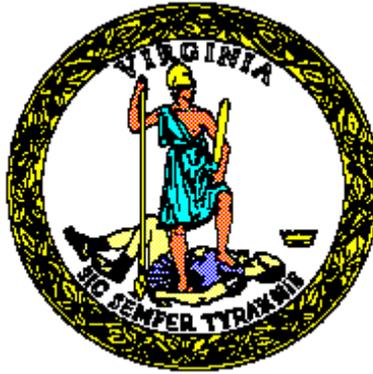


**Commonwealth of Virginia's
Proposal to the Center for Medicare and Medicaid Innovation**

**State Demonstration to Integrate Care For
Dual Eligible Individuals**



April 13, 2012

Draft for Public Comment

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DRAFT

A. Executive Summary

Individuals eligible for both Medicare and Medicaid (“dual eligibles”) often have complex health care needs. However, the current delivery system is fragmented, and Medicare and Medicaid often work at cross purposes and impede care coordination. Medicaid and Medicare have overlapping and sometimes conflicting benefits and requirements. Individuals often receive multiple conflicting notices from Medicare and Medicaid without the assistance to help them navigate the systems, and their care is provided in silos that contribute to less than optimal service delivery and health outcomes. Because Medicare is the primary payor for acute health care services, State Medicaid agencies have had no leverage to control costs for dual eligible individuals and little financial incentive, as savings on acute care services would accrue to Medicare and not offset new State expenditures for providing care coordination services.

The goals of the Financial Alignment Demonstration are to reduce cost shifting between providers and payors, create a seamless, integrated service delivery system, align Medicare and Medicaid rules, improve accountability, produce savings for both the states and the Federal governments, and share Federal savings with the states in order to provide care coordination and other supplementary benefits. This Demonstration is one in a series of initiatives the Department of Medical Assistance Services (DMAS) is undertaking to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the Department.

The Virginia Demonstration will be implemented in four regions of the State in the first year of the Demonstration (Central Virginia, Northern Virginia, Tidewater and Western/Charlottesville). Virginia requests the opportunity to consider expansion to the Southwest/Roanoke region in a subsequent year. The Demonstration will combine Medicare and Medicaid funding under a blended capitation payment to provide integrated, comprehensive care to full-benefit dual eligibles ages 21 and over, including participants in the Elderly or Disabled with Consumer Direction (EDCD) Waiver (and participants in the Technology Assisted Waiver in year two). The Demonstration will integrate Medicare and Medicaid benefits and services to create a unified delivery system that is easier for enrollees and their families to navigate. Selected managed care organizations (MCOs) will be responsible for delivering medical, behavioral health, pharmacy, and long-term services and supports (LTSS) for enrollees. Integrated financing streams will improve care delivery by eliminating conflicting incentives between Medicare and Medicaid that often result in cost shifting, fragmented care, higher costs, and unfavorable outcomes.

DMAS and the Centers for Medicare & Medicaid (CMS) will enter into a Memorandum of Understanding (MOU) to establish risk-based contracts with MCOs. Contracted MCOs will be accountable for the care delivered to enrollees, including care coordination efforts. MCO performance will be measured, and payment will be tied to measured quality goals. Care will be delivered using integrated care teams and care management services that are based on the needs and goals of enrollees. MCOs may offer supplemental/enhanced benefits that exceed those currently provided in either Medicare or Medicaid, in order to encourage and retain enrollment, promote health, and provide services in the most appropriate and efficient settings.

DMAS is requesting that the MOU serve as the Federal authority required to implement the Demonstration and thereby obviate the need to submit §1915(b)/(c) waiver applications. Allowing the MOU to serve as the authority will streamline Medicaid requirements and reduce duplicative administrative burden while preserving strong beneficiary protections. Waiver requirements, such as provider network adequacy standards, enrollee communications and marketing rules, quality improvement projects and monitoring, and external quality review are encompassed in the Demonstration proposal, the MOU, embedded in the Medicare Advantage and Part D HPMS processes and will be written into MCO contracts. In addition, because capitation rates will include up-front adjustments for savings and quality withholds, the administrative burden of demonstrating Medicaid waiver cost effectiveness and neutrality would be unnecessary. CMS does not require waivers to operate the PACE program, which is very similar to the Demonstration. Eligible individuals will have a choice of whether or not to enroll using the passive enrollment with opt out option. Enrollment will be supported by clear and accessible information and facilitated by a neutral and impartial enrollment broker. Because of the large overlap of Demonstration and Medicaid waiver requirements, and in keeping with the Demonstration’s Medicaid/Medicare alignment goals, the submission of wavier applications represents a significant duplication of effort and offers no added value to the State, the Federal government, or to Demonstration enrollees.

DMAS will ensure sufficient consumer protections, including the choice to enroll in the Demonstration, choice of providers, choice of services, rules and processes to maintain relationships with existing providers when possible, facilitated transitions to new providers when necessary, and the ability to change or opt out of the Demonstration at any time. The Demonstration will also include unified requirements and administrative processes that accommodate both Medicare and Medicaid requirements, including network adequacy requirements, outreach and education, marketing, quality measures, consumer experience and satisfaction assessments, and grievances and appeals processes.

DMAS expects that the Demonstration will improve quality of care, improve health and functional outcomes, and reduce costs by reducing or avoiding preventable hospital stays and nursing facilities admissions, reducing emergency department utilization, and improving transitions across care settings.

DMAS will work collaboratively with stakeholders during the implementation and operational phases of the Demonstration. DMAS will monitor enrollee and provider experiences and will require that MCOs develop processes for ongoing consumer input for effective managed care operations that result in high quality service delivery and care. Table I below provides a high-level overview of DMAS’ proposal.

Table I. Features of Demonstration Proposal

Target Population	<p>All full benefit Medicare-Medicaid adults, <u>including</u>:</p> <ul style="list-style-type: none"> • Individuals enrolled in the following Home and Community Based (HCBS) Waivers: <ul style="list-style-type: none"> ○ Elderly or Disabled with Consumer Direction;
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	<ul style="list-style-type: none"> ○ Technology Assisted Waiver (in Year Two of the Demonstration); ● Individuals residing in a nursing facility; ● Auxiliary grant recipients (these individuals reside in Assisted Living Facilities (ALFs) or Adult Foster Homes). Auxiliary grant recipients cannot receive long-term care services. <p><u>Excluding:</u></p> <ul style="list-style-type: none"> ● All children < 21 years old; ● Individuals enrolled in the Title XXI CHIP program; ● Individuals in the following HCBS Waivers: <ul style="list-style-type: none"> ○ Individual and Family Developmental Disabilities; ○ Intellectual Disabilities; ○ Day Support; or ○ Alzheimer’s Assisted Living. ● Money Follows the Person Demonstration participants; ● Individuals who are institutionalized in State mental hospitals, Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MRs), Residential Treatment Facilities, or long stay hospitals); ● Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE) program (however, these participants will have the option to choose the Demonstration); ● Individuals enrolled in Hospice at the time of program implementation; ● Individuals enrolled in the Family Planning Program; ● Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	102,784 as of March 1, 2012.
Total Number of Beneficiaries Eligible for Demonstration	56,884 as of March 1, 2012.
Geographic Service Areas	Central Virginia, Northern Virginia, Tidewater and Western/Charlottesville, encompassing eighty (80) Virginia localities.

	Southwest/Roanoke region in Year Two of the Demonstration, encompassing twenty-four (24) localities.
Summary of Covered Benefits	<ul style="list-style-type: none"> • Medicare Parts A, B, and D benefits (see Attachment A); • Current Medicaid state plan primary and acute care services, including behavioral health and transportation services; • Medicaid-covered EDCD Waiver services, including those utilizing the consumer direction option, and Technology Assisted Waiver services in Year 2; • Nursing Facility coverage; and, • Person-centered care coordination. • Supplemental/enhanced services will be at the option of participating MCOs
Financing Model	Capitated Model
Summary of Stakeholder Engagement/Input	<ul style="list-style-type: none"> • Stakeholder meetings: January-March 2012; • Formation of an Advisory Committee for program development, implementation and evaluation activities; • Dedicated website and e-mail box; and; • 30-day public comment period for the draft Demonstration Proposal: April-May 2012.
Proposed Implementation Date	January 1, 2014

B. Background

1. Rationale

Although Virginia has provided services under a capitated managed care model to both Temporary Assistance for Needy Families (TANF) and the Aged, Blind and Disabled (ABD) populations since 1991, individuals who are dually eligible for both Medicare and Medicaid services in Virginia are excluded from participating in current Medicaid regional managed care programs (other than PACE). They receive care driven by conflicting federal rules and separate funding streams resulting in fragmented and uncoordinated care. Dual eligible individuals continue to receive services through a patchwork of health and social programs that are not necessarily person-centered or responsive to individual needs. Acute care is provided in a fee-for-service (FFS) environment with few opportunities to receive chronic care management support. Long-term care is provided in a nursing facility or through a variety of home and-community-based care services with no assigned primary care providers or overall coordination between providers. This fragmented system encourages cost shifting between Medicare and Medicaid and contributes to a lack of accountability, sub-optimal quality and health outcomes, and unnecessary costs.

DMAS has the goal of developing care coordination programs and integrating acute and long-term care services for the Commonwealth's most vulnerable citizens. In 2006, with support from both the Governor and the General Assembly, a major reform of the Virginia Medicaid-funded long-term care system was set in motion. 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 long-term care system. DMAS was directed to move forward with two different models for the integration of acute and long-term care services: a community model and a regional model. DMAS successfully developed a community model by implementing a robust PACE program. There are currently eight PACE sites in the Commonwealth and plans are underway for six additional PACE sites to be opened during the next year.

DMAS achieved partial success in implementing a regional model that would provide all Medicaid acute and most LTSS under a capitated managed care model. The first phase of the capitated model, referred to as Acute and Long-Term Care (ALTC), became effective on September 1, 2007. Under this program, MCO enrollees remain in a MCO for their primary and acute medical care services after they are approved for home and community-based (HCBS) long-term care services (prior to this, these individuals were disenrolled from managed care).¹ Their HCBS waiver services, including transportation to the waived services, continue to be paid through the fee-for-service (FFS) program. Approximately 2,600 individuals are being served through the ALTC program. However, this program neither addressed dual eligible individuals nor individuals residing in nursing facilities. It also did not fully integrate acute and long term care services.

2. Barriers

After successfully implementing ALTC, DMAS spent two years developing the Virginia Acute and Long-Term Care (VALTC) Program. VALTC was scheduled to be implemented in 2009 in phases to include approximately 23,000 adult (age 21 and over) Medicaid recipients enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver or who were classified as full benefit dual eligible individuals (receiving both Medicaid and Medicare).² These individuals would have been mandatorily enrolled in MCOs under a full-risk capitated model that provided Medicaid covered primary, acute, and long-term care services in an integrated, person-centered managed care system. Although DMAS invested considerable time and effort in developing the program, several barriers were encountered which affected program implementation, including:

- The new care coordination costs would not have been offset by savings to Medicaid; rather, the majority of savings would have accrued to Medicare.
- Keeping the program budget-neutral under the above constraints resulted in capitation rates that were not attractive to MCOs.

¹ ALTC excluded enrollees receiving Technology Assisted Waiver, nursing facility, and PACE services.

² Enrollees in the HIV/AIDS, Individual and Family Developmental Disabilities Support Waiver (IFDDS), Day Support, Intellectual Disability (ID) Waiver, Alzheimer's, and Technology Assisted Waivers would have been excluded, as well as enrollees under the age of 21 who are full benefit duals or participating in the EDCD Waiver.

- Challenges associated with CMS review and approval of §1915(b) and §1915(c) waivers. This also included inconsistencies and conflicting requirements between §1915(b) and §1915(c) quality and reporting requirements.
- The model did not include nursing facility clients due to the concerns expressed by the Nursing facility (NF) industry (a key stakeholder).

3. Response to Barriers

Because VALTC was not implemented, dual eligible individuals remain covered under FFS for all services, unless they are enrolled in a Medicare Advantage (MA) plan and/or Part D plan for Medicare services. Consequently, Virginia leaders have continued to look for opportunities to implement integrated and coordinated care models. In 2011, Governor Robert McDonnell with support from the General Assembly set forth Medicaid reform initiatives (Item 297 MMMM.1 of the Virginia 2011 Appropriations Act), which directed DMAS to expand principles of care coordination to all geographic areas, populations, and services under programs administered by the Department (see Attachment 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. Item MMMM.1.g specifically allows DMAS to develop and implement a care coordination model for dual eligible individuals. Prior to the legislation, in December 2010, DMAS applied for the Center for Medicare and Medicaid Innovation grant opportunity entitled “State Demonstrations to Integrate Care for Dual Eligible Individuals”. Unfortunately, DMAS was not among the 15 states selected for an award. Therefore, DMAS has significant interest in the Financial Alignment Demonstration and submitted a letter of intent in October 2011. DMAS envisions implementing a capitated model that integrates Medicare and Medicaid funding and services under one risk-based contract.

4. Vision

The three-way contract model provides a tremendous opportunity to create a seamless, integrated health care delivery program for individuals who receive Medicare and Medicaid services. Integrating and coordinating care across the spectrum of services should result in fewer gaps in service delivery, as all health care needs will be managed by one entity. Aligned quality measurement and reporting will facilitate a more efficient monitoring system and contribute to improved enrollee outcomes and satisfaction. Lastly, it is expected over time that the demonstration could reduce emergency department use, hospital admissions, nursing facility days and duplicative or unnecessary services. The Demonstration will be implemented initially in four regions in the state with possible expansion into a fifth region, furthering the goal of integrating acute and LTSS for a large portion of dual eligible individuals in Virginia.

