measures are subject to change per final three-way contract terms.**

EDCD Waiver Quality Oversight

Plans will work with DMAS to monitor elements of the EDCD Waiver quality improvement strategy which must address assurances as required by CMS, including: (i) service plan, (ii) qualified providers, (iii) financial authority, (iv) health, safety, and welfare, (v) level of care; and (vi) administrative authority.

12. Additional Element #1: Hospital and Nursing Facility Transition Programs

Describe the process, systems, and goals in detail for ensuring smooth transitions to and from hospitals, nursing facilities and the community, including:

- a. How the plan will ensure that communication of an admission or discharge will be conveyed to the PCP, care manager and home and community-based providers within 24 hours;
- b. How the plan will ensure that admissions and lengths of stay are appropriate to the individual's needs;
- c. How the plan will ensure that there is timely and adequate discharge planning and medication reconciliation;
- d. How the plan will work to reduce the need for hospital transfers and emergency room use; and
- e. How the plan will work with nursing facility staff (including obtaining MDS Section Q data), hospital staff, and the state Long-Term Care Ombudsman to facilitate transitions to the community. This shall include how individuals are referred to local contact agencies in order to facilitate

transitions and are linked with other community resources that provide support to individuals and their families/caregivers, such as Centers for Independent Living, Community Services Boards, and local Area Agencies on Aging, and MFP.

13. Additional Element #2: Enhanced Care Management for Vulnerable Subpopulations

The plan shall describe how it will provide care management functions for *all* enrollees.

At a minimum, all enrollees shall have access to the following supports:

1. A single, toll-free point of contact for all questions;
2. Develop, maintain and monitor the POC.
3. Assurance that referrals result in timely appointments;
4. Communication and education regarding available services and community resources; and
5. Assistance developing self-management skills to effectively access and use services.

Enhanced Care Management for Vulnerable Subpopulations

All individual's identified as a "Vulnerable Subpopulation" as described in **Element # 10(a)** must, at a minimum, receive Enhanced Care Management services.

Describe how the organization will ensure that the following activities will be performed:

1. Ensure that individuals receive needed medical and behavioral health services, preventative services, medications, LTSS, social services and enhanced benefits; this includes setting up appointments, in-person contacts as appropriate, strong working relationships between care managers and physicians; evidence-based patient education programs, and arranging transportation as needed.
2. Monitor functional and health status;
3. Ensure seamless transitions of care across specialties and settings;
4. Ensure that individuals with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options;
5. Connect individuals to services that promote community living and help avoid premature or unnecessary nursing facility placements;
6. Coordinate with social service agencies (e.g. local departments of health, social services, Area Agencies on Aging, and Community Services Boards) and refer enrollees to state, local, and other community resources; and
7. Work with nursing facilities to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the NF benefit.

14. Additional Element #3: Partnering with Community Care Management Providers

Describe any innovative arrangements the plan will use to provide care management. Plans are strongly encouraged to partner and/or contract with entities that currently perform care management and offer support services to individuals eligible for the Demonstration. This flexibility includes the use of innovations such as health homes, sub-capitation, shared savings, and performance incentives. Entities can include, but are not limited to Community Services Boards (CSBs), adult day care centers, and nursing facilities.

Model of Care Assessment and Plan of Care Expectations¹⁹

	Implementation Health Risk Assessment (at program launch ²⁰)	Implementation of MCO Plan of Care (at program launch)	Initial Health Risk Assessment (for new enrollees after program launch)	Initial Plan of Care (for new enrollees after program launch)	Reassessment and POC Review	As Needed POC Revised	Level of Care Annual Reassessment
Community Well	Within 90 days of plan enrollment ²¹	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner. ²²)	Within 60 days of enrollment	Within 90 days of enrollment	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Vulnerable Subpopulation²³ (Excluding EDCD & nursing facility)	Within 60 days of plan enrollment	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.)	Within 60 days of enrollment	Within 60 days of enrollment	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
EDCD Vulnerable Subpopulation	Within 60 days of plan enrollment (must be face-to-face)	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.) The POC must be developed and implemented by the MCO no later than the end date of any existing PA.	Within 30 days of enrollment (must be face-to-face)	Within 30 days of enrollment	By POC anniversary date, not to exceed 365 days ²⁴ (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan conducts annual face to face assessment (functional) for continued eligibility for the EDCD Waiver. ²⁵
Nursing Facility Vulnerable Subpopulation	Within 60 days of plan enrollment (must be face-to-face and incorporate MDS)	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.)	Within 60 days of enrollment (must be face-to-face)	Within 60 days of enrollment	Follow MDS guidelines/time frames for quarterly and annual POC development	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan works with facility on annual assessment (functional) for continued nursing facility placement.

¹⁹ This chart is subject to final revision pursuant to DMAS and CMS Memorandum of Understanding and three-way contract negotiations.

²⁰ “At Program Launch” includes the opt-in period and passive enrollment period during year 1 of the demonstration.

²¹ The clock starts at the effective date of enrollment and days are measured in calendar days.

²² Prior authorizations for Medicaid services will be provided in the enrollee’s transition report.

²³ Vulnerable Subpopulation is defined in Element #10(a) of the Model of Care.

²⁴ Plans must comply with requirements for the EDCD Waiver as established in [12 VAC 30-120-900 et. seq.](#)

²⁵ Local and Hospital Preadmission Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, and PACE).

3.7 Covered Services

As outlined in this Section, the participating plan shall cover the following services:

1. All Medicare Parts A, B, and D services in accordance with 42 C.F.R. 422.101 (including inpatient, outpatient, DME, skilled NFs, home health, and pharmacy);
2. The majority of Medicaid State Plan services that are not covered by Medicare, including behavioral health and transportation services (see Appendix G for a list of services that will be included and excluded from the Demonstration);
3. Medicaid-covered EDCD Waiver services: adult day health care, personal care (consumer-and agency-directed), respite services (consumer-and agency-directed), personal emergency response system (PERS), transition coordination, and transition services;
4. Personal care services for persons enrolled in the Medicaid Works program;
5. Nursing facility services; and
6. Flexible benefits that will be at the option of participating plans.

3.7.1 Medicare Services

Selected Offeror shall provide or arrange to provide the full array of benefits and supportive services afforded individuals under Medicare in accordance with 42 CFR § 422.101 including: Medicare Part A (inpatient, hospice, home health care); Part B (outpatient); and, Part D (pharmacy services).

Participating plans must adhere to CMS rules regarding choice of health professionals for services historically provided by Medicare.

3.7.2 Medicaid Services

Participating plans shall promptly provide, arrange, purchase, or otherwise make available all covered Medicaid services as defined under the State Plan for Medical Assistance (State Plan) as amended, the 1932(a) State Plan Amendment, the §1915(c) EDCD Waiver, written Department policies (including, but not limited to, contracts, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. Each Offeror's response to this RFP shall provide a description of the understanding of each service and how services shall be provided. It is not acceptable to state that services shall be provided.

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

Coverage decisions that depend upon service authorization and/or concurrent review to determine medical necessity must be rendered in accordance with the medical necessity requirements that will be outlined in the three-way contract.

Participating plans shall cover all pre-existing conditions.

3.7.3 Telemedicine Services

DMAS encourages participating plans to cover telemedicine services as medically necessary. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

3.7.4 Covered Drug Classes

There are specific drug classes that, by law, are not covered under the Medicare Part D program but are covered by Medicaid. The plan shall include these drugs in the HPMS formulary submission (on the ADD file) and cover these medications in accordance with existing Medicaid policy as described in Chapter 50 of the Virginia Administrative Code (12 VAC 30-50; “Amount, Duration, and Scope of Medical/Remedial Services”). The drug classes that Medicare does not cover, but that are covered by Virginia Medicaid for dual eligibles include:

- i. Select medications for weight loss (service/prior authorization required);
- ii. Select legend and non-legend medications for symptomatic relief of cough and colds;
- iii. Select prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations);
- iv. Select FDA approved over-the-counter medications (prescriptions are required);

Participating plans shall also cover compounded prescription drug products for Part D recipients that contain: (1) all Part D drug product components; (2) some Part D drug product components; or (3) drug components covered by Virginia Medicaid (i.e., drugs listed above, i-iv).

3.7.5 Nursing Facility (NF) Services

DMAS shall require contractual agreements between NFs and plans. Payment for services shall be made to NFs directly by participating plans. Participating plans shall contract with any NF that is eligible to participate in Medicare and Medicaid and is willing to accept the plan’s payment rates and contract requirements. Plans shall respond to the following specific questions regarding nursing facilities:

- a. Please describe the credentialing process that the Plan will use with nursing facilities.
- b. Under the Demonstration, skilled nursing level care may be provided in a long term care facility without a preceding acute care inpatient stay for individuals enrolled in the Demonstration, when the provision of this level of care can avert the need for an inpatient stay. Attest that the plan will meet this requirement during the Demonstration.
- c. What specific criteria and metrics, if any, will be used by the plan to evaluate nursing facility quality? How will these quality outcomes impact payment, patient placement, referral, and case management?
- d. When it is determined that a nursing facility is not able to safely meet the needs of an enrollee (e.g., due to dangerous behaviors) or because the enrollee no longer meets the nursing facility level of care requirement, will payment to the facility continue until a safe, alternate placement is secured? What specific resources and assistance for alternate placement will be provided by the plan?
- e. Plans will be required to pay no less than the Medicaid rate for Medicaid covered days. DMAS will publish Medicaid rates by nursing home based on current effective rates or the most recent effective rates inflated to the contract period. During the demonstration, DMAS expects to modify the nursing facility reimbursement methodology so that facility rates will be adjusted by

acuity using Resource Utilization Groups (RUGs). Plans must be able to accommodate the new payment methodology, unless an alternate reimbursement methodology is agreed upon by contracted nursing facilities. Attest that the plan will meet these requirements during the Demonstration.

- f. Will claims be processed within the same payment timelines as current Medicaid and Medicare payments (e.g., DMAS currently sends remittances within 14 days).
- g. What will constitute a clean claim for nursing facility payment?

3.7.6 Long-Term Services and Supports Provided Through the EDCD Waiver

Participating plans shall cover the LTSS services provided through the EDCD Waiver for individuals who are enrolled in the EDCD Waiver (see Appendix G). EDCD Waiver services include: adult day health care, personal care (agency and consumer-directed), personal emergency response systems and medication monitoring, respite care (agency and consumer-directed), transition services, and transition coordination.

3.7.7 Consumer-Directed Fiscal/Employer Agent (F/EA) Services

Under consumer-directed service options, many individuals will be able to achieve greater independence if they hire and manage their own personal and respite care attendants rather than depend solely on home health care/nurses/aides or family members. Describe the plan's experience with consumer directed services in other states and best practices that could potentially be applied in Virginia. The Department will contract with a consumer-directed F/EA and participating plans shall use this F/EA as the F/EA for their enrollees and the Department will pay the F/EA administrative fees directly to the contracted F/EA. This amount will not be included in the capitation rate. However, participating plans will be responsible for covering the cost of personal and respite services provided through the consumer-directed model. Expectations regarding F/EA services will be outlined in the three-way contract.

3.7.8 Medicaid Covered Behavioral Health Services

Plans shall cover the Medicaid behavioral health services outlined in Appendix C.

3.7.9 Transportation Services

Participating plans shall cover emergency and Medicaid non-emergency transportation to ensure that enrollees have necessary access to and from providers of covered medical, behavioral health, and LTSS services, per 12VAC30-50-530.

3.7.10 Flexible Benefits

Offerors that are considering providing flexible benefits shall include in their proposals a preliminary list of the flexible benefits they may offer, the benefit limits, and criteria for the approval of requests for each flexible benefit. Flexible benefits shall also be included in the plan benefit package submitted via HPMS and approved by both CMS and DMAS.

Examples of potential flexible benefits include, but are not limited to: chiropractic care; vision; dental; hearing; assistive technology; environmental modifications; personal care services for individuals who do not meet the level of criteria for the EDCD Waiver, or a service whereby a "coach" goes into members' homes at critical times to prepare an individual's and his/her environments for conditions he/she may

soon experience (e.g., discharge from hospital for hip replacement, an individual with a visual impairment).

No increased reimbursement shall be made for flexible benefits provided by participating plans. Flexible benefits may not be used to substitute for Medicaid State Plan covered services. Flexible benefits offered by participating plans will be listed in the Department's and CMS' comparison charts. Comparison charts are revised once annually. Any additions to flexible benefits occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Participating plans must be able to provide to the Department and CMS, upon request, data summarizing the utilization of and expenditures for flexible benefits provided to enrollees during the contract year.

3.7.11 Integrated Health Home Systems of Care

DMAS intends for participating plans to provide the flexibility for and encourage the development of behavioral health homes (BHHs) appropriate for individuals with serious and persistent mental illness (SPMI) using Community Services Boards (CSBs) as BHHs in partnership with the plans.²⁶ The BHHs shall collectively serve as a comprehensive behavioral health management program that integrates physical and behavioral health services and that has the staff and resources to improve health care delivery, including the ability to rapidly respond to acute episodes for individuals with severe mental illnesses.

Offerors are also encouraged to establish health homes for individuals with other complex health conditions. Ideally, health homes should leverage existing community systems currently in place that serve individuals with complex health and social needs. Examples may include, but are not limited to, health homes for individuals with dementia utilizing area agencies on aging, rural health clinics, adult day care centers, or other community provider.

RFP responses shall include information on how the plan will ensure that health home providers coordinate with the plan and interdisciplinary care teams to promote a seamless experience for enrolled individuals. Responses provided by the plans shall include how it will partner with CSBs for individuals with SPMI (and other community health partners as appropriate for individuals with other needs as described above) within the designated regions to incorporate the principles of a health home, which include:

- Lowering the rates of hospital emergency department (ED) use;
- Reducing hospital admissions and re-admissions;
- Improving access to urgent care services;
- Reducing healthcare costs;
- Identification of improper pharmaceutical services;
- Facilitating improved collaboration and exchange of information among treating providers;
- Decreasing reliance on hospitals or long-term care facilities;
- Improving the experience of care, quality of life and consumer satisfaction; and,
- Improving overall health outcomes.

3.8 Medical Necessity

The process to determine medical necessity for covered services will be addressed in the three-way contract.

²⁶ Behavioral Health Homes will not be implemented under Section 2703 of the Affordable Care Act in the Demonstration; enhanced matching funds will not be claimed for these activities.

3.9 Coverage of Previously Authorized Services

Participating plans shall assume responsibility for all services covered under this RFP authorized by either the Department, CMS or a previous plan, which are in effect after the enrollment effective date. Plans must honor all existing POCs and Medicaid prior authorizations until the authorization ends or 180 days from enrollment, whichever is sooner. Participating plans will provide automatic transfer of service/prior authorizations for traditional Medicare-paid services that conform to Medicare Advantage and Medicare Part D timeframes. Individuals in a NF at the time of implementation may remain in that facility as long as they remain eligible for nursing facility-level of care, if they or their families so choose. Specifics will be outlined in the three-way contract.

3.10 Patient Pay Amount

When an individual's income exceeds an allowable amount, he or she must contribute toward the cost of their LTC services. This contribution, known as the *patient pay amount*, is required for individuals residing in a NF and for those receiving EDCD Waiver services. Patient pay is required to be calculated for every individual receiving NF or EDCD Waiver services, although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be outlined in the three-way contract.

3.11 Marketing and Promotional Materials and Activities

Participating plans shall adhere to marketing and promotional requirements that will be specified in the three-way contract.

3.12 Provider and Recipient Grievances and Appeals

Participating plans shall be required to comply with the provider and recipient grievance and appeals processes that will be specified in the three-way contract.

3.13 Quality Ratings, Quality Assurance and Evaluation

Medicare and Medicaid: Offerors with Medicare and/or Medicaid plans that are accredited by the National Committee for Quality Assurance (NCQA) in Virginia and/ or other states shall provide the following for each:

- 1) Name of each health plan as it appears on NCQA's website and whether it is a Medicare or Medicaid product.
- 2) Current accreditation level (must include a copy of the most recent accreditation/re-accreditation confirmation letter from NCQA). If the current accreditation level is different from the confirmation letter, an explanation must be included.
- 3) A copy of the auditor-locked interactive data submission system (IDSS) from the most recent HEDIS audit.
- 4) A copy of the most recent Adult CAHPS report.

Medicaid (applicable to those with Medicaid experience): Offerors shall also submit the most recent two (2) years of external quality review organization (EQRO) reports from up to two (2) states (if applicable) where they have their Medicaid book of business. The EQRO reports should include the three mandatory external quality improvement activities per the BBA, Section 438.358) a comprehensive operational systems review, performance measure validations, and performance improvement projects validations.

Offerors shall comply with all DMAS and CMS or their designated agents (e.g., EQRO and/or independent evaluator) on quality improvement activities and studies and Demonstration evaluations, in accordance with the three-way contract. This will include, but will not be not limited to readiness reviews; the collecting and reporting of specified quality measures and assurances; operational systems reviews; performance measure validation; performance improvement project validations; EDCD Waiver specific performance activities; and all other Demonstration evaluation activities.

3.14 Overview of Relevant Experience

Offerors shall provide a description of the plan's experience working with Medicare and Medicaid enrollees including vulnerable populations. Responses must include a table with columns indicating experience with Medicare, Medicaid, and integrated programs containing the following information:

- a. Location (statewide or geographic region(s) covered);
- b. Programs/product lines (e.g., Medicare Advantage, Special Needs Plan, etc.);
- c. Duration;
- d. Average enrollment size;
- e. Whether enrollment is/was mandatory or voluntary;
- f. Populations included (Document using the "Plan-Specific Target Populations" included in Element #1 of the Model of Care);
- g. Age range of enrollees;
- h. General type of services covered (e.g., medical, nursing facility, home and community-based services, behavioral health, etc.); and
- i. Prevalent conditions of the enrolled population.

3.15 Vignettes

Offerors shall include responses to each of the vignettes included in Appendix D. The RFP evaluation process will also include an in-person presentation by each plan on a minimum of two (2) of the vignettes. Further details regarding the presentation will be provided to respondents, but the presentation should demonstrate the plan's structural capability and ability to excel at meeting the needs of the enrolled population. The standards outlined in the following sections will be used to evaluate the respondent's MOC structure and capabilities.

To complete this requirement, the plan should describe how it would apply its Model of Care to provide services and supports to the individuals depicted in each vignette. Responses do not need to include all elements of the Model of Care. Plans should focus their responses on the elements that they deem most applicable. The timeframe addressed should begin at initial enrollment and include the next 18 months. Vignettes should be a maximum of five pages, single spaced. Responses to the vignettes should be detailed, responsive to individual needs and preferences, and take into account the health, safety and welfare of enrollees. To respond to these vignettes, plans may use the information included to draw inferences about the individuals' needs.

3.16 Readiness Review

CMS and DMAS, either directly or with contractor support, shall conduct a readiness review of each selected plan. CMS and DMAS must agree that a plan has passed readiness review prior to that plan conducting any marketing or accepting any enrollment. CMS and DMAS will collaborate in the design and implementation of the readiness review process and requirements. This readiness review shall include an evaluation of the capacity of each potential plan and its ability to meet all program requirements, including having an adequate network that addresses the full range of enrollee needs, and the capacity to

uphold all individual safeguards and protections. Any changes required to a plan's processes as identified through readiness review activities shall be made by the plan prior to implementation. Costs associated with these changes shall be borne by the plan. In response to this RFP, the plan must provide written assurances that it will submit to an operational readiness review and adhere to the all requirements of the readiness review (including reporting). CMS has published guidance on capitated financial alignment demonstration plan readiness reviews at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Mass_RR_memo.pdf. This guidance is somewhat specific to Massachusetts but may be an indication of priority areas for readiness reviews. CMS will update the Medicare-Medicaid Coordination office website to include subsequent state-specific review tools as they are developed.