The goals of the demonstration include:

- Improvement in enrollee lives, health outcomes and experience of care;
- Provide a seamless, one-stop system of care;
- Services and settings that meet the needs of members with cognitive impairments, behavioral health needs, and other special medical needs;
- Care coordination - the non-clinical but important functions such as providing information and logistical help to referred patients, assuring timely and effective transfer

of patient information, and tracking referrals and transitions to identify and address barriers to accessing timely care or support;

- Case management - the more intensive care provided to high-risk patients by nurses and other health workers, including interdisciplinary care teams (ICTs). Case management encompasses both referral/transition management and clinical services such as monitoring, self-management support, medication review and adjustment. Case management will integrate the medical and social models of care;
- Disease and medication management for all who need them, especially for individuals with disabilities, behavioral health disorders, and/or chronic health conditions;
- Support for seamless transitions between treatment settings that reduce unnecessary inpatient and nursing facility admissions;
- Reduction of emergency department visits;
- Facilitation of communication between providers;
- The arrangement of services and supports that maximize community living;
- Implementation of quality improvement and monitoring systems;
- Behavioral health care services as needed, including services for individuals residing in nursing facilities, in collaboration with the enrollee, the enrollee's family, and all others involved in the enrollee's care, including other agencies or systems;
- Coordination between covered physical health, behavioral health, and long-term care services and collaboration between relevant providers;

5. Description of the Population

The Demonstration population will include adult full-benefit dual eligible individuals, including those enrolled in the Elderly or Disabled with Consumer Direction Waiver and individuals in nursing facilities. Individuals in the Technology Assisted Waiver will be included in year two of the Demonstration. As of March 1, 2012, 56,884 duals were eligible to participate in the proposed Demonstration. The following individuals will be excluded:

- Children < 21 years old;
- Individuals enrolled in the following HCBS Waivers:
 - Individual and Family Developmental Disabilities;
 - Intellectual Disabilities;
 - Day Support; and
 - Alzheimer's Assisted Living.
- Money Follows the Person Demonstration participants;
- Individuals who are institutionalized in State mental hospitals, ICF/MRs, Residential Treatment Facilities, and long stay hospitals;
- Individuals enrolled in a PACE program (they will not be passively enrolled, however, they will have the option to change their enrollment to the Demonstration);
- Individuals enrolled in Hospice at the time of program implementation;
- Individuals in the Family Planning Program; and,
- Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare.

The eligible population utilized a variety of medical services and LTSS based on their acuity, functional status, waiver enrollment and care setting. Table II below shows the diversity of the population according to their care setting and LTSS use.

Table II. Populations (as of March 1, 2012)³

	Total Eligible Population	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings	Individuals not receiving LTSS
Target Population	56,884	5,957	6,918	44,009
Individuals age 65+	33,838	5,011	4,999	23,828
Individuals under age 65*	23,046	946	1,919	20,181
Individuals with serious mental illness	7,394	718	453	6,223

*Note: Individuals < 21 years old will be excluded from the Demonstration.

C. Care Model Overview

1. Proposed Delivery System

Through the Demonstration, DMAS, in partnership with CMS, will contract with MCOs that will be responsible for the delivery of all covered Medicare and Medicaid benefits and for the provision of extensive case management and care coordination activities. Care delivery will be supported by interdisciplinary care teams (ICTs) that are tailored and personalized to meet individual care needs. In addition, MCOs will be responsible for coordinating referrals for non-covered services, such as supportive housing and other social services to maximize opportunities for independence in the community.

DMAS proposes to implement the Demonstration in four regions of the Commonwealth, including Central Virginia, Northern Virginia, Tidewater and the Western/Charlottesville regions. (Attachment C lists the specific localities within each region that will be included). In addition, DMAS would like the option to expand the Demonstration to additional areas in the Southwest/Roanoke region after the first year. DMAS selected these regions because they contain a large number of the eligible population, have well-developed health care systems and have favorable market characteristics. It is believed these factors will contribute to the success of the Demonstration and will allow at least two competing MCOs to operate in each region. MCOs will have the option of participating in one or more of the Demonstration regions. It is anticipated that several current Medicaid MCOs, as well as MCOs that are new to the Virginia Medicaid market, will apply to participate.

Enrollment - DMAS proposes to use passive enrollment with an opt-out option to enroll dual eligible individuals into the program. DMAS will work with CMS, beneficiaries, stakeholders

³ The numbers in Table II will be updated for the Final Proposal.

and other partners to implement a unified, passive enrollment process that provides dual eligible beneficiaries the opportunity to enroll in an MCO or disenroll from an MCO at any time as required; although, DMAS would like to request the consideration of a limited lock in period (six (6) months). A limited lock in period would allow time for MCOs to perform health assessments, medication reviews, assemble care coordination teams, and develop integrated care plans, in order to provide high-quality care and allow enrollees time to experience the benefits of the integrated care model. In addition, a lock-in period would provide stability to the new program and reduce uncertainty surrounding the significant investment that MCOs will make, in order to establish the infrastructure needed to deliver integrated care.

Beneficiary protections will be mandated to ensure a smooth transition to the health plans. Protections will include:

- Algorithms to maintain current enrollee-provider relationships;
- Automatic transfer of pre-authorizations for a predetermined period;
- Transition reports that alert the plan of individuals with chronic conditions and those using LTSS; and,
- Maintenance of successful drug regimes during the transition period.

If a lock in period is approved, an exceptions process can be implemented that would allow 'good cause' disenrollment using criteria, such as the need to maintain a relationship with an out-of-network provider. If the request for a limited lock in period is denied, enrollees will not be locked in and may disenroll or transfer MCOs on a month-to-month basis.

To support enrollment decisions, DMAS will ensure that enrollees are educated on MCO benefits and provider networks, the process for opting out of the Demonstration and for changing MCOs. DMAS will focus on developing clear and accessible information (ensuring availability in alternative formats and languages) on available MCOs and consumer protections. To help facilitate enrollment choices, DMAS will contract with a neutral enrollment broker to (1) help educate enrollees; (2) assist with enrollment and MCO selection; (3) operate a toll-free enrollee helpline; (4) assist with and tracking enrollees' grievance resolutions; and, (5) possibly marketing and outreach.

DMAS (or its contractor) will offer sufficient advance notice and information to help enrollees either select a MCO in his/her geographic area or remain in the fee-for-service environment (effectively opting out of the integrated care program). If an enrollee does not select an MCO within a prescribed time frame, DMAS or its contractor will assign the member to an MCO. DMAS will confirm the member's choice of MCO, or MCO assignment, before coverage begins. Once members are enrolled, DMAS and the MCO will take steps to maximize continuity of care as individuals transition to accessing care through the integrated care program. When a member expresses a desire to change from one MCO to another in his/her geographic region or to opt out and return to the fee-for-service environment, DMAS will provide information on how this process works. The enrollment process and opt out procedures will be described in the MCO contracts with DMAS and CMS, in any agreements between DMAS and CMS, and in state regulations.

Provider Networks - MCOs will be required to establish and maintain a network of providers, either directly or through subcontract agreements, that assures access to all Medicaid and Medicare benefits and will provide access to a wide range of credentialed and contracted providers that will meet the unique medical, behavioral health, long-term care, and social needs of the population. Networks must at least meet State Medicaid access standards for long-term care services and Medicare access standards for medical services and prescription drugs. The networks must include a broad array of providers including primary care physicians, specialists, behavioral health providers, ancillary providers, hospitals, pharmacists, long-term services and supports providers, and other community supports. More specifically, MCOs' provider networks will include providers pertinent to the care of the dual eligible population including:

Acute hospitals
Ambulatory Surgical Centers
Community Mental Health Centers
Diagnostic Radiology Facilities
Dialysis Centers
Federally Qualified Health Centers
Laboratories
Outpatient Mental Health Facilities

Pain Management Centers
Rehabilitation Facilities
Skilled Nursing facilities
Durable Medical Equipment
Home Health and Personal Care Providers
Hospice
Transportation Providers

The MCOs will maintain in their networks and in their referral listings a number of primary care providers and specialists in the following specialties which are adequate to provide covered services to beneficiaries:

Audiology
Allergy/Immunology
Anesthesiology
Cardiology
Colon/Rectal Surgery
Dermatology
Endocrinology
Gastroenterology
General Surgery
Genetics Metabolism
Geriatrics
Hematology
Infectious Diseases
Internal Medicine
Neonatal/Perinatal Medicine
Nephrology
Neurological Surgery

Neurology
Oncology
Ophthalmology
Oral Surgery
Orthopedic Surgery
Otolaryngology
Periodontists
Physical Medicine/Rehabilitation/Physiatrist
Plastic Surgery
Pulmonology
Preventive Medicine
Psychiatry
Psychology
Radiology
Rheumatology
Thoracic Surgery
Urology

Because the prevalence of mental health in the eligible population is high and mental health and substance abuse are often co-occurring with physical and cognitive conditions, the inclusion of a range of behavioral health providers and services in the Demonstration will be crucial. Behavioral health specialists will include, but will not be limited to, psychiatrists, clinical

psychologists, licensed professional counselors, licensed clinical social workers, licensed alcohol and drug addiction counselors (including ones with experience in smoking cessation), mental health counselors, etc.

Nursing professionals will include registered nurses, nurse practitioners, nurse managers, nurse educators, etc. Allied health professionals will include dietitians, pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists, radiology specialists, etc. Finally, MCOs will also enter into provider contracts for HCBS waiver services.

A detailed description of MCOs' networks will be evaluated to assure sufficient access including variety of available providers given the anticipated enrollment, after hour availability, geographic location of providers, distance, travel time and means of transportation, and physical accessibility for members with visual or mobility disabilities (see http://www.ada.gov/medicare_mobility_ta/medicare_ta.htm, for example).

Each MCO will be required to include in its network providers with open panels who will accept new patients. For on-going services, such as long-term care, home health, outpatient behavioral health, and outpatient rehabilitation therapies, etc., the MCO shall continue prior authorized services without interruption until the MCO completes its health risk assessment to determine medical necessity of continued services or to transition services to a network provider.

To ensure against adverse disenrollment, the MCOs will provide out-of-network coverage in the following circumstances: (1) when a service or type of provider is not available within the MCO's network or the MCO cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas; (2) for up to 30 days in order to transition the member to an in-network provider when a provider that is not part of the MCO's network has an existing relationship with the beneficiary, is the beneficiary's main source of care, and has not accepted an offer to participate in the MCO's network; or, (3) when the providers that are available in the MCO's network do not, because of moral or religious objections, furnish a service the client seeks.

As part of implementation planning, DMAS will work with stakeholders and CMS to define specific criteria for network adequacy that will be incorporated into the MCO contracts. The contracts will require MCOs to report regularly (such as monthly or quarterly) on their adherence to the established criteria. The MCOs will develop recruitment strategies to fill network deficiencies. MCOs will also be required to have contingency plans in situations of network inadequacy, a provider contract termination, or insolvency.

MCOs will be responsible for management of their network, including credentialing and re-credentialing providers. MCOs will have the ability to determine whether physicians and other health care and long-term care professionals are licensed by the State and have received proper certification or training to perform medical and clinical services agreed to under contract, and are in good standing with professional and legal entities. The MCOs will ensure that long-term support service (LTSS) providers in their networks meet, at a minimum, DMAS provider qualification requirements and have received proper certification and/or training to perform the services for which they are contracted.

DMAS will require that participating MCOs employ sufficient resources to support a provider relations function that will effectively communicate with and educate existing and potential network providers. MCOs will neither participate with nor enter into any provider contract with any individual or entity that has been excluded from participation in federal health care programs. The MCOs' standards for licensure and certification will be included in provider network contracts and the MCOs will perform re-credentialing on all providers throughout the Demonstration to assure that the providers and personnel under contract continue to be qualified to perform covered services.

Outreach and Marketing - DMAS and CMS will develop unified marketing and outreach rules that include both Medicaid and Medicare requirements as appropriate. CMS and DMAS will review and approve all MCO marketing materials prior to use. To ensure effective communication, written documents must meet the sixth (6th) grade reading level and MCOs must offer translated materials and alternative methods of communication, to also include audio recordings for the blind or those with very low literacy levels. DMAS will contract with a neutral enrollment broker to increase awareness about the Demonstration and to inform enrollment choices through mailings, audio, or print and virtual media.

DMAS and CMS will require MCOs to develop a comprehensive marketing plan and submit it to the Department and CMS for initial approval and at least annually thereafter. MCOs' contracts will prohibit them from direct marketing to potential enrollees and from distributing any marketing materials that have not been pre-approved by CMS and DMAS, that are inaccurate or false, that mislead, confuse, or defraud potential enrollees.

Grievances and Appeals Process - DMAS and CMS will develop a grievance (complaint) and appeals process for enrollees. The appeals process will include an exhaustion of the MCO's internal appeals process prior to review by the Medicare-qualified independent contractor. Internal appeals processes will be governed by a unified set of requirements for MCOs that incorporate relevant Medicare Advantage, Part D, and Medicaid managed care requirements. DMAS will ensure enrollees and their families will be informed of their grievance and appeals rights within this program.

Quality Measurement and Performance Improvement - Quality measures from both Medicaid and Medicare will be used to assess MCO performance. DMAS will work jointly with CMS to determine the measures to be used as pay-for-performance/quality withholds. DMAS and CMS will develop a single, consolidated comprehensive quality management and reporting process that meets Medicare and Medicaid requirements. DMAS, along with CMS, will require that each MCO develop and implement an ongoing quality improvement program that includes performance improvement projects (see Section F below for more detail).