SECTION IV: PAYMENT TO THE PARTICIPATING PLANS

Payment processes described in this section must be tested as part of the implementation readiness review. Any changes required to a plan's processes as identified through readiness review activities shall be made by the plan prior to implementation. Costs associated with these changes shall be borne by the plan.

CMS and the Department shall issue capitation payments on behalf of enrollees at the rates established in the three-way contract and which may be modified during the annual contract renewal process. Capitation rates will be net of a quality withhold amount to be identified in the three-way contract. The plan shall accept the annually established capitation rates paid each month by the Department and CMS as payment in full for all Medicaid and Medicare services to be provided pursuant to this RFP and all administrative costs associated therewith, pending final recoupments, reconciliation, sanctions or payment of quality withhold amounts. Quality withhold amounts may be paid to the plan after the end of the contract year, if the plan meets the performance measure standards established in the three-way contract between the plan, CMS and DMAS. Any and all costs incurred by the plan in excess of the capitation payment shall be borne in full by the plan. The plan shall accept the Department's electronic transfer of funds to receive capitation payments.

4.1 Reinsurance

Participating plans shall obtain reinsurance from an insurer other than the Department for coverage of enrollees under the contract.

4.2 Recoupment/Reconciliation

The Department shall recoup an enrollee's capitation payment for a given month in cases in which an enrollee's exclusion or disenrollment was effective retroactively. The Department shall not recoup an enrollee's capitation payment for a given month in cases in which an enrollee is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to: death of an enrollee, cessation of Medicaid eligibility, inpatient admission to a State mental hospital, or approval for HCBS waiver services other than the EDCD Waiver. The Department shall also recoup capitation payments made in error by the Department.

When membership is disputed between two plans, the Department shall be the final arbitrator of plan enrollment and reserves the right to recoup an inappropriate capitation payment.

Participating plans shall not be liable for the payment of any services covered under the contract rendered to an enrollee after the effective month of the enrollee's disenrollment.

If the contract is terminated, Medicaid recoupments shall be handled through a payment by the plan within thirty (30) calendar days after contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile payments on a quarterly basis. Included in the quarterly reconciliation shall be adjustments that may be required in accordance with the terms established in the three-way contract. This reconciliation shall be based on adjustments known to be needed through the end of the quarter. If reconciliation withholdings exceed reconciliation payments, the Department may, at its option, withhold from subsequent monthly payments or bill the plan for the difference, in which case the plan shall provide payment within thirty (30) calendar days of the bill date.

4.3 Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC)

Participating plans must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs for any historically Medicaid-covered services.

SECTION V: REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

Remedies for non performance will be specified in the three-way contract between DMAS, CMS and the participating plans.

SECTION VI: PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

Each plan shall submit a Proposal by May 15, 2013, in relation to the requirements described in this RFP. The following describes the general requirements for each proposal.

General Requirements for Proposals

6.1 Overview

Proposals shall be developed and submitted in accordance with the instructions outlined in this section. Proposals shall be prepared simply and economically, and shall include a straightforward, concise description of the plan's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the plan's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the offeror considers relevant to this RFP.

Proposals shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks a lower score or elimination from consideration if the evaluators are unable to find where the RFP requirements are specifically addressed. The Department and the evaluators are not obligated to ask the plan to identify where an RFP requirement is addressed, and no plan should assume that it will have an opportunity to supplement its proposal or to assist the evaluators in understanding and evaluating its proposal. Failure to provide information required by this RFP may result in rejection of the proposal.

6.2 Binding of Proposal

Proposals shall be clearly labeled “RFP 2013-05” on the front cover. The legal name of the organization submitting the proposal shall also appear on the cover.

The proposal shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2” x 11” paper with 1” margins, and printed on one side only. Offerors may use a larger size font for section headings and may use a smaller font size for footers, tables, graphics, exhibits, or similar sections, if necessary. Larger graphics, exhibits, organization charts, and network diagrams may also be printed on larger paper as a foldout if 8 1/2” x 11” paper is not practical. Each copy and all documentation shall be contained in single three-ring binder volumes where practical. The proposal shall contain a Table of Contents (reference requirements in Section 6.3). A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The plan shall submit one original and seven (7) copies of the bound proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked “RFP 2013- 05”. The plan shall also submit five electronic copies (thumb drives preferred) of its proposal in MS Word format (Microsoft Word 2007 or compatible format). In addition, the plan shall submit a redacted electronic copy in PDF format of its proposal, in which the plan has removed proprietary and trade secret information. DMAS reserves the right to make a determination regarding what constitutes redacted information. Please note that, as described below, merely redacting information is not sufficient to comply with *Code of Virginia* §2.2-4342(F).).

6.3 Table of Contents

The proposal shall contain a Table of Contents that cross-references the RFP submittal requirements. Each section of the proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist DMAS and CMS in determining uniform compliance with specific RFP requirements.

6.4 Submission Requirements

All information requested in this RFP shall be submitted in the plan’s proposal. By submitting a proposal, the plan certifies that all of the information provided is true and accurate. Plans will be accountable for providing services and meeting requirements as described in their response to this RFP.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP shall belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the proposal and reasons the information should be confidential shall be clearly stated.

Trade secrets or proprietary information submitted by a plan are not subject to public disclosure under the Virginia Freedom of Information Act; however, the plan shall invoke the protections of Section 2.2-4342(F) of the *Code of Virginia*, in writing, either before or at the time the data is submitted. The written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The plan assures that information and data obtained as to personal facts and circumstances related to Medicaid individuals will be collected and held confidential during and following the term of the three-way contract between CMS, DMAS and participating plans, and will not be divulged without the

individual's and the DMAS' written consent. Any information to be disclosed, except to DMAS, must be in summary, statistical, or other form, which does not identify particular individuals.

The proprietary or trade secret materials submitted shall be identified by some distinct method, such as highlighting or underlining, and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. **The classification of an entire proposal as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal.** Appendix H of this RFP shall be used for the identification of proprietary or confidential information and submitted with the proposal.

6.5 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the plan to contracts and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the contract and Addenda (if issued).

At a minimum, the transmittal letter shall contain the following:

1. A statement that the plan meets the required conditions to be an eligible candidate for the contract award including:

- The plan must identify any contracts or contracts it has with any state or local government entity that is a Medicaid provider or plan and the general circumstances of the contract. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest;
- The plan must be able to present sufficient assurances to the Department that the award of the contract with the plan will not create a conflict of interest between the plan, the Department, and its subcontractors; and
- The plan must be licensed to conduct business in the Commonwealth of Virginia.

2. A statement that the plan has read, understands and agrees to perform all of the plan responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the contract and addenda;

1. The plan's general information, including the address, telephone number, and facsimile transmission number;
2. Designation of an individual, to include their e-mail and telephone number, as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the resultant contract; and
3. A statement agreeing that the plan's proposal shall be valid for a minimum of 180 days from its submission to DMAS.

6.6 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda (if issued) to the RFP, the Certification of Compliance with Prohibition of Political Contributions and Gifts during the RFP Process form (Appendix I), and the State Corporate Commission form (Appendix J) and submit them along with its proposal.

6.7 Department Contact

The principal point of contact for this RFP at DMAS shall be:

Karen Kimsey
Deputy Director, Complex Care and Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Email: DualIntegration@dmas.virginia.gov

When submitting questions or comments to this mailbox please identify your inquiry as related to RFP 2013-05. All communications with DMAS regarding this RFP should be directed to the principal point of contact. All RFP content-related questions shall be in writing to the principal point of contact. All questions must be submitted by April 19, 2013. A plan that communicates with any other employees or Contractors of DMAS concerning this RFP after issuance of the RFP may be disqualified from the selection process.

6.8 Submission and Acceptance of Proposals

The proposal, whether mailed or hand delivered, shall arrive at DMAS no later than 10:00AM EST on May 15, 2013. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals shall not be accepted and shall be automatically rejected from further consideration. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:

Attention: Christopher Banaszak
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:

Attention: Christopher Banaszak
Department of Medical Assistance Services
7th Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

DMAS reserves the right to reject any and all proposals. DMAS and CMS reserve the right to delay implementation of the Demonstration if satisfactory plans are not identified or if DMAS and CMS determine a delay is necessary to ensure that the implementation goes smoothly without service interruption. Plans must check the DMAS web site at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx for all official postings of addendums or notices regarding this RFP. DMAS will also post the information on the eVA web site at <http://www.eva.virginia.gov> but the DMAS web site will serve as the official and controlling posting site

6.9 Oral Presentations and Site Visits

At any point in the evaluation process, DMAS may employ any or all of the following means of evaluation:

- Reviewing Industry Research
- Proposal Presentations
- Site Visits
- Contacting Offeror References
- Product Demonstrations
- Requesting Offeror to elaborate on or clarify specific portions of their proposals.

No plan is guaranteed an opportunity to explain, supplement or amend its initial proposal. Plans must not submit a proposal assuming that there will be an opportunity to negotiate, amend or clarify any aspect of their submitted response. Therefore, each plan is encouraged to ensure that its initial submission contains and represents its best offering.

Plans should be prepared to conduct product demonstrations, presentations or site visits at the time, date and location of DMAS' or CMS' choice, should DMAS or CMS so request.

DMAS or CMS may make one or more on-site visits to see the plan's operation of another contract. DMAS and CMS shall be solely responsible for its own expenses for travel, food and lodging.

6.10 Proposal

The following describes the required format, content and sequence of presentations for the Proposal which is due May 15, 2013.

6.10.1 Chapter One: Executive Summary

The Executive Summary Chapter shall highlight the Offeror's:

- i. Understanding of the Demonstration's requirements;
- ii. Qualifications to serve as a plan for the Demonstration; and,
- iii. Overall Approach to the Demonstration and a summary of the contents of the proposal.