2. Proposed Benefit Design

Participating MCOs will be responsible for the delivery, coordination, authorization and management of Medicare and Medicaid covered services for each of their members. The MCOs will receive a global capitation payment for carrying out required responsibilities, with one portion of the rate coming from CMS for the Medicare payment and one portion from DMAS for

the Medicaid payment. The proposed program's benefits will be structured to bring added value to the services available to members. The program is intended to replace the distinction between Medicare and Medicaid services with a single robust benefit package that integrates covered Medicare and Medicaid services.

The MCOs will manage and fully integrate the combined inpatient, outpatient, and pharmacy services covered by Medicare and Medicaid in a seamless manner, eliminating administrative burden and delays for both enrollees and providers in arranging for and accessing care. More specifically, all Medicare-covered Part A (i.e., inpatient, hospice, home healthcare), Part B (outpatient services), Part D (pharmacy services) benefits, and a large majority of Medicaid State Plan services (see Attachment D) will be included in the capitated payment to participating MCOs. The MCOs will determine the utilization management tools, including prior authorization requirements, for all services, and will have procedures for determining medically necessary services.

The LTSS for EDCD Waiver participants (and Technology Assisted Waiver participants in Year Two) will also be included in the capitated payment. Services covered under the EDCD and Technology Assisted Waivers include (see Attachment E for definitions of each service):

EDCD Waiver:

- Adult day health care;
- Personal care (agency and consumer-directed options);
- Personal emergency response services (PERS);
- Respite care (agency and consumer-directed options);
- Transition coordination; and,
- Transition services.

Technology Assisted Waiver (in Year Two):

- Assistive technology;
- Environmental modifications;
- PERS;
- Personal care (agency-directed option);
- Private duty nursing (RN and LPN);
- Skilled PDN respite care; and,
- Transition Services.

EDCD Waiver participants who receive personal and respite care have the option of *consumer-direction*. Consumer direction allows the participant to serve as the employer of their personal care attendant(s). Under consumer direction, the participant is responsible for hiring, training, supervising, and firing the attendant. The consumer-directed model of care is freely chosen by the participant or their authorized representative, if the participant is not able to direct their own care.

Under the Demonstration, MCOs will have the option of directly supporting the participant in his/her role as the consumer-directed employer, or subcontracting with an area provider. In the EDCD Waiver, individuals who support waiver participants in their role as the employer are termed, "service facilitators." Service facilitators currently provide consumer directed employer support (e.g., initial comprehensive visit, training, routine on-site visits, etc.). MCOs will also have the option of directly supporting the participant by serving as the fiscal employer agent or by subcontracting with the State's current FFS fiscal employer agent.

3. Care Coordination

Person-centered care coordination and case management will be added as new benefits under the Demonstration. MCOs will be required to provide care coordination and case management services that ensure effective linkages and coordination between providers and services, monitor transitions between levels of care, facilitate discharge planning and provide case management for those identified to have complex needs. Effective care coordination will include the following components:

Health Risk Assessments - MCOs will have processes in place to evaluate the baseline needs of each enrollee using a Health Risk Assessment (HRA). MCOs will be required to conduct an initial assessment within sixty (60) days of enrollment and annual reassessments within one year of last assessment (requirements for duals who are also EDCD Waiver participants (and Technology Assisted Waiver participants in Year Two are described below). MCOs' assessment tools may vary and must be pre-approved by DMAS and CMS, but each will capture medical, psychosocial, functional, cognitive, and behavioral health information that will be used to produce health status profiles and risk scores for developing individualized care plans.

MCOs will conduct health risk assessments by telephone, face-to-face, telehealth or via electronic or written forms completed by the member, etc., to best determine the member's needs. MCOs must have knowledgeable staff (e.g., physicians, nurses, pharmacists, and psychologists) experienced in analyzing the HRAs, stratifying members by risk status, and determining the services and benefits needed for care planning. MCOs will ensure that all HRA information is communicated to the integrated care team, pertinent providers, members, and others as needed, in order to incorporate it into the individualized care plan. In addition, members will receive a summary of the results of their assessments. MCOs must have the capacity to produce aggregate reports on health risk assessment for monitoring on an annual basis.

Virginia has used the Uniform Assessment Instrument (UAI) since the mid-nineties to determine eligibility for long-term care services for EDCD and Technology Assisted waiver enrollees. The UAI is a comprehensive, multidimensional, standardized questionnaire that provides a review to assess each participant's ability to perform activities of daily living, instrumental activities of daily living, cognitive ability and other dimensions. The UAI is used to establish eligibility for LTSS and the level of care required by each individual, including the need for support in performing activities of daily living, and for planning and monitoring an individual's care across various agencies and long-term care services. The UAI can be accessed through DMAS' web portal at <http://www.virginiamedicaid.dmas.virginia.gov>.

DMAS will continue to use the current process in place for administering the initial UAI. DMAS uses Pre-Admission Screening Teams (contracted through the Virginia Departments of Health and Social Services) or an acute care hospital to conduct the UAI and evaluate care needs and service eligibility. A service plan will be developed based on information obtained from the UAI. The Pre-Admission Screening Team will be responsible for notifying individuals of their ability to choose between institutional and community-based services, including consumer directed care, PACE and the Demonstration. The data collected from the UAI will be sent to the MCOs by DMAS. The MCOs will also receive the initial assessment date for each Waiver

participant that enrolls in the Demonstration and will be responsible for the timely completion of reevaluations for EDCD and Technology Assisted Waiver (in Year 2) participants.

Care Coordination - The goals of care coordination are to: ensure the delivery of high quality care; improve health status; enhance coordination across the spectrum of health care and support systems, with particular emphasis on transitions between levels of care; reduce avoidable hospitalizations and emergency room visits; and identify opportunities that support recovery and independence in the community. The MCOs will be required to develop a strategy to stratify enrollees into different levels of care coordination/case management, based on information gathered from the enrollee's HRA and UAI (for waiver enrollees). The MCO's risk stratification shall consist of a minimum of the two levels (e.g., basic and enhanced) in order to address enrollees' needs.

MCOs will be expected to devote significant resources to ensuring effective linkages and coordination across the spectrum of care. Based on assessments and other methods (such as predictive modeling), MCOs will coordinate the placement of enrollees into case management and develop an individualized care plan, with active involvement from enrollees, their families and/or their caregivers. MCOs will provide care coordination/case management services that are performed collaboratively by a team of professionals (which may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers as part of interdisciplinary care teams) appropriate for the enrollee's medical diagnoses and health condition, co-morbidities, and community support needs. While there will be a team of professionals engaged in care, the MCOs will be required to establish a single-point-of-contact for enrollees who need this level of coordination to ease enrollee burden and to prevent frustration and disengagement by the member.

Among other services, **basic care coordination** will include: (1) assurance that referrals result in timely appointments and do not result in duplication or provision of inappropriate services; (2) linkages to community-based services as necessary; (3) communication and education regarding available services and resources; (4) establishment of a single point of contact at the MCO for all questions; and, (5) assisting enrollees in developing self-management skills to effectively access and use services. **Enhanced care coordination/case management** will be available to members who have a need for more intensive monitoring and follow-up (e.g., have multiple chronic diseases, behavioral health needs, use LTSS, etc.). The goals of the enhanced care coordination will include: (1) improving and maintaining functional health status; (2) enhancing coordination across specialties and settings; (3) eliminating duplicate services; (4) reducing avoidable medical complications, emergency room use and hospitalizations; and, arranging services that promote community living among others.

Integrated Care Teams - Care coordination/case management will be delivered using an interdisciplinary care team model. Toward that end, enrollees will be assigned to an Integrated Care Team (ICT), led by a care coordinator housed within or under contract to the MCOs, who is culturally competent and has the training to work with and address the diverse needs of the Demonstration population. The composition of an enrollee's ICT (e.g., primary care physician, specialist, social worker, behavioral health specialist, pharmacist, etc.) will depend upon each enrollee's requirements and level of need. For example, a gerontologist and long-term care

service providers may be involved in ICTs for dual eligibles who are also Waiver participants, and a psychiatrist may be involved in ICTs for individuals with serious behavioral health issues.

ICTs will be responsible for developing, maintaining, and monitoring the enrollee's individualized care plan, coordinating critical information sharing among the care team and the enrollee, and ensuring that enrollees are meaningfully informed about and involved in planning and selecting their care options. Other responsibilities of the ICT will include: medication reviews, self-management training, health education, post discharge support to help transition between levels of care, identifying available community-based resources, chronic disease self-management skills, monitoring that services are accessed, etc. MCOs also must ensure that enrollees have adequate access to his/her ICT through methods, such as regularly scheduled appointments, including face-to-face visits, e-mail, and telephone options.

Individualized Care Plans - MCOs will be required to work with enrollees and their family and/or caregivers to develop a comprehensive person-centered, individualized care plan (ICP). The ICP must incorporate identifiable goals that take into account individuals' needs, preferences and unique requirements (e.g., Waiver participant, individuals with serious behavioral health issues, individuals with chronic conditions, etc.), and evidence-based strategies to achieve the goals.

Based on the needs and preferences identified in the health risk assessment, the individualized care plan should include:

- Summary of enrollee's health history and identified needs;
- Attainable goals and measureable expected outcomes selected by the enrollee and/or caregiver;
- Target dates for reaching specified goals and objectives;
- Strategies and actions, including interventions to be implemented;
- Progress noting enrollee's success;
- Barriers or obstacles;
- Timeframes for completing actions;
- Status of enrollee's goals; and,
- Determined need for community resources and non-covered services.

Individualized care plans will be developed in consultation with a variety of providers that are integral to the enrollee's care (e.g., long-term care providers for dual eligibles who are also Waiver participants). Enrollees and/or their caregivers will be encouraged to direct and actively engage in the ICP development process, including determining which providers will be included in the process. Each ICP will be reviewed, monitored, and modified by appropriate staff during contact with the enrollee, as the enrollee's health status changes, or at least annually. For Waiver participants, monitoring of the individualized care plan will include ensuring choice of LTSS provider(s); the effectiveness of back-up plans (e.g., cases in which caregivers do not show up); and, the health, safety, and welfare of participants. MCOs will have mechanisms to document and maintain the ICPs and make them accessible (or communicate information from them) to providers and individuals as needed and upon request. Information will be secured for privacy and confidentiality.

Hospital and Nursing Facility Care Transition Programs - MCOs will be required to operate care transition programs in hospitals and nursing facilities. The care transition programs in hospitals will be designed to ensure the appropriateness of admissions and lengths of stay and to ensure adequate discharge planning, with the goal of reducing the need for hospital readmissions and emergency department visits after discharge. MCOs will also be required to have an adequate network of providers specializing in care for the population residing in nursing facilities (NF), including behavioral health providers. As part of the care transition programs in NFs, MCOs will conduct onsite care and/or coordinate with NF staff to help reduce the need for hospital transfers and emergency room use, to improve access to primary and specialty care and care coordination, and to assist with transfers to the community, when appropriate.

Information Technology - DMAS and CMS will seek participation by MCOs that have the information technology capacity to assist with care coordination that includes a clinical information system (e.g., secure, web-based portal) to track referrals, service authorizations and care delivered. The information technology will be used by providers and the care teams to monitor: provider/enrollee communication; enrollee profiles (e.g., goals, care plan adherence, service delivery, lab results, etc.), and inbound and outbound enrollee contact, among other things. MCOs will ensure the privacy of enrollee health records and provide for access to such records by enrollees, upon request.

DMAS will also seek participation by MCOs that facilitate and support the use of telemedicine and electronic health records with active engagement from members or a secure, web-based application for enrollees that provides general information, enrollee health history and care plans, etc. and increased access to services.

Other Requirements - In addition to providing the care coordination services outlined above, MCOs will be required to assure enrollee access to quality care including:

- Telephone Access - MCOs will be required to employ customer service representatives that are culturally competent and sensitive to the population served. MCOs must operate a toll-free number, twenty-four (24) hours a day and seven (7) days a week, for benefits and eligibility information and to file complaints/grievances. MCOs will also be required to provide telephone access twenty-four hours, seven days per week for confirmation of eligibility and service authorizations and a nurse advice line.
- Health Education - MCOs must offer health education programs in the community to educate enrollees about chronic health conditions and self-care, smoking cessation, and how to access plan benefits and supports. MCOs must also offer health screenings for blood pressure, body mass index, etc.

Supplemental/Enhanced Services - MCOs may propose to offer supplemental/enhanced benefits that exceed those currently provided in either Medicare or Medicaid, in order to encourage enrollment, promote health, and provide services in the most appropriate and efficient setting. Examples of potential supplemental/enhanced benefits include: vision; dental; hearing; assistive technology; environmental modifications; over-the-counter drugs; or a service whereby a “coach” goes into members’ homes at critical times to prepare the enrollees’ and their

environments for conditions they will soon experience (e.g., discharge from hospital for hip replacement, individual becoming blind). Furthermore, MCOs will be responsible for coordinating referrals for non-covered services, such as supportive housing and other social services to maximize opportunities for independence in the community.

4. Evidence-Based Practices

MCOs must utilize well-established evidence-based clinical guidelines developed by leading academic and national clinical organizations. MCOs will be required to have processes in place for educating providers on employing evidence-based guidelines and for monitoring adherence to evidence-based practices. MCOs will adopt clinical guidelines for chronic conditions including asthma, diabetes, behavioral health conditions, asthma, coronary heart disease, clinical pharmacy reviews, etc. Rigorous evidence is not available to inform all health decision making, and enrollees with complex needs may require flexibility in treatment approaches. In developing person-centered care plans, evidence-based practice will be appropriately balanced by an approach that takes enrollees' individual needs into account.

5. Context of Other Initiatives

Current Waivers and/or State Plan Services Available to the Population - Under the Demonstration, enrollees will continue to access a large majority of Medicaid State Plan services to the extent that they are medically necessary, either solely or in combination with Medicare-covered primary care, acute and post-acute services. Dual eligibles who are enrolled (or who become enrolled) in the EDCD or Technology Assisted waivers will continue to be enrolled in the waiver (unless CMS grants the request for the MOU to act as program authority) and will access all HCBS services through participating MCOs.

Existing Managed Long-Term Care Programs - Virginia operates PACE programs, which are described below. Individuals enrolled in PACE will be excluded from passive enrollment but may choose to disenroll from PACE and enroll in the demonstration. In addition, if a dual enrollee is determined to need long-term care services, the enrollee will be informed of the option to receive waiver or nursing facility services through the Demonstration as well as the option to enroll in a PACE program.

Existing Specialty Behavioral Health Plans - DMAS recently released a Request for Proposals for a Behavioral Health Services Administrator (BHSA) contractor to provide care coordination for behavioral health and substance abuse services. The BHSA contract will include all services for individuals in fee-for-service and carved out behavioral health services for individuals enrolled in Managed care. The contract is anticipated to be implemented in 2012.

When Demonstration is implemented, the MCOs will assume the responsibilities of the BHSA contractor and will provide all Medicaid and Medicare covered behavioral health services for the enrolled population, including Medicaid-covered community based mental health rehabilitative services (e.g., psychosocial rehabilitation, mental health and substance abuse crisis intervention, crisis stabilization, mental health support services, etc.). Dual eligibles who are not enrolled in the Demonstration will continue to receive behavioral health supports through the BHSA contractor.

Integrated Programs (SNP, PACE, MA), Bundled Payments, Multi-Payer Initiatives, etc. - This Demonstration builds upon Virginia’s experience with its PACE programs which were implemented in 2007 and serve non-institutionalized individuals (including dual eligible individuals) ages 55 and over. Under PACE, all health and long-term care services are provided in the community centered on an adult day health care model using combined Medicaid and Medicare funds. There are currently eight PACE sites in the Commonwealth, and plans are underway for six additional sites. Because of the age overlap between PACE and the integrated care program, some individuals may be eligible for both programs. Individuals eligible for both programs will be given the option of participating in either PACE or the Demonstration

DMAS contracts with one Medicare Special Needs Plan (SNP) that operates in some of the demonstration localities. The SNP contract does not include Medicaid services. Individuals enrolled in the SNP will be disenrolled from the SNP and enrolled in the Demonstration, unless they choose to opt out.

Other CMS Payment/Delivery initiatives or Demonstrations (Health Homes, Accountable Care Organizations, Advanced Primary Care Practice Demos, Reduce Preventable Hospitalizations Among NF residents, etc.) - Other key initiatives that are aligned with the Demonstration include DMAS’ continued exploration of health homes and the Money Follows the Person (MFP) Demonstration. Although MFP participants will be excluded from the proposed Demonstration, the two initiatives share common principles. Specifically, both programs are designed to advance the independence of enrollees by redirecting care away from long-term institutional settings and helping enrollees return to the community.

D. Stakeholder Engagement and Enrollee Protections

1. Engagement of Stakeholders in Design Phase

DMAS has actively involved a broad representation of internal and external stakeholders in the planning and development phases of its integrated care model for dual eligibles. DMAS plans several activities to solicit and incorporate stakeholder feedback on the design of the model. Specifically, an Advisory Committee may be established to support the successful design and implementation of the Demonstration. The Committee may include representation from health systems, health plans, long-term care providers, health policy researchers, physicians, consumers, and others with expertise in serving the dual eligible populations.

DMAS also conducted a series of stakeholder meetings with providers, health plans, nursing facilities, hospitals, state agencies, advocacy groups, associations, and enrollees, among others in March 2012. Specific meeting dates and topics discussed at each meeting appear in Table III below. Presentations from the meetings can be accessed at http://dmasva.dams.virginia.gov/Content_pgs/altc-enrl.aspx.

Table III. Stakeholder Meetings

Date	Stakeholders	Topics
January 4, 2012	Representatives from six Medicaid	Demonstration design elements

	MCOs	
February 21, 2012	Virginia Health Care Association Winter Legislative Meeting (200 LTC providers)	Demonstration overview and announcement of future meetings
March 21, 2012	Individuals representing various stakeholder groups (e.g., nursing facilities, hospitals, health plans, long-term care and behavioral health providers, contracts, other state agencies, and advocates)	Demonstration overview – input from attendees
March 21, 2012	Nursing home and hospital representatives	Potential impacts of the Demonstration, design recommendations and input from attendees
March 23, 2012	Community LTSS and behavioral health providers	Potential impacts of the Demonstration, design recommendations and input from attendees
March 26, 2012	Managed Care Organizations/Health Plans	Potential impacts of the Demonstration, design recommendations and input from attendees
March 28, 2012	Dual eligible individuals, families and advocates	Potential impacts of the Demonstration, design recommendations and input from attendees
March 28, 2012	State agencies and DMAS contractors	Potential impacts of the Demonstration, design recommendations and input from attendees
April 4, 2012	Virginia Health Care Association Task Force on Managed Care	Dialogue with Nursing Home operators on issues important to these providers.

Approximately 200 individuals attended the March stakeholder meetings. Presentations were provided describing the Demonstration. Comments were solicited on the design of the Demonstration, elements of care coordination most valued by individuals and providers, recommendations for supplementary benefits, issues around transitions, how to best meet the needs of individuals with complex medical, behavioral and social needs, identification of service gaps and how to fill them, and payment and operational issues.

Stakeholders identified important values including: the need for ‘high touch’ care coordination and case management; the unmet need for behavioral health services for persons living in nursing facilities; the need to provide accessible services for persons with mobility impairments; ensuring that health plans have the flexibility to provide services in the most beneficial manner; the desire for dental and hearing supplemental benefits; the need to reduce paperwork and the

number of payers individuals must deal with; a desire for 24/7 call in lines; the desire for extended provider visits that allow time for communication with patients and their families; simplifying the rules for accessing durable medical equipment; maintaining relationships with current providers; prompt pay requirements; and the need for improved discharge planning. In general, stakeholders expressed positive opinions about the Demonstration's potential to improve the care and lives of enrollees and the DMAS process to involve stakeholders. After each meeting, attendees provided informal comments expressing that DMAS was asking the right kinds of questions and noted the process was very transparent. Many people expressed their support for the Demonstration; others are cautious but are willing to work with the State to identify and address their concerns.

DMAS also created a web site dedicated to the Demonstration which provides public access to stakeholder meeting announcements and agendas, meeting presentations, materials and summary notes, comments received, and other related information http://dmasva.dams.virginia.gov/Content_pgs/altc-enrl.aspx. The web site and all written meeting materials direct interested parties to a dedicated e-mail address (DualIntegration@dmas.virginia.gov) to submit questions, comments or concerns about the Demonstration. The e-mail box is monitored daily and all e-mails are reviewed and directed to the appropriate DMAS staff member.

DMAS complied with CMS requirements regarding public comment on the Demonstration proposal. The proposal was posted on http://dmasva.dams.virginia.gov/Content_pgs/altc-enrl.aspx for thirty days prior to submission to CMS, in order to obtain comments. DMAS also circulated the draft Demonstration proposal to all parties on its stakeholder distribution lists. DMAS reviewed all comments and incorporated them, as appropriate, into the Demonstration proposal.

2. On-going Stakeholder Meetings and Input

DMAS will continue to gather and incorporate stakeholder feedback during the implementation and operational phases of the Demonstration through several mechanisms. For example, DMAS intends to:

- Meet with the Advisory Committee on a periodic basis to receive feedback and to discuss pressing issues and solutions.
- Continue to hold public stakeholder meetings.
- Maintain the dedicated website http://dmasva.dams.virginia.gov/Content_pgs/altc-enrl.aspx and e-mail box so stakeholders can receive and provide information about the Demonstration.
- Communicate with providers through periodic trainings, a provider manual, and Medicaid Memos.
- Conduct periodic enrollee trainings and develop enrollee notices and related materials about the Demonstration that will be sent directly to enrollees and/or their representatives.
- Require in its contract provisions that the MCOs develop meaningful consumer input processes into their ongoing operations, including but not limited to governing or advisory boards that include sufficient numbers of enrollees and representatives.

Once the Demonstration is implemented, enrollee experiences and satisfaction will be monitored through surveys and data analyses, among other methods. Provider experience and satisfaction will also be collected through surveys, interviews, data analyses, etc.

3. Enrollee Protections

DMAS carefully designed the Demonstration to include adequate enrollee protections to ensure enrollees' health, safety and access to high quality health care and supportive services through various methods. Protections include requirements regarding choice of providers, access to a unified set of grievance and appeal rights, and customer service assistance, in addition to the protections regarding network adequacy, the enrollment process, outreach and marketing, and transition reports described in Section C above.

Choice of Providers - DMAS will require MCOs to ensure that enrollees have a choice of primary, acute, behavioral and long term care providers and access to a broad array of specialists, including LTSS providers, who have experience in serving populations with diverse and complex health care conditions. MCO provider networks will be required to have sufficient breadth and medical and supportive service provider expertise to ensure adequate access to all covered services. To the extent possible, MCOs must employ a continuity of care process that allows enrollees to maintain relationships with their existing providers. Section C describes these and other features of the delivery model that constitute protections related to enrollees' choice of providers.

Grievances (Complaints) and Appeals Process - Through contract requirements with MCOs and agreement with CMS, DMAS will ensure that enrollees have full access to grievance and appeals processes. DMAS and CMS will collaborate to develop a set of requirements for MCOs' internal grievances and appeals processes that incorporate relevant Medicare and Medicaid program requirements. MCOs will be required to maintain written policies and procedures for the receipt and timely resolution of grievances and appeals. All internal processes will be subject to DMAS' and CMS' review and prior approval. MCOs will be required to create and maintain records of grievance and appeals activity, using a health management and information system. The system will have the capacity to document: the type and nature of each grievance, internal appeal, and external appeal; and, how the MCO responded to and resolved each grievance or appeal.

DMAS proposes that enrollees also have access to a single external appeals process that meets all required Medicare and Medicaid managed care rules and regulations. DMAS and CMS will develop an integrated and streamlined process that ensures that all the rights and protections afforded by both Medicare and Medicaid are maintained. This will necessitate a comprehensive review and comparison of the requirements for each program noting similarities and differences, and identifying how to address issues such as: (1) timing and notification to enrollees, providers, authorized appeal representatives, DMAS and external appeal entities; (2) criteria for type of appeal (expedited or standard); (3) levels of appeal (internal and external); (4) continuing services and reimbursement; and, (5) authorized appeal representatives.

Enrollee Customer Service - The MCOs will maintain and staff a toll-free Member or Customer Services function to be operated at least during regular business hours and to be responsible for

the following: (1) explaining the operation of the MCO, including the role of the PCP and what to do in an emergency or urgent medical situation; (2) assisting enrollees in the selection of a PCP and other providers; (3) assisting enrollees to make appointments and obtain services; (4) arranging medically necessary transportation for enrollees; and, (5) handling enrollee inquiries and grievances.

- The MCOs will also be responsible for: making oral interpretation services available free-of-charge to beneficiaries in all non-English languages spoken by enrollees, including American Sign Language;
- Maintaining the availability of services, such as TTY services or comparable services for individuals who are hearing impaired or who have deafness;
- Making written materials available in alternative formats (e.g., audio recordings), as needed to assure effective communication for individuals who have visual impairments;
- Providing reasonable accommodations needed to assure effective communication and providing enrollees with the means to identify their disability to the MCO;
- Maintaining employment standards and requirements (e.g., education, training, and experience) for enrollee services department staff and providing a sufficient number of staff to meet defined performance measures;
- Ensuring that customer service department representatives, upon request, make available to enrollees and potential enrollees information on the following:
 - The identity, locations, qualifications, and availability of providers;
 - Enrollee rights and responsibilities;
 - Procedures to challenge or appeal the failure of the MCO to provide a core service and to appeal any adverse actions (denials);
 - How to access oral interpretation services and written materials in prevalent languages and alternative formats;
 - Information on covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and,
 - Procedures for changing MCOs or opting out of the Demonstration and returning to the FFS environment.

Other Enrollee Protections - DMAS will implement enrollee protections that ensure privacy of records, access to culturally and linguistically appropriate care, access to providers who can serve individuals with mobility and other impairments, and involvement of caregivers, guardians and other enrollee representatives. DMAS recognizes the importance of beneficiaries having accessible avenues of support and assistance external to the MCO, Medicaid and Medicare-to facilitate access to services, answer questions, and navigate the grievance and appeals processes, etc. DMAS will continue discussions with stakeholders and CMS to determine how this function can best be provided.

E. Financing and Payment

1. State-Level Payment Reforms

DMAS' overall payment reform goals are to:

- Create payment models that hold providers accountable for the care they deliver, reward quality of care and improved health outcomes, link payment incentives with quality metrics, and reduce health care spending;
- Support a delivery system that integrates and coordinates comprehensive services, and incorporates robust quality measurement;
- Reduce cost shifting between Medicare and Medicaid via global payments to entities responsible for effectively delivering and coordinating all the services an enrollee needs. Given that Medicaid generally pays rates that are lower than Medicare rates, Medicare may bear costs for acute care hospitalizations if nursing facilities paid by Medicaid to not maintain the health status of their residents. Conversely, if Medicare-paid acute care is less than optimal, Medicaid may bear the costs related to the accelerated or avoidable need for nursing facility admissions or intensive support in the community.