6.10.2 Chapter Two: Corporate Qualifications and Experience

Chapter Two shall present the Offeror's qualifications and experience to serve as a participating plan. Specifically, the plan shall describe its:

1. Organization Status:
 - A. Name of Project Director for this Contract;
 - B. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written;
 - C. Federal employer ID number;
 - D. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers);
 - E. Name of the parent organization and major subsidiaries;
 - F. Major business services;
 - G. Legal status and whether it is a for-profit or a not-for-profit company;
 - H. A list of board members and their organizational affiliations;
 - I. An organizational chart that lists all entities within the corporate family and definitions and their relationship to one another (i.e. show parent/subsidiary relationships); and
 - J. Any specific licenses and accreditation held by the Offeror.
2. Corporate Experience:
 - A. Plan's overall qualifications to carry out a project of this nature and scope;
 - B. The Offeror shall describe the background and success of its organization and experience in performing the services described in this RFP, including the operation of any Medicare Advantage plans; Medicare Special Needs plans; Medicare Part D plans; and Medicaid plans and/or scope of any planned sub-contracted arrangements; and the most recent Medicare Star

ratings; NCQA rankings and ratings or other benchmarking information received from national certifying organizations;

- C. The plan's knowledge of the Medicaid and Medicare recipient populations;
- D. Experience with the delivery of or contracting for the provision of managed long-term services and supports, behavioral health and other human services, the plan shall indicate the contract or project title, dates of performance, scope and complexity of contract;
- E. Any other related experience the plan feels is relevant shall be included;
- F. The plan shall indicate whether the plan has had a contract terminated for any reason within the last five years; and,
- G. The plan also shall indicate if a claim was made on a payment or performance bond. If so, the plan shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.
- H. Three references of non- Offeror owned customers or previous clients that will serve to substantiate the Offeror's qualifications and capabilities to perform the services required by the RFP. The Offeror shall complete the Reference Form in Appendix L for each reference, which includes the contract name, address, telephone number, contact person, and periods of work performance for each reference.

3. Financial, Management, and Administrative Capabilities:

The plan must submit the following:

- A. If currently operating in Virginia, a copy of a valid and current license (not under suspension or revocation) from the Virginia State Corporation Commission's Bureau of Insurance, and copies of quarterly and annual filings submitted to the BOI within the past two calendar years. The plan must retain the appropriate licensures at all times during the period of the contract, including licensure by the State Corporation Commission as set forth in the Code of Virginia § 38.2-4300 through 38.2-4323, 14 VAC5-211-10 et. seq. and any and all other applicable laws of the Commonwealth of Virginia, as amended.
- B. Documentation of submission of a Notice of Intent to Apply (NOIA), a Capitated Financial Alignment Demonstration Application, and other requirements in accordance with CMS timelines and specifications as outlined in all Demonstration-relevant CMS notices and guidance. Plans should be aware that there is some information that will be collected through CMS' HPMS that will be evaluated as part of this RFP.
- C. Copy of service area approval and certificate issued by the Center for Quality Health Care Services and Consumer Protection. Pursuant to §32.1-137.1 through §32.137.7 Code of Virginia, and 12VAC5-408-10 et. seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services they deliver.

6.10.3 Chapter Three: Tasks and Technical Approach

The plan shall submit all required information and documentation, and fully describe how it intends to meet all of the tasks required in the RFP. DMAS does not want a "re-write" of the requirements. Specifically, the plan shall describe in detail its proposed approach for each of the required tasks. This includes how each task will be performed, what problems need to be overcome, what functions the staff will perform, and what assistance will be needed from DMAS and CMS, if any. Supporting documentation for the Technical Approach may be included as Appendices.

Note: DMAS welcomes new and innovative approaches for the Demonstration. While fully addressing the objectives of this RFP, the plan may also include alternate approaches for consideration.

6.10.4 Chapter Four: Required Forms

This chapter shall contain the signatory documents as outlined in the RFP. These include the following:

1. RFP Cover Sheet
2. RFP Addenda (if issued).
3. Plans Transmittal Letter
4. Proprietary/Confidential Information Identification Form (Appendix H)
5. Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process (Appendix I)
6. State Corporation Commission Form (Appendix J)

6.11 Misrepresentation of Information

Misrepresentation of an offeror's status, experience, or capability may result in rejection of a proposal. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department and CMS, result in rejection of a proposal or immediate contract termination or rejection of the proposal.

6.12 Schedule of Events

If it becomes necessary to revise any part of this RFP, or if additional data is necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be issued to all plans by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. The contract and subsequent information will be listed on the Department's website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx. DMAS will also post the information on the eVA web site at <http://www.eva.virginia.gov> but the DMAS web site will serve as the official and controlling posting site

SECTION VII: PROPOSAL EVALUATIONS AND AWARD CRITERIA

DMAS will evaluate the Proposals received in response to this RFP in a fair and impartial manner provided for by law. The Evaluation Team will be responsible for reviewing and scoring of all proposals. This group will be responsible for making the final recommendation to award to the DMAS Director. This Request for Proposals is governed by, and shall be administered in accordance with, the Virginia Public Procurement Act (Code of Virginia § 2.2-4300, *et seq.*)

7.1 Evaluation of Minimum Requirements

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the proposal. Proposals shall comply with the instructions to plans contained throughout this RFP and take into account past Medicare experience, as specified by CMS. DMAS will select a minimum of two plans to operate the demonstration in each demonstration region. Failure to comply with the instructions may result in a lower score or elimination from further consideration. DMAS reserve the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

Signature Sheets: RFP Cover Sheet, Addenda (if issued), Transmittal Letter, Proprietary/Confidential Information Identification Form (Appendix H), Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process (Appendix I), and State Corporation

Commission Form (Appendix J). These forms shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section 6.8, before the closing of acceptance of proposals in the number of copies specified.

Compliance: The proposal shall comply with the entire format requirements described in this RFP.

7.2 Proposal Evaluation Criteria

All proposals will be reviewed for network adequacy for Medicaid services. All plans must demonstrate the capacity to meet all financial, management, and administrative capabilities outlined in this RFP.

The broad criteria for evaluating proposals include the elements below:

Criteria	Weight %
Response to Model of Care Including Virginia-specific requirements	25%
Quality (Medicare and/or Medicaid)	20%
Demonstrated Understanding of Virginia’s Medicare-Medicaid Enrollees and Provider Systems (including integrated health homes, nursing facilities, consumer-directed service delivery model)	20%
Experience with Population	15%
Past Plan Performance (including references, poor performance, sanctions, and unsatisfactory resolution of requested corrective action plans)	15%
Response to Vignettes (including written responses and in-person presentations)	5%

7.3 Intent to Contract

The Department will select qualified and licensed plans for participation in the Demonstration. The Department will notify the selected plans of the intent to contract. The Department and CMS reserve the right to conduct an on-site review to assess the readiness of the plan to effectively administer the Demonstration and to provide all the functions and tasks defined in the RFP and CMS plan selection process.

At any time, the Department may terminate all activities and cancel or re-release this RFP. The reasons for such termination will be documented and made part of the State file.

APPENDIX A:**Regions and Localities for Demonstration****Central Virginia**

FIPS	Locality
7	Amelia
25	Brunswick
33	Caroline
36	Charles City
41	Chesterfield
49	Cumberland
53	Dinwiddie
57	Essex
75	Goochland
81	Greensville
85	Hanover
87	Henrico
97	King And Queen
99	King George
101	King William
103	Lancaster
111	Lunenburg
117	Mecklenburg
119	Middlesex
127	New Kent
133	Northumberland
135	Nottoway
145	Powhatan
147	Prince Edward
149	Prince George
159	Richmond Co.
175	Southampton
177	Spotsylvania
179	Stafford
181	Surry
183	Sussex
193	Westmoreland
570	Colonial Heights
595	Emporia
620	Franklin City
630	Fredericksburg
670	Hopewell
730	Petersburg
760	Richmond City

Northern Virginia

FIPS	Locality
13	Arlington
47	Culpeper
59	Fairfax County
61	Fauquier
107	Loudoun
153	Prince William
510	Alexandria
600	Fairfax City
610	Falls Church
683	City of Manassas
685	Manassas Park

Tidewater

FIPS	Locality
1	Accomack ²⁷ (OPTIONAL)
73	Gloucester
93	Isle Of Wight
95	James City County
115	Mathews
131	Northampton ²⁸ (OPTIONAL)
199	York
550	Chesapeake
650	Hampton
700	Newport News
710	Norfolk
735	Poquoson
740	Portsmouth
800	Suffolk
810	Virginia Beach
830	Williamsburg

²⁷ Offerors are encouraged, but not required to participate in these localities. Non-participation will not result in a lower score for the offeror.

²⁸ Offerors are encouraged, but not required to participate in these localities. Non-participation will not result in a lower score for the offeror.

Western/Charlottesville

FIPS	Locality
3	Albemarle
15	Augusta
29	Buckingham
65	Fluvanna
79	Greene
109	Louisa
113	Madison
125	Nelson
137	Orange
165	Rockingham
540	Charlottesville
660	Harrisonburg
790	Staunton
820	Waynesboro

Roanoke

FIPS	Locality
005	Alleghany
017	Bath
019	Bedford County
023	Botetourt
045	Craig
063	Floyd
067	Franklin County
071	Giles
089	Henry
091	Highland
121	Montgomery
141	Patrick
155	Pulaski
161	Roanoke County
163	Rockbridge
197	Wythe
515	Bedford City
530	Buena Vista
580	Covington
678	Lexington
690	Martinsville
750	Radford
770	Roanoke City
775	Salem

APPENDIX B: Budget Language

2011 Appropriations Act Language

297.MMMM.1. The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department shall engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 of each year to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees detailing implementation progress including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change. The intent of this Item may be achieved through several steps, including, but not limited to, the following:

g. The department may seek the necessary waiver(s) and/or State Plan authorization under Title XIX of the Social Security Act to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

2012 Appropriations Act Language

Item 307. RRg. The Department may seek the necessary waiver(s) and/or State Plan authorization under Title XIX of the Social Security Act to develop and implement a care coordination model for individuals dually eligible for services under both Medicare and Medicaid. The Director of the Department of Medical Assistance Services, in consultation with the Secretary of Health and Human Resources, shall establish a stakeholder advisory committee to support implementation of dual-eligible care coordination systems. The advisory committee shall support the dual-eligible initiatives by identifying care coordination and quality improvement priorities, assisting in securing analytic and care management support resources from federal, private and other sources and helping design and communicate performance reports. The advisory committee shall include representation from health systems, health plans, long-term service and support providers, health policy researchers, physicians, and others with expertise in serving the aged, blind and disabled, and dual-eligible populations. The department shall have the authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.