In keeping with overall payment reform goals and strategies, DMAS intends to use the capitated three-way contract model, outlined by CMS in the July 8, 2011 State Medicaid Directors letter, as the mechanism to implement integrated care for dual eligible members.

The State's reimbursement goals of emphasizing quality, transparency, patient-centeredness, and value will be carried through the reimbursement structure. The capitation-based reimbursement model will be designed to produce plan incentives to provide high quality, coordinated care that will reduce overall system costs. The blended capitation payment structure is expected to provide plans with the flexibility to utilize the most appropriate cost effective service for the enrollee, eliminating incentives to shift costs between Medicare and Medicaid. DMAS will work with CMS and the Medicare-Medicaid Coordination Office to develop a sound reimbursement structure to cover the populations and services to be provided under the contract.

2. Payments to MCOs

The prospective blended capitation payments to MCOs will include expenses associated with the medical, behavioral health, and long term care services and supports provided to enrollees, as well as the non-medical expenses required to provide and coordinate those services. Both Medicare and Medicaid will contribute to the blended payments in a manner such that aggregate expected savings are shared proportionately between the two programs.

Rate Cell Structure - Appropriate payment structures start with a foundation of well-designed rate cells. Rate cells stratify the target population into homogenous risk groups, so that payments to MCOs can be aligned with the mix of risk they enroll. Selected rate cells will be based on objective, measureable characteristics of the target population that correlate well with their expected cost. Careful consideration will be given to ensure that the structure appropriately compensates MCOs while encouraging the provision of sufficient, coordinated, cost effective services needed by their enrollees.

Risk Adjustment - Risk adjustment techniques address the potential for plans to attract individuals with risk profiles that may be higher or lower than the average risk profile within a rate cell. This may occur even within carefully constructed rate cells. When this occurs, an appropriate average rate for a given rate cell can overpay some health plans while underpaying

others. Significant misalignment in this manner is not conducive to a stable, cost effective program. Effective risk adjustment models for managed long term care populations are in their infancy; therefore, CMS, DMAS and their actuaries will work with stakeholders, potential vendors and CMS to evaluate additional risk adjustment techniques.

Pay For Performance - DMAS promotes the philosophy that reimbursement should reward value; therefore, it may be appropriate to incorporate a financial incentive program within the reimbursement structure. A CMS requirement of the demonstration is that participating plans will be subject to an increasing quality withhold over the three-year period (1, 2, and 3 percent in years 1, 2, and 3 of the demonstration). Quality measures and thresholds will be established for each year. Plans will be able to earn back the withheld capitation revenue if they meet predetermined quality thresholds. DMAS will work with CMS to construct a withhold-based quality incentive program that incorporates indicators that have been chosen specifically for the dual eligible population. Furthermore, because providers are the key to improved health outcomes, DMAS may require that a portion of the quality withhold be passed on to providers whose care leads to increases in quality indicator scores.

F. Expected Outcomes

1. Key Metrics Related to the Demonstration's Quality and Cost Outcomes

DMAS has extensive experience monitoring and tracking quality and cost outcomes of capitated managed care and long-term care programs. DMAS will build upon this experience to ensure that the care provided to Demonstration enrollees is of high quality and is cost effective. DMAS will also work with CMS and stakeholders to finalize a list of quality measures that are the most feasible and meaningful to a significant portion of the population that will be served by the Demonstration and that meet federal requirements, as necessary to comply with 1915(b)/(c) waiver requirements (although as stated previously, DMAS is requesting that the MOU serve as the Federal authority required to implement the Demonstration; thereby eliminating the need to submit a 1915(b)/(c) waiver application).

Examples of potential quality activities and reporting requirements include:

- A Quality Improvement Plan that includes a written description of the MCO's ongoing quality assessment and performance improvement program.
- Satisfaction surveys and HEDIS measures Demonstration, such as:
 - CAHPS Surveys;
 - Breast cancer screening via mammogram;
 - Vaccines (flu and pneumococcal);
 - Comprehensive Diabetes Care;
 - Cholesterol Management for Patients with Cardiovascular Conditions;
 - Pharmacotherapy of COPD Exacerbation;
 - Controlling High Blood Pressure;
 - Antidepressant Medication Management;
 - Follow-up After Hospitalization for Mental Illness; and,
 - Ambulatory Care.

- Other measures may include:
 - Hospital admission and readmission rates
 - Follow-up contact by a primary care physician or care manager within seven days of a hospital discharge.
 - Emergency department utilization
 - Percent of enrollees on multiple atypical antipsychotics;
 - Percent of enrollees meeting self-defined goals in their individualized care plans;
 - Percent of enrollees receiving facility-based care who want to transition to the community that either transition or have a plan to do so;
 - Nursing facility admissions; or,
 - Performance measures currently being used for EDCD and Technology Assisted Waiver enrollees. The performance measures revolve around the following quality assurance domains and their sub-assurances: level of care; service plans; qualified providers; health and welfare; administrative authority; and, financial accountability (see Attachment F for additional details).

- Quality studies conducted by an EQRO.

- An annual Performance Improvement Project (PIP), based on input from DMAS, stakeholders and CMS, that is anticipated to have a beneficial effect on health outcomes and enrollee satisfaction (e.g., related to LTSS, health and safety aspects and special needs of the targeted population).

- MCOs must also comply with performance measurement related to the Medicare Model of Care and Medication Therapy Management Program and may also be required to provide information related to:
 - Prescription drug formulary and prior authorization requirements;
 - Generic versus brand prescription drug utilization;
 - Utilization management plan;
 - Provider networks (to include LTSS providers);
 - Abuse, corrective action, overpayment/recovery;
 - Sentinel events;
 - Number of enrollees referred for long term care screenings (for NF and waiver services);
 - Prompt transfer of medical record when member transfers setting;
 - Provision of alternate forms of communication other than written materials;
 - Prompt payment compliance reports;
 - Claims performance; and,
 - Grievances, appeals and inquires.

Data collection will be primarily performed through the MCOs, and the data will be reported to DMAS on a periodic basis. If DMAS is required to obtain §1915 waivers, the MCOs will be required to follow all quality assurance standards and performance measures for managed care organizations and the EDCD Waiver (and Technology Assisted Waiver in Year Two). This is an extensive list and DMAS would appreciate the opportunity to work with CMS and stakeholders

to determine a more streamlined, yet comprehensive list of quality activities and reporting requirements that will monitor the health and safety of Demonstration enrollees.

2. Potential Improvement Targets

DMAS will finalize the quality measures the Department will use to monitor quality and cost in the Demonstration after significant input from CMS and stakeholders. Therefore, DMAS has not yet developed the potential improvement targets for the key metrics, but hopes to align waiver and Demonstration requirements into a streamlined program of quality improvement. The final performance measures and improvement targets will be included in DMAS' upcoming Request for Proposal and in the MCO contracts. However, it is important to note, that it will take time for the care coordination activities to achieve measurable results.

3. Expected Impact on Medicare and Medicaid Costs

The current lack of alignment between Medicare and Medicaid creates incentives for providers to shift costs by transferring enrollees from one service or setting to another, based on payer source. Furthermore, care is fragmented across systems and providers leading to more costly outcomes. In the current, unaligned system, DMAS has not been able to implement programs that would lead to overall savings, because the new state expenditures that would be required to do so would not be offset by savings, which would largely go to Medicare.

Virginia's eligibility requires that individuals have a high acuity level in order to qualify for long term care services; individuals must need help with at least four activities of daily living and have a medical need. Therefore, expected Medicaid savings are centered on delaying the need for LTSS and maintaining optimum health status of enrollees through better delivery of medical, behavioral health and other support services. DMAS anticipates savings on Medicare-paid services such as hospital and emergency room visits as a result of care coordination/case management and transition coordination and savings on Medicaid-paid services resulting from better outpatient care that helps to keep people in the community.

Virginia's nursing facilities, in particular, are sensitive to how the Medicare and Medicaid reimbursement systems impact their businesses and are seeking some assurances of rate protection in the capitation reimbursement model.

CMS has contracted with an actuary to perform an analysis of the population eligible for enrollment in the Demonstration and to provide detailed financial Medicare and Medicaid projections over the next three years, including estimates of anticipated savings. Therefore, detailed financial projections and further analysis of cost savings will be provided at a later date.

G. Infrastructure and Implementation

1. Staffing

DMAS is one of eleven agencies within the Virginia Health and Human Resources Secretariat. DMAS is composed of an Agency Director, three Deputy Directors (Administration, Operations,

and Finance), and fifteen divisions, each led by a Director. DMAS is the single state agency responsible for administering the Medicaid program.

For this demonstration, DMAS' Agency Director and Deputy Directors will provide executive oversight and guide the policies of the program. They will draw on internal staff across several divisions who are highly qualified and experienced in policy analysis, managed care and PACE program design and operations, complex data analysis (SAS, claims, and encounter data), rate setting, information management, contract management, and budgeting. Specifically,

- The Policy & Research Division, which has responsibility for several areas (eligibility, research and policy analysis, behavioral health and substance abuse services, regulatory review, and program development), will provide input on policy, design, management and program evaluation.
- The Health Care Services (HCS) Division, which consists of four operational units (Managed Care, Dental, Pharmacy, and Transportation) and a Systems and Reporting unit, will play an integral role in the demonstration given its responsibility for program implementation, monitoring, and oversight of the contracted MCOs and DMAS' §1915(b) waiver. The HCS Division also provides oversight of the (1) contracted enrollment broker that operates a helpline and assists eligible enrollees enroll in managed care and (2) External Quality Review Organization (EQRO) that is responsible for focused studies, on-site monitoring, and preparation of annual quality reports.
- The Long-Term Care (LTC) Division develops, implements, and administers programs designed to improve the lives of the elderly and persons with disabilities, promulgates long-term care regulations, policies and procedures, and oversees DMAS' §1915(c) home and-community-based waivers as well as PACE and the Money Follows the Person Demonstration. For the proposed Demonstration, the LTC Division will provide input into long-term care services policy, design, implementation, quality reporting, and §1915(c) waiver requirements.
- The HCS and LTC Divisions report directly to the Deputy Director of Operations. This administrative structure will help streamline program coordination and management across the operational divisions that will be involved in the dual eligible demonstration.
- The Provider Reimbursement (PR) Division sets capitation rates for managed care and PACE. For the demonstration, the PR Division will work with the CMS actuary, receive and analyze Medicaid and Medicare data and provide oversight of DMAS' contracted actuary firm that will help calculate capitation rates.
- The Information Management (IM) Division is responsible for the development, implementation, and maintenance of all computer software systems within the agency. Much of the work is performed in tandem with the Agency's fiscal agent. Under DMAS' direction, the fiscal agent designs, develops, and maintains the agency's Medicaid Management Information System (MMIS). IM will be responsible for the systems changes required to implement the dual eligible demonstration, including enrollment and collection of encounter data.

- The Budget and Contract Management Division is responsible for developing and managing the Department's budget and directing procurement and contract activities. For this demonstration, the Budget and Contract Management Division will oversee program expenditures and contracting activities.

Specific proposed DMAS staff that will play key roles in the Demonstration's planning, design, implementation, and oversight are outlined in Attachment G.

2. Expected Use of Contractors

DMAS anticipates using the following contractors to help plan, design, and implement the integrated care program for the dual eligibles:

- MCOs - A procurement process will be used to select at least two MCOs in each of the four targeted Demonstration regions. The proposal review process will be conducted jointly with CMS and will result in the negotiation of three-way contracts.
- Actuary - DMAS anticipates contracting with an actuary (DMAS' current actuary is PricewaterhouseCoopers) for the analysis of past service utilization and costs resulting in the base year's *databook*, the program's rate cell structure, and the risk-adjusted capitation rates. PwC has extensive experience with Medicaid eligibility, Medicaid Management Information System (MMIS) claims, MCO encounter data and other vendor data, and with the dual-eligible population through rate setting for the PACE program and their previous work on VALTC. PwC is also familiar with Medicare payment systems, claims data, risk adjustment, and Medicare Advantage (MA) and Medicare Part D rates. For the past six years, PwC has had a contract with CMS to annually review MA and Part D drug plan bids, which requires review or calculation of CMS-HCC model risk scores and application of low income, Community and Long-Term Care and new enrollee multipliers. PwC has worked with the provider-specific Medicare data, comparing and benchmarking the data using the Medicare Limited Data Set National 5% Sample and MEDPAR files.
- Fiscal Agent - Under DMAS' direction, the Department's fiscal agent designs, develops, and maintains the agency's Medicaid Management Information System (MMIS). For the dual demonstration, DMAS anticipates the fiscal agent and the Department's Information Management (IM) Division will analyze the MMIS for systems changes required for program implementation.
- External Quality Review Organization (EQRO) - DMAS anticipates using an EQRO for consultation on the development of quality and outcome measures for the Demonstration and for external quality reviews.
- Enrollment Broker - DMAS anticipates using an enrollment broker for enrollee education, enrollment and MCO selection, operating a toll-free enrollee service helpline, assistance with and tracking of grievance resolution, and possibly marketing and outreach.

- *Mailing Contractor* - DMAS anticipates using a mailing contractor for enrollee and provider notification mailings.
- *Center for Health Care Strategies (CHCS)* - DMAS receives technical assistance from the CHCS on the integration of LTSS and anticipates assistance on program development for duals program. DMAS has received technical assistance from CHCS in the past and has benefited greatly from their national and state specific knowledge of integrated care models.

During the planning and design process, project staff will evaluate the potential impact of the dual eligible demonstration on other DMAS contracts and amend them (e.g., non-emergency transportation and pharmacy), as needed.⁴

3. Capacity to Receive and Analyze Medicare Data as Part of a Linked Database

For this project, DMAS will primarily draw on internal staff in the Provider Reimbursement division for Medicaid/Medicare data matching and analysis, with contributions from the Policy and Research, Budget and Contract Management, and Health Care Services divisions. External analytical capacity will be provided via a contract with our actuary for analyzing FFS, managed care encounter and Medicare data for capitation rate setting.

In regards to capacity for linking Medicare and Medicaid data, DMAS currently receives monthly claim files from GHI, the Coordination of Benefits Contractor (COBC), subject to a Coordination of Benefits Agreement (COBA) between DMAS and CMS. DMAS provides a monthly eligibility file to GHI, which uses the information to process the remaining Medicaid liability and send the resulting crossover claims to DMAS. Crossover claims sent to DMAS include claims for which DMAS has potential liability. Claims are not provided to DMAS if Medicare denies or pays the entire claim.

The crossover claim files are utilized by DMAS staff to perform analysis related to the dual-eligible population. These analyses include determinations as to how changes in the Medicaid fee schedule would impact expenditures on behalf of dual-eligible enrollees. In addition, the crossover, FFS claim and managed care encounter files are sent to the Department's current actuary PwC to develop capitation payment rates for the DMAS Program of All-Inclusive Care for the Elderly (PACE) and the previously proposed VALTC program. PwC also develops capitation rates annually for managed care programs largely based on encounter data.

In the planning and development of the integrated care program, DMAS will request Medicare files from CMS and seek information on Medicare administrative expenses, in order to accurately estimate the costs for providing and managing the combined Medicare/Medicaid services. DMAS anticipates that Medicaid/Medicare data linkage would be performed by PwC staff, drawing on their past experience in working with Medicaid data, with consultation and review provided by DMAS and the MCOs.

⁴ Under the Demonstration, since the target population will be transitioned from fee-for-service to managed care, some of DMAS' fee-for-service contractors will experience a reduction in the number of enrollees they serve.

DMAS anticipates that PwC would continue to calculate risk-adjusted capitation rates for program implementation. PwC is thoroughly familiar with Medicaid eligibility, MMIS and other vendor data, and with the dual-eligible population through rate setting for the PACE program and previous work on VALTC. PwC is also familiar with Medicare payment systems, claims data, risk adjustment and MA and Medicare Part D rate and program development. For the past six years, PwC has had a contract with CMS to annually review health plan MA and Part D drug plan bids, which require review or calculation of MCS-HCC model risk scores and application of low income, Community and Long Term Care and new enrollee multipliers. PwC has worked with the provider-specific Medicare data, comparing and benchmarking the data using the Medicare Limited Data Set National 5% Sample and MEDPSR files. DMAS will engage PwC for the analysis of past service use and costs resulting in the base year's *databook*, and on program rate structure.

4. Overall Implementation Strategy and Anticipated Timeline

As stated in this proposal, DMAS' overall strategy is to build off its past experience and seek assistance from stakeholders, CMS, and the Integrated Care Resource Center (ICRC; a joint venture between CHCS and Mathematica Policy Research) to develop, implement, and evaluate an integrated care model that provides: (1) Medicare and Medicaid-covered services; (2) person-centered care coordination; and, (3) ensures enrollee health and safety and access to high quality health and supportive services. DMAS will develop a financial model that has the potential to achieve meaningful savings while maintaining or improving quality. DMAS will also collect and/or provide data to CMS to inform program management, rate development, and evaluation, including tracking data on key metrics related to the integrated care program's quality and cost outcomes.

Toward that end, DMAS has developed an aggressive timeline to ensure the Department achieves the necessary steps associated with this demonstration and can begin program operations on January 1, 2014. DMAS is confident that the Department will meet the timeline given previous work and the highly qualified and experienced staff and contractors assigned to work on the project.

Specifically, DMAS plans to:

- Solicit stakeholder input on the design, implementation, and evaluation of the Demonstration;
- Conduct data analysis on the dual eligible population to assess their costs and service use, among other characteristics. The data analysis will help drive key decisions about the care model;
- Finalize program design elements;
- Submit a proposal to CMS (after posting for public comment) for CMS' approval;
- Sign a Memorandum of Understanding with CMS;
- Develop capitation rates in conjunction with CMS;
- Develop §1915(b) and §1915(c) waiver applications for CMS' approval;
- Identify and implement needed systems changes;
- Prepare regulations changes;
- Procure health plans and execute three-way contracts;

- Execute contract modifications with all of DMAS’ impacted contractors (e.g., enrollment broker, EQRO, SA, non-emergency transportation broker, etc.);
- Prepare, disseminate, and conduct enrollee and provider communications and trainings;
- Conduct a readiness review;
- Begin program implementation;
- Monitor the program; and,
- Continue to engage stakeholders to identify areas in need of modification and improvement.

DMAS will collaborate with CMS during every step of the process and will keep CMS abreast of the Department’s progress and key decisions as they are made. DMAS anticipates this constant communication will facilitate all the review and approval processes. Furthermore, DMAS will receive valuable technical assistance from the ICRC, particularly around how to streamline Medicare and Medicaid processes and how other states have implemented integrated care programs for dual eligibles.

DMAS’ anticipated high-level project timeline, including key tasks, dates, and responsible parties, appears in Table 3 below.

Table IV. Proposed High Level Project Plan

Timeframe	Key Activities/Milestones	Responsible Parties
October 2011-ongoing	Stakeholder engagement	DMAS
December 2011-April 2012	Draft Demonstration proposal	DMAS, CMS
December 2011-September 2013	Rate setting process	DMAS, CMS
March 2011-August 2013	IT/systems changes	DMAS
April-May 2012	State public notice of initial proposal and public comment period	DMAS
May 2012	Incorporate public comments, revise proposal as appropriate	DMAS
May 2012	Submission of State proposal to CMS	DMAS
June- July 2012	CMS makes proposal publicly available for comment	DMAS & CMS
June-July 2013	Promulgate regulations	DMAS
June 2012	State submits draft §1915(b) and §1915(c) waiver applications needed for Medicaid authority to enroll dual eligible beneficiaries into integrated program	DMAS
July-September 2012	MOU development/finalization	DMAS & CMS
March-October 2012	RFP for health plan selection developed	DMAS & CMS
October 2012	RFP released	DMAS
February-June 2013	State/CMS plan RFP submission review	DMAS, CMS

Timeframe	Key Activities/Milestones	Responsible Parties
June-September 2013	Three-way contract documents finalized	DMAS, CMS, MCOs
July 2013	Final Plan Selection completed	DMAS, CMS
August –September 2013	Readiness reviews	DMAS, CMS, MCOs
September 2013	Three-way contracts signed	DMAS, CMS, MCOs
August – September 2013	Plans finalize policies, procedures	MCOs
October 1, 2013	Beneficiary notification	DMAS, CMS, MCOs
October 15-December 7, 2013	Enrollment period	DMAS, CMS, MCOs
January 1, 2014	Demonstration start	DMAS, CMS, MCOs

H. Feasibility and Sustainability

1. Potential Barriers/Challenges and/or Future State Actions that Could Impact Successful Implementation and Strategies to Addressing Them

Several challenges, some of which DMAS encountered during VALTC, could potentially impact the success of the Demonstration. A description of these challenges and the strategies DMAS has developed to resolve them are described below.

Financial Challenges - Under VALTC, interested MCOs believed that they would not be able to operate the program within the capitation rates offered. The MCOs were also concerned about recovering their considerable start-up costs. Furthermore, MCOs were concerned that the cost of care coordination would not have been offset by savings, as a significant portion of savings would have been realized for Medicare-paid services rather than the Medicaid services that were included in the contracted benefit package.

Under the three-way contract, participating plans will receive both Medicare and Medicaid payments that reflect the full set of covered services, as well as administrative costs. In addition, CMS will share expected Medicare savings with the State, giving the State greater flexibility in paying MCOs a care coordination load that they will find realistic. All six of the current Virginia Medicaid MCOs, in addition to two health plans that do not currently participate in the Virginia Medicaid market, have submitted letters to DMAS indicating their intent to apply to participate in the Demonstration. Under the Demonstration, DMAS will work with CMS and the Department's actuary contractor to ensure payment is sufficient given the risks and health needs of the population, and that appropriate risk adjustments and shared savings arrangements are established.

Impact on Service Providers – Under the Demonstration, payment to providers will transition from a FFS system with DMAS and Medicare as the payors, to an arrangement where network providers will receive payments from MCOs. While managed care is not a new concept to physical and behavioral health providers, nursing facilities and community LTSS providers will experience some change. When DMAS attempted to implement VALTC, the nursing facility

(NF) industry was hesitant to contract with the MCOs because of concerns regarding changes in Medicare and Medicaid payments, timeliness of payments and perceived administrative burdens. DMAS proposed a NF payment method that would hold the MCOs at risk for sixty days of NF care, thus providing an incentive for helping individuals remain in the community. DMAS proposed to include NF costs in the capitation rate but would retract the cost of NF days from the MCOs once an enrolled individual was admitted to a NF, and DMAS would pay the NF directly. CMS was not agreeable to this arrangement, and consequently DMAS had to carve out NF services from the capitation rates, thus eliminating a major area and incentive for potential savings.

Since that time, the landscape in Virginia has shifted. Providers who were initially resistant to managed care models in the past have expressed a willingness to reevaluate their positions. Consequently, under the three-way contract, DMAS plans to work very closely with providers and advocates to address and overcome past barriers and to design a program that addresses their concerns. NF stakeholders have expressed that they would like the Demonstration to address the Medicare three-day hospital stay requirement; that they would like help with increasing the number of providers who will visit patients in the NF, especially behavioral health providers; that they would like prompt service authorization decisions and claims payment; that they welcome meaningful help with transition coordination; and, that they are concerned about potential changes to the mix of reimbursement levels, as Medicaid pays rates that are below their costs. DMAS is committed to working with NF providers in finding common solutions to these concerns. In addition, DMAS has strong support from the Secretary of Health and Human Services and Governor for including LTSS in a managed care model. DMAS is committed to meaningful stakeholder engagement and has a long-standing commitment and history of involving stakeholders in the design process of integrated care programs.

Enrollment - DMAS proposes to use passive enrollment with an option for voluntary opt out. Under passive enrollment, individuals will be automatically enrolled into the Demonstration, unless they indicate a choice to opt out during the enrollment process. DMAS is requesting a limited lock in period (six (6) months) to allow individuals to experience the benefits that coordinated care can deliver, although 'good cause' criteria for disenrollment during the lock in period will be developed. If the request for a limited lock in period is denied, individuals may opt out at any time.

DMAS will develop information materials explaining individual's options. Materials will include introduction letters and comparison charts that display MCO options, network features and supplemental/enhanced benefits offered by each MCO. DMAS will use an enrollment broker to assist individuals with enrollment, MCO selection and disenrollment processes. The enrollment broker will operate a toll-free phone line, in order to respond to questions. Demonstration information will be displayed on the DMAS website, and DMAS will conduct outreach activities to potential enrollees.

The Department will implement the features that will provide the most value to enrollees to encourage maximum participation (e.g., continued access to existing providers, expanded access to community-based supports, enhanced benefits, etc.).

Other Challenges - Under VALTC, DMAS developed and submitted §1915(b) and §1915(c) wavier applications. Inconsistencies and conflicting requirements between §1915(b) and §1915(c) quality and reporting requirements and challenges associated with CMS review and approval of §1915(b) and §1915(c) waivers created many obstacles and contributed to the inability to implement the program. For these, and for other reasons stated above, DMAS is requesting that the MOU between CMS and DMAS serve as the Federal authority to implement the Demonstration.

2. Remaining Statutory and/or Regulatory Changes Needed

As mentioned previously, legislative language directs the Department to develop a care coordination model for dual eligible individuals. Specifically, Item 297 MMMM.1.g allows DMAS to develop and implement a care coordination model for dual eligible individuals. This language gives DMAS the required state authority to implement the Demonstration, so no other statutory changes will be required.

In terms of regulatory changes, , DMAS will need to promulgate new regulations to operate the demonstration, although Item 297 MMMM.1 of the 2011 Appropriations Act gives DMAS the authority to implement the care coordination model for dual eligibles upon federal approval and prior to the completion of any regulatory process.

If the CMS does not grant DMAS' request to use the MOU as the Demonstration authority, DMAS will submit a new 1915(b)/(c) wavier application.

3. New State Funding Commitments or Necessary Contracting Processes

Prior to implementation, DMAS will need to execute three-way contracts with participating MCOs and CMS. Furthermore, as described in Section G of this proposal, DMAS anticipates using several other contractors to help plan, design, and implement the Demonstration (e.g., an actuary, a fiscal agent, an EQRO, an enrollment broker, and a mailing contractor). DMAS currently has agreements with each of these entities, but will need to execute contract modifications to alter each entity's scope of work to account for changes resulting from the Demonstration.

Under the Demonstration, the target population will transition from fee-for-service to managed care. Therefore, some DMAS contractors will experience a reduction in the number of enrollees they serve (e.g., non-emergency transportation, FEA and service authorization vendor). Therefore, during the planning and design process, project staff will evaluate the potential impact of the Demonstration on all of DMAS' contracts and amend contracts, as necessary.

4. Scalability of Proposed Model and Replicability in Other Settings/States

Under this demonstration and with CMS' assistance, DMAS anticipates successfully implementing an innovative and effective Demonstration program of integrated care that can be replicated across the Commonwealth. DMAS' plan to develop an integrated care program for dual eligible individuals mirrors the manner in which the Department implemented its current Medicaid managed care program. Specifically, managed care was first implemented in 1996 in

seven localities. Since that time, the program has experienced multiple regional and several health plan expansions. Effective January 1, 2012, DMAS completed an expansion in the Roanoke/Alleghany region that impacted 24 localities. Another expansion, that will impact 15 localities in far Southwest Virginia, will be effective July 1, 2012. When completed, this expansion will result in the availability of MCO coverage to eligible individuals (non-dual eligible individuals) in all areas of the Commonwealth for acute care services.