APPENDIX C: Medicaid Covered Behavioral Health Services

Providers who have the appropriate licensure and qualifications may provide the services below. Please refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.

Crisis Intervention - Defined as immediate behavioral health care, available 24 hours a day, seven days a week, to assist individuals who are experiencing acute behavioral dysfunction requiring immediate clinical attention such as individuals who are a danger to themselves or others. This service's objective is to prevent exacerbation of a condition, to prevent injury to the consumer or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention includes assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family unit with ongoing care to prevent future crises. Crisis intervention activities may include office visits, home visits, pre-admission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the Virginia Administrative Code at 12 VAC 30-50- 226.

Crisis Stabilization - Is provided to non-hospitalized individuals experiencing an acute psychiatric crisis that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the Virginia Administrative Code at 12 VAC 30-50- 226.

Day Treatment/Partial Hospitalization Services - Sessions of two or more consecutive hours per day are provided. Sessions may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services include the major diagnostic, medical, psychiatric, psychological, and psycho-educational treatment modalities designed for individuals with serious behavioral disorders. The day treatment center could be attached to a psychiatric hospital or CSB clinic site. Services are for individuals with a serious behavioral health disorder and goal is to keep them out of a psychiatric hospital.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-60-61 and 12 VAC 30-50-226.A.

Intensive Community Treatment, or ICT - Is an array of behavioral health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. ICT is provided through a designated multi-disciplinary team of behavioral health professionals. It is available 24 hours per day.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-226 and 12 VAC 30-60-143.

Mental Health Support Services - Training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. These services may be authorized for six consecutive months. This program shall provide the following services in order to be reimbursed by Medicaid: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-226.

Opioid Treatment - Services that are similar to Substance Abuse Day Treatment, but it is provided to persons with Opioid dependence and who need medication to prevent withdrawal.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-228.

Psychosocial Rehabilitation - (“Clubhouse Model”) for the severely behaviorally ill. Psychosocial rehabilitation is provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services include assessment, education about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature. Staff may observe medication being taken, watch and observe behaviors and note side effects of medications. These services are limited to 936 units annually.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the Virginia Administrative Code at 12 VAC 30-50- 226.

Residential Substance Abuse Treatment for Pregnant and Post Partum Women– Services are for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. The member's care is supervised by a nurse case manager. The member must agree to actively participate in her care. Services provided are substance abuse rehabilitation, counseling, and treatment, pregnancy and fetal development education, symptom and behavior management, and personal health care training. No reimbursement for any other Community Mental Health/Mental Retardation/Substance Abuse rehabilitative services are available while the member is participating in the program.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-510.

Substance Abuse Targeted Case Management - Assists individuals and their families with accessing needed medical, psychiatric, psychological, social, educational, vocational services and other supports essential to meeting basic needs. The Medicaid eligible member shall meet the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) diagnostic criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence is not covered.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-491.

Substance Abuse Crisis Intervention - Substance abuse treatment services, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute dysfunction related to substance use which requires immediate clinical attention. The objectives are to prevent exacerbation of a condition; and injury to the member or others; and to provide treatment in the least restrictive setting. Crisis intervention services are provided following a marked reduction in the member’s psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress related to the use of alcohol or other substances.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-420, 12 VAC 30-50-430 and 12 VAC 30-50-228.

Substance Abuse Day Treatment - Services of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week. Substance abuse day treatment may not be provided concurrently with intensive outpatient (IOP) or Opioid treatment services.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-228.

Substance Abuse Day Treatment for Pregnant and Post Partum Women -Comprehensive intensive services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, and achieving and maintaining a sober and drug-free lifestyle. Only behavioral health crisis intervention services or behavioral health crisis stabilization may be reimbursed for members of day treatment services. A billing unit is equal to a minimum of two hours, but less than four hours.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-510.

Substance Abuse Intensive Outpatient Treatment - Services two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is 19 hours per week. This service should be provided to those members who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. Intensive outpatient services may not be provided concurrently with day treatment services or Opioid treatment Services.

Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-228.

Temporary Detention Orders (TDO) - A TDO is an order issued by a magistrate for a person who is in imminent danger to themselves or others as a result of behavioral illness or is so seriously behaviorally ill to care for self and is incapable or unwilling to volunteer for treatment.

The TDO's time duration shall not exceed 48 hours prior to a commitment hearing unless the 48 hours terminates on a Saturday, Sunday, legal holiday or there is an unusual circumstance. The hearing must be held on the next workday. Coverage and reimbursement is provided to the facility and for physician services provided that relates to emergency medical or psychiatric care. Medical screenings or services provided that do not relate to the behavioral illness are excluded from coverage.

Service criteria for TDOs as an inpatient acute hospitalization are described in detail in the Hospital Manual (see <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>).

APPENDIX D: Vignettes

Plans must respond to each of the vignettes included in this Appendix. The RFP evaluation process will also include an in-person presentation by each plan on a minimum of two (2) of the vignettes selected by the Department. Further details regarding the presentation will be provided to respondents, but the presentation should demonstrate the plan's structural capability and ability to excel at meeting the needs of the enrolled population. The standards outlined in the following sections will be used to evaluate the respondent's MOC structure and capabilities.

Vignette 1: Ashley, 22 year old female

Ashley has severe Intellectual Disability (ID) (formerly called mental retardation) and lives with her adoptive family consisting of her mother, brother, and sister. Ashley meets the criteria for the Urgent Care Wait List for the ID Waiver because her parents are over 55 and her primary care givers indicate they are having difficulties helping to care for Ashley due to her physical care needs and their own physical conditions.

Ashley has Rett Syndrome, a neuro-developmental disorder which is characterized by repetitive movements, seizures, and mobility issues as well as severe ID. It is often confused with Autism. In addition to the developmental and medical conditions associated with Rett Syndrome, Ashley has seasonal allergies and a history of seizures. Furthermore, Ashley's birth mother was HIV positive and drug addicted.

With severe ID and Rett Syndrome, Ashley has limited verbal communication and uses mostly gestures. She needs a wheelchair, primarily for safety because she is very unsteady on her feet, has impaired mobility and is at risk of wandering if left alone. Currently, Ashley receives in-home personal care and respite services through the EDCD Waiver and Targeted Case Management through the local Community Services Board (CSB) to coordinate these and other vital services.

Vignette 2: Henry, 46 year old male

Henry has schizoaffective disorder and alcohol dependence. He also has diabetes and hypertension. Henry has a history of psychiatric hospitalizations and has been involved with public safety agencies. With help from the CSB Intensive Community Treatment team he has begun to manage his mental illness, hypertension, and diabetes and has learned to administer his insulin appropriately and consistently. He has become sober, in part because of the medication assisted treatment drug, Vivitrol, that he receives monthly along with the counseling and monitoring components required for medication assisted treatment. With support of the team, Henry has gained benefits and, thanks to a voucher he received through the CSB, he will be able to be in a stable housing situation. He will be receiving ongoing community based, wrap around supports from the ICT Team, which is and will continue helping to coordinate his medical care.

Vignette 3: Laura, 68 year old female

Laura has multiple sclerosis and uses a motorized wheel chair for traveling distances further than about twenty feet. She has lived alone for many years. She continued to work as a sales consultant for a large retail company for many years after her diagnosis. She slipped while bathing and stayed in a nursing facility for 80 days after a brief hospitalization. She returned to work for several months after returning home but quit work due to extreme fatigue and began receiving Social Security Disability Income.

Laura enrolled in the Medicaid Elderly or Disabled with Consumer Direction (EDCD) Waiver. Some months she could not afford to pay the patient payment amount and cut down on personal attendant services. Laura fell and broke her collarbone resulting in a hospitalization and nursing facility admission. She contracted MRSA and developed decubiti. After a five month stay in the facility, Laura determined that she wanted to return to the community and live in her own home.

Laura transitioned to her own apartment. Although she received personal care services, she was not able to receive assistance to prepare the special dietary meals she required. The bathroom in her apartment was not accessible; she had to use a bedside commode and was limited to sponge baths once she was no longer able to stand and pivot, to assist with transfers in the bathroom.

Laura became isolated and stayed at home other than medical appointments. Her medications were provided by Medicare Part D, which only partially covered the costs. She fell behind in her monthly rent and utilities payments. Her electricity was discontinued twice due to late payments. She was evicted from her apartment. A referral was made to Adult Protective Services (APS). APS was unable to locate a shelter that was accessible. Laura went to a hospital emergency room where she stayed for two nights before being transferred to a nursing facility. Laura wants to leave the nursing facility and go back to work. Her health and stamina continue to decline and she is increasingly socially isolated.

Vignette 4: Fred, 70 year old male

Fred has a diagnosis of CHF, CAD, Cardiomyopathy, HPTN, Renal Insufficiency, EF 25%, and depression. Fred is currently taking the following medications: Tylenol; Lipitor; Coreg; Plavix; Lasix; Imdur; Maalox; NTG; Prilosec; Ranolazine; Venlafaxine; and, Ambien. ACEI and Beta blocker were discontinued during a recent visit due to renal insufficiency.

Fred lives with his daughter who works full-time and is concerned because he is doing “crazy things like putting keys in freezer, forgetting all the time and his personality seems changed.” His daughter is increasingly concerned because he is alone while she is at work. The daughter must work for the family to be financially viable.