As indicated, DMAS plans to pilot the Demonstration in four geographic regions and would like to expand to a fifth region in the second year. After the conclusion of the Demonstration, DMAS will leverage its experience to expand the program into the remaining geographic regions of the state. This approach will enable DMAS to develop the needed infrastructure, obtain stakeholder buy-in, produce tangible results, and make program modifications before expanding the program to other areas.

5. Letters of Support

DMAS received letters of support confirming the endorsement of the Department's proposed Demonstration for dual eligibles from the following stakeholders (see Attachment H):

I. Additional Documentation

DMAS will provide additional documentation at CMS' request.

J. Interaction with other HHS/CMS Initiatives

DMAS will work with HHS and CMS to coordinate and build upon their initiatives aimed at improving health and health care including but not limited to the Partnership for Patients, Million Hearts Campaign, and HHS Action Plan to Reduce Racial and Ethnic Health Disparities. For example:

Partnership for Patients - One of the two major goals of the Partnership for Patients is to reduce hospital readmissions by 20 percent by the end of 2013, primarily by improving care transitions. The proposed Demonstration seeks to reduce hospital admission rates by addressing many of the elements of safe, effective, and efficient care transitions identified by the Partnerships for Patients. Under the Demonstration, all beneficiaries will develop person-centered care plans to ensure services are responsive to their needs and social situation and will be managed by an integrated care team that coordinates care among providers in all settings. The integrated care team will provide a service coordination and linkage role to ensure standardized, accurate and timely information exchange among providers. Two of DMAS' current MCOs have signed the Partnership for Patients pledge.

HHS Action Plan to Reduce Racial and Ethnic Health Disparities - The Demonstration will build upon the strategies and activities in HHS' Action Plan to Reduce Racial and Ethnic Health Disparities (Action Plan). Several key strategies within the Action Plan are also essential components of this Demonstration, including increasing access to care coordination and increasing the ability to identify and address racial and ethnic disparities by ensuring access to information for people with limited English proficiency. Through the proposed Demonstration's

benefit package, enrollees will have access to culturally competent and appropriate care. MCOs will be required to provide notices and materials in prevalent languages and alternative formats. Customer service oral interpretation services also will be available. DMAS will also work with CMS and the MCOs to report data on health and quality of care measures that include demographic information on race and ethnicity.

Million Hearts Campaign - The goal of the Million Hearts Campaign is to prevent one million heart attacks and strokes in the United States over the next five years through a variety of activities. The Demonstration seeks to reduce the prevalence of these conditions by including chronic disease management programs, monitoring progress through quality management, and promoting the use of well-established evidence-based clinical practice guidelines. As part of the care planning process, enrollees and their integrated care teams may elect to engage community health workers, wellness coaches, etc., to enable beneficiaries to improve cardiovascular health. Specific quality measures related to cardiovascular health may also be collected from each MCO to monitor continuous quality improvement.

K. Workplan/Timeline Template

See Section G.4 above.

Attachment A: Medicare Services

Part A Hospital Insurance: helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

Part B Medical Insurance: helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists and some home health care.

Part D Prescription Drug Coverage: helps cover prescription drugs. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium.

DRAFT

Attachment B: Item 297 MMMM.1 of the 2011 Appropriations Act

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:

a. In fulfillment of this Item, the department may seek any necessary federal authority through amendment to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to expand the current managed care program to the Roanoke/Alleghany area by January 1, 2012, and far Southwest Virginia by July 1, 2012. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

b. In fulfillment of this Item, the department may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to allow, on a pilot basis, foster care children, under the custody of the City of Richmond Department of Social Services, to be enrolled in Medicaid managed care effective July 1, 2011. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

c. In fulfillment of this item, the department may seek federal authority to implement a care coordination program for Elderly or Disabled with Consumer Direction (EDCD) waiver participants effective October 1, 2011. This service would be provided to adult EDCD waiver participants on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

d. In fulfillment of this item, the department may seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medicaid managed care organizations for the purposes of receiving acute and medical care services effective January 1, 2012. The department shall have authority to promulgate

emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

e. In fulfillment of this item, the department and the Department of Behavioral Health and Developmental Services, in collaboration with the Community Services Boards and in consultation with appropriate stakeholders, shall develop a blueprint for the development and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a managed care organization. The overall goal of the project is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. Targeted case management services will continue to be the responsibility of the Community Services Boards. The blueprint shall: (i) describe the steps for development and implementation of the program model(s) including funding, populations served, services provided, timeframe for program implementation, and education of clients and providers; (ii) set the criteria for medical necessity for community mental health rehabilitation services; and (iii) include the following principles:

1. Improves value so that there is better access to care while improving equity.
2. Engages consumers as informed and responsible partners from enrollment to care delivery.
3. Provides consumer protections with respect to choice of providers and plans of care.
4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.
5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.
6. Improves quality, individual safety, health outcomes, and efficiency.
7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.
8. Builds upon current best practices in the delivery of behavioral health services.
9. Accounts for local circumstances and reflects familiarity with the community where services are provided.
10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.
11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.

12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.

13. Promotes availability of access to vital supports such as housing and supported employment.

14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.

15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.

f. The department may seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model, that is consistent with the principles in Paragraph e, for individuals in need of behavioral health services not currently provided through managed care to be effective July 1, 2012. This model may be applied to individuals on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act.

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 to be effective April 1, 2012. 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.

h. In fulfillment of this item, the department may seek the federal authority through amendment to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow for the implementation of a Health Home Program for Chronic Kidney Disease utilizing available funding included in the Patient Protection and Affordable Care Act of 2010 to be effective May 1, 2012. 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.

Attachment C: Proposed Regions and Localities for Demonstration

Central Virginia

FIPS	Locality
1	Accomack
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
115	Mathews
117	Mecklenburg
119	Middlesex
127	New Kent
131	Northampton
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
73	Gloucester
93	Isle Of Wight
95	James City County
199	York
550	Chesapeake
650	Hampton
700	Newport News
710	Norfolk
735	Poquoson
740	Portsmouth
800	Suffolk
810	Virginia Beach
830	Williamsburg

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

Attachment C: Proposed Region and Localities for Demonstration Expansion

Southwest/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

DRAFT

Attachment D: Summary of Medicaid Covered Services for Dual Demonstration Program

This attachment is not intended to be a comprehensive list of benefits. All benefit limits should be verified through the State Plan for Medicaid 12VAC30-50 and the appropriate DMAS Provider Manual.

Children <21 will be excluded from the Demonstration, so this chart does not list services specific to this population, such as:

- Dental Services (child- 21 and under);
- Treatment Foster Care (TFC) for children under age 21 years; and,
- Residential Treatment Facility Services (RTF) for children under age 21 years.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Abortions, induced	12 VAC 30-50-100 12 VAC 30-50-180 42 C.F.R. § 441.203 and § 441.206 Chapter IV of the Physician Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual	No	The MCO is not required to cover services for abortion. This service will be covered through a carve out. Requests for abortions where the life of the mother is endangered shall be forwarded to the Department for review to ensure compliance with Federal Medicaid rules. The Department will be responsible for payment of abortion services meeting Federal Medicaid requirements under the fee-for-service program.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	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)	Yes (pursuant to 12VAC30-10-320)	The MCO is not required to cover this service. This service will be covered through a carve out.
Case Management Services for the Elderly	12 VAC 30-50-460 Chapter 4 of the Elderly Case Management Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	No	The MCO is not required to cover this service. Upon implementation of the Dual Demonstration, this service will no longer be available in the Dual Demonstration pilot area.
Chiropractic Services	12 VAC 30-50-150	No	This service is not a Medicaid covered service. The MCO is not required to cover this service.
Christian Science Nurses and Christian Science Sanatoria	12 VAC 30-50-300	No	This service is not a Medicaid covered service. The MCO is not required to cover this service.
Clinic Services	12 VAC 30-50-180 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover all clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Court Ordered Services	Code of Virginia Section 37.1-67.4	Yes (pursuant to 12VAC30-10-320)	The MCO 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.
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)	No, except for certain circumstances. See notes.	This service will be covered through a carve-out. The MCO shall cover CPT codes billed by an MD as a result of an accident. The MCO shall cover CPT and other “non-CDT” procedure codes billed for medically necessary procedures of the mouth. The MCO shall cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care. Optional: The MCO, at its option, may cover certain dental services as for Dual Demonstration participants.
Emergency Services	12 VAC 30-50-110 12 VAC 30-50-300 12 VAC 30-50-300 12 VAC 30-120-395 42 C.F.R. § 434.30 42 CFR §438.114 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	In accordance with 42 C.F.R. § 434.30, the MCO shall ensure that all covered emergency services are available, without requiring prior authorization, twenty-four (24) hours a day and seven (7) days a week through the MCO’s network. The MCO shall cover all emergency services without prior authorization. The MCO shall cover the services needed to ascertain whether an emergency exists and to stabilize the patient. The MCO may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the “prudent layperson” standard, as defined herein, was in fact non-emergency in nature. In the absence of a contract otherwise, these services shall be reimbursed at the applicable Virginia Medicaid fee-for-service program rate in effect at the time the service was rendered. The MCO may not restrict an enrollee’s choice of provider for emergency services. In the absence of a contract or otherwise, all claims for emergency services shall be reimbursed at the applicable Medicaid fee-for-service program rate in effect at the time the service was rendered. Required payments for emergency services are summarized 12 VAC 30-50-300, 12 VAC 30-50-310, and 12VAC 30-120-395.
Emergency Services - Post Stabilization Care	42 C.F.R. 422.100(b)(1)(iv) 42 CFR § 422.113(c)	Yes (pursuant to 12VAC30-10-320)	The MCO shall pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred. This shall include payment for post stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. Coverage shall include treatment that may be necessary to assure, within reasonable medical probability that no material deterioration of the patient’s condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Experimental and Investigational Procedures	12 VAC 30-50-140 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	No	This service is not a Medicaid covered service.
Family Planning Services	12 VAC 30-50-130 42C.F.R. § 441.20 42 C.F.R. § 431.51(b)(2) Chapter 4 of the Baby Care Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover all family planning services and supplies for individuals of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The MCO may not restrict an enrollee’s choice of provider for family planning services or supplies, and the MCO shall cover all family planning services and supplies provided to its enrollees by network providers and by out-of-network providers. Federal law (42CFR § 441.20) requires that the MCO also allow the participant, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. The MCO shall comply with the requirements set forth in 42 C.F.R. § 441, Subpart F, as amended, and shall comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia, § 54.1-2974. The MCO may not impose a 30-day waiting period for hysterectomies that are not performed for rendering sterility. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. The Department’s Family Planning Program as approved in the 1115 Waiver by the Centers for Medicare and Medicaid Services is not covered under the Duals Demonstration.
General Obstetrical Hospital Services	12 VAC 30-50-100 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and home visits as set forth in 12 VAC 30-50-220.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
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)	Yes (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 participants with appropriate services to ensure comprehensive, continuous health care. These coordination services will include: a. Assessment to determine participants’ needs which includes psychosocial, nutrition, and medical factors. b. Service planning to develop individualized descriptions of what services and resources are needed to meet the service needs of the client and how to access those resources. c. Coordination and referrals that will assist the client in arranging for appropriate services and ensure continuity of care. d. The MCO 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.
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The MCO shall ensure that, as a routine component of prenatal care, every pregnant enrollee 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 enrollee consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Any pregnant enrollee 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 enrollee’s medical record.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Home Health Services	12 VAC 30-50-160 Chapter IV of the Home Health Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO 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 enrollee’s home health benefit. The MCO 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 participant 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 MCO may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option. The MCO shall not refer for skilled nursing under the home and community based waivers for these conditions. The MCO 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.
Hospice Services	12 VAC 30-50-270 Chapter IV of the Hospice Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	The MCO is required to cover this service. .