Fred has been admitted to the hospital four (4) times in the past four (4) months and has had one emergency department visit and a Cath Lab visit. Fred was admitted for dyspnea progressive over five (5) days. It was noted that he has gained 25lbs over past month and 3-4lbs in the past week. Fred’s daughter admits to taking him to fast food restaurants and giving him Gatorade for convenience and as a distraction from his “concerning behavior.” His daughter has been doubling his Lasix to accommodate for weight gain. She states that he drinks fluids all the time and is home alone during the day. Fred had defibrillator upgraded four (4) weeks prior. Fred’s weight at admit was 92kg and 90kg at discharge. Fred has a follow-up appointment scheduled for five (5) days.

Excerpts from Fred’s patient-centered care coordination plan include:

- 1) Patient
 - a. Refer for Mental Status Exam for possible Alzheimer’s Disease Dx- discontinue Venlafaxine and Ambien possibly start Aricept
 - b. Adult Day Program w/ Transportation five (5) times per week to provide:
 - Supervision
 - Medication Management
 - Heart Healthy meals; 1/3 of RDI
 - Exercise
 - Socialization
 - c. Personal Care
 - d. The Program of All-Inclusive Care for the Elderly (PACE)
- 2) Daughter
 - a. Caregiver Support Coordination
 - b. Education on heart healthy meal preparation
 - c. Respite

Vignette 5: Rose, 80 year old female

Rose is a long-stay nursing facility resident with primary medical/physical needs. She has the following diagnoses/conditions: Hypertension; Diabetes; Coronary Artery Disease; Low to Moderate Dementia; Arthritis; Vascular Disease; Incontinence; Parkinson's; and, Depression. Rose has limited and inconsistent access to Hospice services. She also has limited financial income and resources. Rose requires extensive assistance with all activities of daily living (ADLs), medication administration, treatment, restorative nursing, and intermittent rehab therapy services. Her communication abilities (receptive/expressive) cause moderate staff concern.

Rose has moderate care needs. Her family's involvement is low. Rose has moderately utilized laboratory and diagnostic (including radiology and ultrasound) services. She is on 10 medications (includes over-the-counter). Rose has access to limited transportation services which are inconsistent in terms of quality and reliability. At their own expense, Roses' nursing facility sometimes elects to send staff escorts. Since Rose resides in a rural nursing facility, her nursing facility experiences greater difficulty in securing primary care services for their long-stay residents. Geriatric-focused primary care physicians are in very short supply. Access to medical specialists is a significant problem for all specialty areas – more problematic in rural areas and especially acute for wound care, dermatology and dental. Access to dialysis services in rural areas is challenging as a result of both geographic proximity and limited transportation resources. In terms of access to behavioral health specialists, Rose experiences limited access to psychiatric and psychology services. Telehealth access shows promise but current limited availability. There is limited CSB support.

**APPENDIX E:
EDCD Waiver Plan of Care Form**

Agency-Directed Services Consumer-Directed Services Assessment Date: _____

Recipient: _____ Medicaid ID#: _____
 Provider: _____ Provider ID#: _____

DD WAIVER: WRITE THE AMOUNT OF TIME FOR EACH TASK TO THE NEAREST 15 MINUTES

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADL's							
Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
Total ADL Time:							
2. Special Maintenance							
Vital Signs							
Supervise Meds							
Range of Motion							
Wound Care							
Bowel/Bladder Program							
Total Maint. Time:							
3. Supervision Time							
4. IADLS							
Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Recipient							
Shop/List Supplies							
Laundry							
(CD only) Money Management							
Medical Appointments							
Work/School/Social							
Total IADLS Time:							
TOTAL DAILY TIME:							

This Section Must Be Completed in its Entirety for Agency- & Consumer-Directed Services

Composite ADL Score = (The sum of the ADL ratings that describe this recipient.)			
BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers w/ HH or w/HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		EATING SCORE	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/etc.	2
AMBULATION SCORE		CONTINENCY SCORE	
Walks/Wheels without help w/MH only	0	Continent/incontinent < wkly self care of internal /external devices	0
Walks/Wheels w/ HH or HH & MH	1	Incontinent weekly or > Not self care	2
Totally dependent for mobility	2		
Level of Care (LOC)	<input type="checkbox"/> A (Score 0 - 6) Maximum Hours of 25/Week	<input type="checkbox"/> B (Score 7 - 12) Maximum Hours 30/Week	<input type="checkbox"/> C (Score 9 + wounds, tube feedings, etc.) Maximum Hours 35/Week
	<input type="checkbox"/> D Exceeds 35 Hours per Week	<input type="checkbox"/> E	Exceptions by Department

Recipient: _____ Medicaid ID#: _____
 Provider: _____ Provider ID#: _____

Initial Plan of Care hours must be pre-authorized & should not exceed the maximum for the specified LOC category. Documentation must support the amount of hours provided to the recipient.

Reason Plan of Care Submitted: New Admission ↑ In Hours ↓ In Hours Transfer
 Reason for change/additional instructions for the aide: _____

Backup Plan (Person's name) for CD Services: _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____
 Recipient / Care Giver Signature: _____ Date: _____
 RN or SF Signature: _____ Date: _____

Instructions for the DMAS-97A/B (09/05)

Provider Notification To Client

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, please contact the RN Supervisor who has signed the plan of care to discuss the reason that you disagree with the change. If the provider agency is unwilling or unable to change the information, and you still disagree, you have the right to an appeal by notifying, in writing, The Appeals Division, The Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request for an appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for an appeal before the effective date of this action, _____ (effective date), services may continue unchanged during the appeal process.

Instructions for Completion of the DMAS-97A/B
Category/Tasks:

FOR DD WAIVER ONLY: Write the amount of time for each task to be done to the nearest 15 minutes. This should be done for each task for each day. Then put the total time for each category, for each day.

OTHER WAIVERS: Place a check mark for each task and put the total time for each category, for each day. Writing the amount of time for each task to the nearest 15 minutes is not necessary, but it greatly assists in the review of authorization requests.

Level of Care Determination For Maximum Weekly Hours:

Enter a score for each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B, C, D, or E. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC of A, B, or C. Check LOC D if the amount of hours per week exceeds 35. Category D can only be used with prior approval from DMAS or the PA contractor. Prior-authorization (PA) must be obtained prior to initiating a change outside the authorized LOC category.

Provider Notification To Client:

Anytime the RN Supervisor or Service Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require PA approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to appeal. The client should get a copy of both the front and back of the form.

PA Contractor Notification To Client:

If the changes to the Plan of Care require PA approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to PA contractor for approval. If supervision is requested, please remember to attach the Request for Supervision form (DMAS-100). Once received by the PA contractor, the analyst will review the care plan and indicate whether the request is pended, approved, or denied. The recipient will receive by mail the decision letter from the DMAS Fiscal Agent.

Recipient / Care Giver Signature

The recipient's signature is necessary on the original plan of care and decreases to the hours of care. It is not needed if the hours increase in a new plan of care. The provider may substitute the signature with documentation in the recipient's record that shows acceptance of the plan of care.