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A) Chapter 4 of the Hospital Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover inpatient stays in general acute care and rehabilitation hospitals for all enrollees. The MCO shall comply with maternity length of stay requirements. MCO shall comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements. The MCO shall cover an early discharge follow-up visit if the mother is discharged earlier than 48 hours after the day of delivery.
Inpatient Rehabilitation Hospitals	12 VAC 30-50-200 and 12 VAC 30-50-225 Chapter IV of the Rehabilitation Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and rehabilitation hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.
Laboratory and X-ray Services	12 VAC 30-50-120 Chapter IV of the Independent Laboratory Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner of the healing arts. All laboratory testing sites providing services under this Contract must have Clinical Laboratory Improvement Amendments (CLIA) certification and either a clinical laboratory license, a certification of waiver, or a certificate of registration and an identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform the full range of services for which they are certified.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Mammograms	12 VAC 30-50-220 Chapter IV of the Independent Laboratory Manual & Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover low-dose screening mammograms for determining presence of occult breast cancer for female enrollees age thirty-five (35) and over, consistent with the guidelines published by the American Cancer Society.
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)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover all medical supplies and equipment at least to the extent they are covered by DMAS. The MCO is responsible for payment of any specially manufactured DME equipment that was prior authorized by the MCO, 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 MCO. 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: i. Customized wheelchairs and required components; ii. Customized prone standers; and, iii. Customized positioning devices 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. Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula.
Nurse-Midwife Services	12 VAC 30-50-260	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover nurse-midwife services as allowed under State licensure requirements and Federal law.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Nursing Facility	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover this service. The MCO shall also be responsible for non-nursing home services and shall work with the nursing home on discharge planning if appropriate. The MCO 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. MCOs will help facilitate individuals returning to community settings when possible and desired by the individual. The MCO 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 enrollees.
Obstetric and Gynecologic Services	Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall permit any female enrollee of age direct access, as provided in subsection B of § 38.2-3407.11 of the Code of Virginia, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without prior authorization from the primary care physician. Routine and medically necessary obstetric and gynecologic (OB/GYN) health care services covered under Medicaid for covered individuals. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. The MCO shall reimburse OB/GYN services at least the amount reimbursed under the Medicaid fee schedule.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Organ Transplantation	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes (pursuant to 12VAC30-10-320)	Organ transplantation services for kidneys and corneas for all eligible individuals, regardless of age. The MCO shall cover services for bone marrow transplants and high-dose chemotherapy for adult (age twenty-one (21) or over) enrollees diagnosed with breast cancer, leukemia, lymphoma and myeloma. The MCO shall cover liver, heart and lung transplantation procedures for individuals over the age of 21 years when medically necessary. Coverage of liver transplants includes coverage for partial or whole, and orthotopic or heterotopic liver transplantation, from cadaver or living donor (and for individuals meeting the criteria). The MCO must use Department prior authorization criteria or other medically sound, scientifically based criteria in accordance with national standards in making medical necessity determinations for all transplantations. The MCO is not required to cover transplant procedures determined to be experimental or investigational. However, scheduled transplantations authorized by DMAS must be honored by the MCO, as with all authorizations, until such time that DMAS can disenroll the enrollee from the MCO, if applicable, if the transplant is scheduled to occur concurrently with the participant's enrollment with the MCO.
Outpatient Hospital Services	12 VAC 30-50-110	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, except in the case of nurse-midwife services that are furnished under the direction of a physician, and are furnished by either a rural health center (RHC), a Federally Qualified Health Center (FQHC), or an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting and meets the requirements for participation in Medicare, as set forth in 12 VAC 30-50-110. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient pre-certification and admission.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Pap Smears	12 VAC 30-50-220 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	MCO shall cover annual pap smears
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)	Yes (pursuant to 12VAC30-10-320)	The MCO 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 MCO 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 MCO shall also cover all medically necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Physician Services	12 VAC 30-50-140 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered unless performed for medically necessary physiological reasons.
Podiatry	12 VAC 30-50-150 Chapter IV of the Podiatry Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO 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 MCO 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.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Pregnancy-Related Services	12 VAC 30-50-220 12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-410	Yes (pursuant to 12VAC30-10-320)	<p>The MCO shall cover services to pregnant women, including:</p> <ul style="list-style-type: none"> a. Pregnancy-related and postpartum services for sixty (60) calendar days after the pregnancy ends, as set forth in 12 VAC 30-50-290; b. Services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290; c. 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; d. Case management services for high-risk pregnant women, as set forth in 12 VAC 30-50-410 and 12 VAC 30-50-280. Case management services for neonatal intensive care. <p>In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the MCO 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 and a newborn assessment, as set forth in 12 VAC 30-50-220.</p>

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	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)	Yes (pursuant to 12VAC30-10-320 and in coordination with Medicare Part D)	The MCO 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 MCO is not required to cover Drug Efficacy Study Implementation (DESI) drugs. The MCO 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 for fee-for-service enrollees. If the drug is prescribed for an “emergency medical condition,” the MCO must pay for at least a 72-hour supply of the drug to allow the MCO time to make a decision. The MCO 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 MCO shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The MCO 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 MCO may not impose co-payments on payments on prescription drugs.
Private Duty Nursing	42CFR441.50 and 1905(a) of Social Security Act EPSDT Nursing Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	No	Not covered for
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRG) for the screening of male enrollees for prostate cancer.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
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)	Yes (pursuant to 12VAC30-10-320)	The MCO 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 MCO shall cover medically necessary prosthetics and orthotics for an enrollee regardless of the enrollee's age when recommended as part of an approved intensive rehabilitation program.
Prostheses, Breast	12 VAC 30-50-210 Chapter IV of the Prosthetic Devices Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes (pursuant to 12VAC30-10-320)	MCO shall cover reconstructive breast surgery. Provide coverage for at least a 48-hour hospital stay following a radical or modified radical mastectomy and not less than 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 709 of 1998 Virginia Acts of Assembly, § 32.1-325 (A) of the Code of Virginia.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Regular Assisted Living Services Provided to Residents of Assisted Living Facilities	12 VAC 30-120-450 12 VAC 30-120 12 VAC 30-120-470 12 VAC 30-120-480 Chapter iv of the Assisted Living Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	No	The MCO is not required to cover this service. When appropriate, the Department will reimburse the Assisted Living Facility as a carve-out payment.
Second Opinions	42CFR438.206	Yes (pursuant to 12VAC30-10-320)	The MCO shall provide coverage for a second opinion when requested by the enrollee for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. The MCO may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.
Telemedicine Services	Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO 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	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Temporary Detention Orders (TDOs) & Emergency Custody Orders (ECOs)	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 Appendix B of the Hospital Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual	Yes (pursuant to 12VAC30-10-320)	The MCO 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 MCO 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 client 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 MCO 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 client may be transferred without medically harmful consequences, the MCO may designate an appropriate in-network or out-of-network facility for the provision of care. The MCO will cover TDO in accordance with Medicaid timely filing requirements which are for one year from the date of the TDO. The MCO shall provide, honor and be responsible for payment of medically necessary screenings and assessments for persons who are under an emergency custody order.
Transportation	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	Yes (pursuant to 12VAC30-10-320)	The MCO 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 MCO shall cover air travel for critical needs. The MCO shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § CFR 440.170(a). The MCO 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 MCO shall cover transportation to and from Medicaid covered community mental health and rehabilitation services.

Service	CFR, SPA or DMAS Manual Reference	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Vision Services	12 VAC 30-50-210 Chapter iv of the Vision Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO 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 enrollees, shall be allowed at least once every two (2) years.

MENTAL HEALTH SERVICES

Service	State Plan Reference or Other Relevant Reference	Full Benefit Dual & Dual Eligible with Waiver	Notes
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover medically necessary inpatient psychiatric hospital stays for covered individuals over age sixty-four (64). The MCO may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid enrollees. All inpatient psychiatric admissions for individuals over sixty-four (64) years of age to freestanding psychiatric facilities shall also be approved by the contractor using its own prior authorization criteria.
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes (pursuant to 12VAC30-10-320)	Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all enrollees, regardless of age, within the limits of coverage prescribed in 12 VAC 30-50-105. All inpatient mental health admissions for individuals of any age to general acute care hospitals shall be approved by the MCO using its own prior authorization criteria.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	No	The MCO is not required to cover this service. This service will be covered through the DMAS fee-for-service system. Notify DMAS of all enrollee admissions to state mental hospitals.

OUTPATIENT MENTAL HEALTH SERVICES

****The MCO 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	Full Benefit Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	Notes
Psychiatric Diagnostic Exam	12VAC30-50-180 12VAC30-50-140	Yes (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.virginia.gov/wps/portal/ProviderManual)	Yes (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.virginia.gov/wps/portal/ProviderManual)	Yes (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	Yes (pursuant to 12VAC30-10-320)	****

	https://www.virginia.gov/wps/portal/ProviderManual		
Electroconvulsive Therapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Yes (pursuant to 12VAC30-10-320)	****
Psychological/ Neuropsychological Testing	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Yes (pursuant to 12VAC30-10-320)	****
Pharmacological Management	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Yes (pursuant to 12VAC30-10-320)	****

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COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES

Service	State Plan Reference or Other Relevant Reference	Full Benefit Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	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.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	The MCO 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.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	No	This service will be covered through a carve out. The MCO must provide information and referrals as appropriate to assist recipients in accessing these services. The MCO 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	Full Benefit Dual Dual Eligible – QMB Plus & Dual Eligible-QMB Plus with Waiver	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)	Yes (pursuant to 12VAC30-10-320)	The MCO shall cover substance assessment and evaluation and outpatient services for substance abuse treatment for Dual Demonstration enrollees. 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 MCO.
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)	No	This service will be covered through a carve out. The MCO must provide information and referral as appropriate to assist recipients in accessing this service. The MCO shall cover transportation to and from Community MH SPO services and prescription drugs prescribed by the mental health provider.
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)	No	This service will be covered through a carve out. See comment directly above.

Attachment E: Description of EDCD (and Technology Assisted Waiver in year two) Waiver Services

EDCD Waiver Services:

Adult day health care services: services designed to prevent institutionalization by providing participants with health, maintenance, and coordination of rehabilitation services in a congregate daytime setting.

Personal care services: direct assistance with activities of daily living (ADLs), instrumental activities of daily living, supervision, and monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home and community settings to enable a participant to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The participant must require assistance with ADLs in order for personal care services to be authorized. ADLs include: eating/feeding, bathing, dressing, transferring, and toileting. When specified in the service plan, personal assistance services may include assistance with Instrumental Activities of Daily Living (IADL), such as housekeeping, laundry, shopping, and meal preparation, but does not include the cost of meals themselves.

Personal emergency response system (PERS): is an electronic device that enables certain individuals to secure help in an emergency. PERS electronically monitors participant 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 participant's home telephone line. When appropriate, PERS may also include medication monitoring devices.

Respite services: personal care (agency-directed or consumer directed) or services of a nurse (only skilled respite must be provided by a nurse) (agency-directed) that are specifically designed to provide temporary, substitute care that is normally provided the unpaid primary caregiver of a participant. Respite is for the relief of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the participant. These services are provided on a short-term basis because of the emergency absence, or need for routine or periodic relief, of the primary caregiver who lives in the home with the participant.

Transition services: cover specific 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/ her own living expenses. 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.

Transition coordination: is provided by the DMAS-enrolled provider who is 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.

Technology Assisted Waiver Services:

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 activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

Environmental modifications: physical adaptations to a house, or place of residence, which shall be necessary to ensure the individual's health or safety, or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to the individual. Such modifications must exceed reasonable accommodation requirements of the Americans with Disabilities Act (42 USC § 1201 et seq.).

Personal care (agency directed): See definition above.

Personal emergency response system (PERS): See definition above.

Private duty nursing (RN and LPN): individual and continuous nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

Skilled PDN respite care: See respite care definition above.

Transition Services: See definition above.

Attachment F: CMS Assurances for the EDCD Waiver (and Technology Assisted Waiver in year two)

Level of Care (LOC)

- An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver.
- The processes and instruments described in the approved waiver are applied to determine LOC.
- The state monitors LOC decisions and takes action to address inappropriate LOC determinations.

Service Plan

- Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.
- The state monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in service plan development.
- Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
- Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
- Participants are afforded choice:
 - Between waiver services and institutional care; and
 - Between/among waiver services and providers.

Qualified Providers

- The state verifies that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- The state verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards.
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The state identifies and remediates situations where providers do not meet requirements.
- The state implements its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the approved waiver.

Health and Welfare

- There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.
- The state, on an ongoing basis, identifies and addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

Administrative Authority

- The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Financial Accountability

- Claims for Federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.

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Attachment G: Proposed Staffing for Demonstration

Agency Division	Role Title	Role
Administration	Administration	
	Agency Director – Cindi Jones	Executive Oversight
	Deputy Director, Operations – Cheryl Roberts	Executive Oversight, Health Care Services and Long-Term Care
	Deputy Director, Finance - Scott Crawford	Executive Oversight, Provider Reimbursement, Budget, & Information Management
	Deputy Director, Administration – Steve Ford	Executive Oversight, Policy & Research, Behavioral Health & Substance Abuse
	Policy and Program Manager – Adrienne Fegans	Policy and Planning – Health Care Services and Long-Term Care
Policy & Research	Division Director, Policy & Research – Karen Lawson	Executive Oversight
	Policy & Planning Manager II – Paula Margolis	Policy and Research Manager – Project Lead
	Senior Policy Analyst – Meredith Lee	Senior Policy Analyst – Project Lead Support
	Senior Policy Analysts – Jeff Nelson & Rhonda Newsome	Data Analysis Design and Reporting
	Behavioral Health Services Manager-Sandy Brown	Behavioral Health & Substance Abuse Services
Budget & Contract Management	Division Director – Seta Vandegrift	Executive Budget Oversight
	Planning & Forecast Manager – Tanyea Amos	Budget Manager
Health Care Services	Division Director – Bryan Tomlinson	Executive Oversight
	Managed Care Program Manager – Mary Mitchell	Managed Care Program Oversight
	Program Administration Specialist II – Tammy Driscoll	Managed Care Contract Management
	Program Administration Specialist II – Patti Davidson	Managed Care Operations
	Program Administration Specialist II – Susan Offie	Enrollment Broker Contract Manager
	Systems & Reporting Manager - Doug Hartman	MMIS Systems & Reporting
	Systems & Reporting Analyst-Patti Taylor	MMIS Systems & Reporting
	Quality Improvement Analyst – Carol Stanley	Quality Improvement and Monitoring, EQRO Contract Monitor
	Policy and Planning Specialist II –	Policy Analyst

	Kayla Anderson	
Provider Reimbursement	Division Director – Bill Lessard	Executive Oversight
	Provider Reimbursement Manager – Nick Merciez	Manager & Actuary, Capitation Rates
	Reimbursement Analyst – Robert Miller	Analyst, Capitation Rates
Long-Term Care	Division Director – Terry Smith	Executive Oversight
	Program Administration Manager – Steve Ankiel	Program design, LTC Services
Information Management	Director – Sylvia Hart	Executive Oversight
	Systems Analyst – Mary Korsun	MMIS Systems Changes

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Attachment H: Letters of Support

DMAS will include letters in final proposal.

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