APPENDIX F

Summary of Select Medicaid Covered Services for the Duals Demonstration

This attachment is not intended to be a comprehensive list of covered benefits. Participating plans will provide Medicare benefits as defined by CMS. A comprehensive list of benefits will be articulated in the three-way contract between the plan, State and CMS. All benefit limits for Medicaid covered services should be verified through the State Plan for Medicaid 12 VAC 30-50 and the appropriate DMAS Provider Manual. Home and community-based long-term care services are outlined in Appendix G.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Case Management Services for Participants of Auxiliary Grants	12 VAC 30-50-470 12VAC30-10-320 Chapter iv of the Assisted Living Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved out (pursuant to 12VAC30-10-320)	The plan is not required to cover this service. This service will be covered through a carve out. This is not a widely used program and is included as part of the annual reassessment screening process for assisted living recipients.
Targeted Case Management for Individuals with Intellectual Disabilities	12 VAC 30-50-440 Chapter IV of the Mental Retardation/Intellectual Disability Community Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved Out	The plan is not required to cover this service. This service is provided by the Community Services Boards.
Court Ordered Services	Code of Virginia Section 37.1-67.4	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover all medically necessary court ordered Dual Demonstration covered services. In the absence of a contract otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Dental Services (ADULT)	12 VAC 30-50-190 38.2-341.12 of the Code of Virginia The Dental Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Non-covered, except for certain circumstances. See notes.	The plan shall cover CPT codes billed by an MD as a result of an accident. The plan shall cover CPT and other “non-CDT” procedure codes billed for medically necessary procedures of the mouth. The plan shall cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care. Optional: The plan, at its option, may cover certain dental services as for Dual Demonstration participants.
High-Risk Prenatal Services	12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-510 12 VAC 30-50-410 Chapter 4 of the Baby Care Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	Provide or arrange for services for pregnant women. These services shall address the following major goals: To reduce infant mortality and morbidity; To ensure provision of comprehensive services to pregnant and postpartum women, and To assist pregnant and postpartum women and caregivers of infants in meeting other priority needs that affect their well-being and that of their families. These needs may include non-medical needs and non-covered services. Program services shall include, at a minimum, the following: Case management services for high-risk pregnant women that include coordination of services for maternal health to minimize fragmentation of care, reduce barriers, and link individuals with appropriate services to ensure comprehensive, continuous health care. These coordination services will include: <ul style="list-style-type: none"> a. Assessment to determine individuals’ needs which includes psychosocial, nutrition, and medical factors. b. Person-centered service planning to develop individualized descriptions of what services and resources are needed to meet the service needs of the individual and how to access those resources. c. Coordination and referrals that will assist the individual in arranging for appropriate services and ensure continuity of care. d. The plan shall develop and offer expanded prenatal care services for all pregnant women comparable to those described in 12 VAC 30-50-510 and 12 VAC 30-50-290. They shall provide a comprehensive prenatal care service package which may include services such as patient education, homemaker services, nutritional assessment and counseling, and provision of blood glucose meters when medically necessary.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01 Chapter IV of the Physician Manual (https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The plan shall ensure that, as a routine component of prenatal care, every pregnant individual shall be advised of the value of testing for HIV infection as set forth in 12 VAC 30-50-510 and shall request of each such pregnant individual consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Any pregnant individual shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the individual's medical record.
Home Health Services	12 VAC 30-50-160 Chapter IV of the Home Health Manual (https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover home health services, including nursing services, rehabilitation therapies, and home health aide services. Visits by a licensed nurse and home health aide services shall be covered as medically necessary. Rehabilitation services (physical therapy, occupational therapy, and speech-language therapy) shall also be covered under the individual's home health benefit. The plan must manage the following service related conditions, where medically necessary and regardless of whether the need is long-term or short-term: B-12 shots, insulin injections, central line and porta cath flushes, blood draws for example where the individual is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance, changing of indwelling catheter. This includes those instances where the member cannot perform the services; where there is no responsible party willing and able to perform the services, and where and the service cannot be performed in the PCP office/outpatient clinic, etc. The plan shall not refer for skilled nursing under the home and community based waivers for these conditions. The plan is not required to, but may at their option, cover the following home health services, except if ordered by a physician as a result of an high-risk pregnancy screen: medical social services, services that would not be paid for by Medicaid if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Medical Supplies and Equipment	12 VAC 30-50-160 12 VAC 30-50-165 12VAC30-120-195 Durable Medical Equipment & Supplies Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	<p>The plan shall cover all medical supplies and equipment at least to the extent they are covered by DMAS. The plan is responsible for payment of any specially manufactured DME equipment that was prior authorized by the plan, even if the member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the member is retro-disenrolled for any reason by the Department and the effective date of the retro-disenrollment precedes the date the equipment was authorized by the plan. The Department and all Contractors must use the valid preauthorization begin date as the invoice date. Specialized equipment includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Customized wheelchairs and required components; • Customized prone standers; and, • Customized positioning devices <p>Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition is administered orally or through nasogastric or gastrostomy tube, and is necessary to treat a medical condition.</p>
Nursing Facility	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	<p>The plan shall cover this service. The plan shall also be responsible for non-nursing facility services and shall work with the nursing facility on discharge planning if appropriate. The plan will establish strong relationships with nursing facilities to ensure that individuals in nursing facilities receive high quality care, maintain good health, and to reduce avoidable hospital admissions among nursing facility residents. Plans will help facilitate individuals returning to community settings when possible and desired by the individual. The plan may provide additional health care improvement services or other services not specified in this contract, including but not limited to step down nursing care as long as these services are available, as needed or desired, to individuals.</p>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-160 12 VAC 30-50-200 12VAC30-130-40 12 VAC 30-50-225 Chapter IV of the Rehabilitation Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP), and audiology services. The scope of coverage for Medicaid specifically includes coverage for both acute and non-acute conditions. Medicaid regulations define “acute conditions” as conditions that are expected to be of brief duration (less than 12 months) in which progress toward goals is likely to occur frequently. “Non-acute conditions” are defined as conditions that are of long duration (greater than 12 months) in which progress toward established goals is likely to occur slowly. PT, OT, SLP, and audiology services are covered regardless of where they are provided, with two exceptions. The plan shall be required to cover services rendered in a nursing facility if the services are not offered as an in-house component of the facility. The plan shall also cover all medically necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Podiatry	12 VAC 30-50-150 Chapter IV of the Podiatry Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover podiatric services that are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. The plan is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture.
Pregnancy-Related Services	12 VAC 30-50-220 12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-410	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover services to pregnant women, including: <ul style="list-style-type: none"> a. Prenatal services, including patient education, nutritional assessment, counseling and homemaker services, as set forth in 12 VAC 30-50-510 and 12 VAC 30-50-290; b. Case management services for high-risk pregnant women, as set forth in 12 VAC 30-50-410 and 12 VAC 30-50-280. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit as indicated by the most recent “Guidelines for Perinatal Care” developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The early discharge follow-up visit shall be provided to all mothers, who meet the Department’s criteria for early discharge, as set forth in 12 VAC 30-50-220. The early discharge follow-up visit shall be provided within forty-eight (48) hours of discharge and must include, at a minimum, a maternal assessment, as set forth in 12 VAC 30-50-220.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Prescription Drugs	12 VAC 30-50-210 12 VAC 30-50 §38.2-4312.1 of the Code of Virginia Chapter IV of the Pharmacy Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320 and in coordination with Medicare Part D)	The plan shall cover all Medicaid covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits. The plan is not required to cover Drug Efficacy Study Implementation (DESI) drugs. The plan may establish a formulary and shall have in place authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary and if Medicaid would cover them under fee-for-service. If the drug is prescribed for an “emergency medical condition,” the plan must pay for at least a 72-hour supply of the drug to allow the plan time to make a decision. The plan shall cover therapeutic drugs even when they are prescribed as a result of non-covered services or carved-out services (e.g., narcotic analgesics after cosmetic surgery). The plan shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The plan is responsible for coverage of specific drug classes that are excluded by law under the Medicare Part D but covered under the currently established guidelines of the DMAS pharmacy benefit program. Drugs for the treatment of erectile dysfunction are not covered by Medicaid. Under the Duals Demonstration, the plan may not impose co-payments on payments on prescription drugs.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120 Chapter IV of the Prosthetic Devices Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover Medically necessary prosthetic and orthotic services and devices. Coverage for prosthetics includes artificial arms, legs and their necessary supportive attachments, internal body parts (implants), breasts, and eye prostheses when eyeballs are missing and regardless of the function of the eye. The plan shall cover medically necessary prosthetics and orthotics for an individual regardless of the individual’s age when recommended as part of an approved intensive rehabilitation program.
Telemedicine Services	Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall provide coverage for telemedicine services at least to the extent covered by the Department. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Department recognizes physicians, nurse practitioners, nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and State laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Temporary Detention Orders (TDOs) & Emergency Custody Orders (ECOs)	<p>42 CFR 441.150 and Code of Virginia 16.1-335 et seq. Code of Virginia § 37.2-808 and the Appropriations Act of 2006 - 2008, Item 300, B</p> <p>Appendix B of the Hospital Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</p>	Carved in (pursuant to 12VAC30-10-320)	<p>The plan shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services. The medical necessity of the TDO services is assumed by the Department to be established, and the plan may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the individual is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. When an out-of-network provider provides TDO services, the plan shall be responsible for reimbursement of these services. In the absence of a contract otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid fee-for-service rate in effect at the time the service was rendered. Temporary detention orders do not accrue toward the total number psychiatric visits. If it is determined by the judge, as the result of a hearing, that the individual may be transferred without medically harmful consequences, the plan may designate an appropriate in-network or out-of-network facility for the provision of care. The plan will cover TDO in accordance with Medicaid timely filing requirements which are for one year from the date of the TDO. The plan shall provide, honor and be responsible for payment of medically necessary screenings and assessments for persons who are under an emergency custody order.</p>
Transportation	<p>12 VAC 30-50-530 12 VAC 30-50-300 Chapter 4 of the Transportation Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</p>	Carved in (pursuant to 12VAC30-10-320)	<p>The plan shall provide emergency transportation as well as non-emergency transportation to all Medicaid covered services. These modes include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The plan shall cover air travel for critical needs. The plan shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § CFR 440.170(a). The plan shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services. The plan shall cover transportation to and from Medicaid covered community mental health and rehabilitation services.</p>
Vision Services	<p>12 VAC 30-50-210 Chapter iv of the Vision Services Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</p>	Carved in (pursuant to 12VAC30-10-320)	<p>The plan shall cover Vision services which are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all individuals, shall be allowed at least once every two (2) years.</p>

BEHAVIORAL HEALTH SERVICES			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Non-covered	The plan is not required to cover this service. Individuals in State Psychiatric Hospitals are excluded from the Demonstration.

OUTPATIENT MENTAL HEALTH SERVICES			
****The plan is responsible to cover outpatient mental health services. The benefit maximum for adults in the first year of treatment shall not be less than 52 visits, and 26 visits per year following the first year of treatment. Medication management visits are not to be counted against the number of outpatient psychiatric visits.			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Psychiatric Diagnostic Exam	12VAC30-50-180 12VAC30-50-140	Carved in (pursuant to 12VAC30-10-320)	****
Individual Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wp/s/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	****
Group Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wp/s/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	****
Family Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wp/s/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	****
Electroconvulsive Therapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****

Psychological/ Neuropsychological Testing	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****
Pharmacological Management	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****
COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Community Mental Health Services	12VAC30-50-130 12VAC30-50-226 12VAC30-50-420 through 12VAC30-50-430 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in	The plan shall cover Community Mental Health Services.
Community Mental Retardation Services	12VAC30-50-440 Chapter IV of the Mental Health/Intellectual Disability Community Services Manual (https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved out	This service will be covered through a carve out. The plan must provide information and referrals as appropriate to assist recipients in accessing these services. The plan shall cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.

SUBSTANCE ABUSE TREATMENT SERVICES			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Out-patient substance abuse treatment	12 VAC 30-50-141 12 VAC 30-50-151 12 VAC 30-50-181 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover substance assessment and evaluation and outpatient services for substance abuse treatment for individuals enrolled in the Dual Demonstration. Emergency counseling services, intensive outpatient services, day treatment, opioid treatment, and substance abuse case management services are carved-out of this contract and shall be covered by the Department. Transportation and pharmacy services necessary for the treatment of substance abuse, including for carved out services, shall be the responsibility of the plan.
Residential Treatment for Pregnant Women	12VAC30-50-510 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in	The plan shall cover Residential Treatment for Pregnant Women.
Day Treatment for Pregnant Women	12VAC30-50-510 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in	The plan shall cover Day Treatment for Pregnant Women.

**APPENDIX G:
Long-Term Services and Supports Provided Through the EDCD Waiver**

Services covered under the EDCD Waiver include: adult day health care, personal care (agency and consumer-directed (CD)), personal emergency response systems (with or without medication monitoring), respite care (agency and CD), transition services, and transition coordination.

The EDCD Waiver includes consumer-direction. Consumer-direction allows individuals to serve as the employer for the individual who provides personal care and respite care. Consumer-direction is optional for EDCD Waiver/Demonstration participants.

Adult Day Health Care (ADHC) Services

Adult Day Health Care Services (ADHC) may be offered to elderly individuals and individuals with physical disabilities who have been assessed to be at risk of institutionalization, meet the criteria for NF care, and have been screened by a Pre-Admission Screening (PAS) Team for EDCD Waiver services and authorized. ADHC services offered through the EDCD waiver are defined as long-term maintenance or supportive services which are necessary to enable the individual to remain at home rather than enter a NF.

ADHC services are designed to prevent institutionalization by providing individuals with health, maintenance, and rehabilitation services in a congregate daytime setting. The significant difference between ADHC and personal care is the congregate setting in which ADHC is rendered. The plan shall enter into Participation Agreements with qualified adult day care centers which are licensed by the Virginia Department of Social Services (DSS).

The services offered by the ADHC Center must be designed to meet the needs of the individual. Thus, the range of services provided by the ADHC Center to each individual may vary to some degree. There must, however, be a minimum range of available services, including: nursing services, rehabilitation services coordination, transportation, nutrition services, social services, recreation, and socialization services.

Service criteria are described in detail in the EDCD Waiver regulations at 12 VAC 30-120-940 and the provider manual at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual> .

Personal Care Services: Agency -and Consumer-Directed

Personal care services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or to participate in community activities. The individual must meet DMAS' requirements for assistance with ADLs in order for personal care services to be authorized. Personal care services are defined as direct assistance with and supervision of activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD).

The unit of service for personal care services is one hour. In the current DMAS EDCD Waiver program, payment is available only for allowable activities that are authorized and provided by a qualified provider in accordance with an approved Plan of Care when the individual is present. Personal care services are limited to the hours specified in the Plan of Care. The 2011 Virginia General Assembly approved budget bill language (Item 297 CCCCC) requires DMAS to develop and implement a 56 hour per week cap for personal care services under the EDCD Waiver. DMAS has implemented exception criteria for those individuals who require more than 56 hours per week of personal care services.

Personal assistance services include assistance with ADLs such as: bathing, dressing, transferring, and, toileting. This service does not include skilled nursing services, with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18 VAC 90-20-420 through 18 VAC 90-20-460. When specified in the Plan of Care, personal assistance services may include assistance with IADLs, such as housekeeping, shopping, meal preparation, etc., but does not include the cost of meals themselves. Assistance with IADLs must be essential to the health and welfare of the individual, rather than the individual's family. These services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. Provision of these services is not limited to the home.

Additional components of personal assistance are work-related and school-related personal assistance where the personal assistance and supports may be provided in the workplace and post-secondary educational institutions. This service is only available to individuals who require personal assistance services to meet their ADLs. Workplace or school supports through the EDCD Waiver are not provided if they are services provided by the Department for Aging and Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act of Section 504 of the Rehabilitation Act.

Service criteria for agency-directed personal assistance and consumer-directed personal assistance are described in detail in the EDCD Waiver regulations at 12 VAC 30-120-950 and 12 VAC 30-120-980, respectively, and the EDCD Waiver provider manual at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

Personal Emergency Response System (PERS)

Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. PERS electronically monitors safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication monitoring devices.

PERS services are limited to individuals who live alone, are alone for significant parts of the day, have no regular caregivers for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency, and who would otherwise require extensive routine supervision. Individuals must be receiving another EDCD Waiver service in order to be eligible to receive PERS services. While medication monitoring services are also available to those receiving PERS services, medication monitoring units must be physician ordered and are not considered a stand-alone service.

Service criteria are described in detail in the EDCD regulations at 12 VAC 30-120-970 and the provider manual at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

Respite Care Services – Agency and Consumer-Directed

Respite services are personal care (agency-directed or consumer-directed) or services of a nurse (agency-directed) that are specifically designed to provide temporary, substitute care that is normally provided by the family or another unpaid primary caregiver. Respite is for the relief of the primary unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the individual. These services are provided on a short-term basis because of an emergency absence, or need

for routine or periodic relief of the primary caregiver who lives in the home with the individual. The maximum amount of respite care services that an individual may receive in the DMAS program is 480 hours in a state fiscal year. In the DMAS EDCD Waiver program, individuals who are receiving consumer-directed, agency-directed, and facility-based respite services cannot exceed 480 hours per state fiscal year combined. Respite care can be authorized as a sole community-based care service, or it can be offered in conjunction with other EDCD Waiver services.

Respite services are usually provided by a personal care attendant. However, a licensed nurse may provide skilled respite in cases where the individual has a skilled nursing need, provided the following circumstances are met:

1. A physician's order must be obtained prior to the start of skilled respite services and must be kept in the individual's record. The order must be renewed every six (6) months;
2. The individual receiving care has a need for skilled care that cannot be provided by unlicensed personnel (e.g., patients on a ventilator, patients requiring nasogastric or gastrostomy feedings, suctioning, etc.);
3. No other individual in the recipient's support system is able to provide the skilled component of the individual's care during the caregiver's absence; and,
4. The individual is unable to receive skilled nursing visits from any other source, including home health, which could provide the skilled care usually given by the caregiver.

Service criteria for agency directed respite (non-skilled and skilled) and consumer-directed respite are described in detail in the EDCD regulations at 12 VAC 30-120-960 12 VAC 30-120-980, respectively, and the provider manual at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

Transition Services and Transition Coordination

Transition Services

Transition services are set-up expenses for individuals who are transitioning from an institution, licensed or certified provider-operated living arrangement, to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. For the purposes of transition services, an institution means an ICF/MR, a NF, a specialized care facility/hospital as defined at 42 CFR 435.1009, Institutions for Mental Diseases (IMDs), Psychiatric Residential Treatment Facility (PRTF), or a combination thereof. Transition services do not apply to an acute care admission to a hospital. Services are available for one transition per individual and must be expended within nine months from the date of authorization. The total cost of these services shall not exceed \$5,000, per-person lifetime limit coverage.

In order to be provided, transition services shall be prior authorized. These services may include security deposits for rent or utilities, essential household furniture and appliances, services necessary for the individual's health and other reasonable expenses incurred as part of a transition. The plan shall ensure that the funding spent is reasonable and does not exceed the \$5,000 maximum limit.

Allowable costs include, but are not limited to:

- i. security deposits that are required to obtain a lease on an apartment or home;
- ii. essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- iii. set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;
- iv. services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
- v. moving expenses;

- vi. fees to obtain a copy of a birth certificate or an identification card or driver's license; and
- vii. activities to assess need, arrange for, and procure needed resources.

The services are furnished only to the extent that they are reasonable and necessary as determined through the Plan of Care development process, are clearly identified in the Plan of Care and the person is unable to meet such expense or when the services cannot be obtained from another source. The expenses do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household items that are intended for purely diversional/recreational purposes. This service does not include services or items that are covered under other waiver services such as chore or homemaker services.

Transition Coordination

Transition coordination is available to individuals enrolled in the EDCD Waiver to support the individual and his or her designated representative, as appropriate, with the activities associated with transitioning from an institution to the community pursuant to the EDCD Waiver.

Transition coordination services include, but are not limited to, the development of a transition plan; the provision of information about services that may be needed, in accordance with the timeframe specified in federal law, prior to the discharge date, and during and after transition; the coordination of community-based services with the case manager, if case management is available; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation; and the provision of ongoing support for up to 12 months after discharge date.

The individual's Plan of Care shall clearly reflect the individual's needs for transition coordination provided to the individual, his or her designated representative, and providers in order to implement the Plan of Care effectively.

**APPENDIX I:
Certification of Compliance with Prohibition of Political Contributions and Gifts During the RFP
Process**

For contracts with a stated or expected value of \$5 million or more except those awarded as the result of
competitive sealed bidding

I, _____, a representative of _____,
Please Print Name *Name of Offeror*
am submitting a proposal to _____ in response to
Name of Agency/Institution
_____, a solicitation where stated or expected contract value is
Solicitation/Contract #
\$5 million or more which is being solicited by a method of procurement other than competitive sealed
bidding as defined in § 2.2-4301 of the *Code of Virginia*.

I hereby certify the following statements to be true with respect to the provisions of §2.2-4376.1 of the *Code of Virginia*. I further state that I have the authority to make the following representation on behalf of myself and the business entity:

1. The offeror shall not knowingly provide a contribution, gift, or other item with a value greater than \$50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the proposal and the award of the contract.
2. No individual who is an officer or director of the offeror, shall knowingly provide a contribution, gift, or other item with a value greater than \$50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the proposal and the award of the contract.
3. I understand that any person who violates § 2.2-4376.1 of the *Code of Virginia* shall be subject to a civil penalty of \$500 or up to two times the amount of the contribution or gift, whichever is greater.

Signature

Title

Date

To Be Completed By Offeror and Returned With Your Proposal

**APPENDIX J:
State Corporation Commission Form**

Virginia State Corporation Commission (SCC) registration information. The Offeror:

is a corporation or other business entity with the following SCC identification number: _____

-OR-

is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**

is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the Offeror in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from Offerors out-of-state location) **-OR-**

is an out-of-state business entity that is including with this Proposal an opinion of legal counsel which accurately and completely discloses the undersigned Offeror's current contacts with Virginia and describes why those contacts do not constitute the transaction of business in Virginia within the meaning of § 13.1-757 or other similar provisions in Titles 13.1 or 50 of the Code of Virginia.

****NOTE**** >> Check the following box if you have not completed any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for proposals (the Commonwealth reserves the right to determine in its sole discretion whether to allow such waiver):

To Be Completed by Offeror and Returned with Your Proposal

Signature

Title

Date

**APPENDIX K:
Reference Form**

RFP 2013-05

Reference Form:

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc)	
Contract Size (# of members eligible, # of members served, etc):	
Contract Period	
Number of Contractor staff assigned to contract:	
Annual Value of Contract:	