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*Department of Medical Assistance Services*

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May 31, 2012

Ms. Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Ms. Bella:

Attached please find the Commonwealth of Virginia's proposal in response to the Centers for Medicare and Medicaid Services (CMS) opportunity, *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. Virginia has had the goal of providing integrated care and care coordination to individuals who receive Medicare and Medicaid and is excited about the opportunity to integrate Medicaid and Medicare services and financing under a unified delivery model. The model promises to help improve the lives and health of some of the state's most vulnerable citizens.

The Virginia Department of Medical Assistance Services (DMAS) looks forward to working with CMS in developing this innovative program. Thank you for considering our proposal.

Sincerely,

A handwritten signature in black ink that reads "Cynthia B. Jones".

Cindi B. Jones, Director  
Virginia Department of Medical Assistance Services

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

**Financial Models to Support State Efforts to Integrate Care  
For Medicare-Medicaid Enrollees**



**May 31, 2012**

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## A. Executive Summary

Individuals eligible for both Medicare and Medicaid (“dual eligibles”) often have complex needs. However, the current delivery system is fragmented, and Medicare and Medicaid often work at cross purposes and impede service 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 outcomes. Because Medicare is the primary payor for acute services, State Medicaid agencies have had no leverage to control costs for dual eligible individuals and little financial incentive, as savings on acute services accrue to Medicare and do not offset new State expenditures for providing coordination services.

The goals of the Financial Alignment Demonstration are to: improve the health of enrolled individuals; create a seamless, integrated service delivery system that reduces burden to individuals and providers; reduce cost shifting between providers and payors; 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 service 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 service coordination to all geographic areas, populations, and services under programs administered by the Department. One initiative that DMAS has implemented over the past several years is a successful PACE program that combines Medicare and Medicaid funding. DMAS operates ten PACE sites and six more will be implemented in the next twelve months.

The Virginia Demonstration will be implemented in four regions of the State in 2014 (Central Virginia, Northern Virginia, Tidewater and Western/Charlottesville). Virginia requests the opportunity to expand to the Roanoke region in 2015. The Demonstration will combine Medicare and Medicaid funding under a blended capitation payment to provide integrated, comprehensive services to full-benefit dual eligible individuals aged twenty-one years and over, including participants in the Elderly or Disabled with Consumer Direction (EDCD) Waiver. The Demonstration will integrate Medicare and Medicaid benefits and services to create a unified delivery system that is easier for individuals 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). Integrated financing streams will improve service 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 Services (CMS) will enter into a Memorandum of Understanding (MOU) to establish the requirements of the Demonstration and risk-based contracts with MCOs. Contracted MCOs will be accountable for the services delivered to individuals, including service coordination and case management. MCO performance will be measured, and payment will be tied to measured quality goals. Services will be delivered using integrated teams and management services that are based on the needs, preferences and goals of individuals. MCOs may offer other 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 and CMS will ensure sufficient consumer protections, including the choice to opt out of the Demonstration, choice of providers, choice of services, rules and processes to maintain relationships with existing providers when possible, and facilitated transitions to new providers when necessary. The Demonstration will also include unified requirements and administrative processes that accommodate both Medicare and Medicaid, including network adequacy requirements, outreach and education, marketing, quality measures, consumer experience and satisfaction assessments, and grievances and appeals processes. Individuals enrolled in the Demonstration will receive services that are culturally and linguistically appropriate and physically accessible. DMAS expects that the Demonstration will improve quality of services, 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 service settings.

DMAS has initiated and will continue a robust process to work collaboratively with stakeholders during the implementation and operational phases of the Demonstration. The Proposal reflects the values and concerns expressed by a wide array of stakeholders. DMAS will monitor individual and provider experiences and will require that MCOs develop processes for ongoing consumer input that result in high quality service delivery and care. Table I below provides a high-level overview of the features of DMAS' proposal.

**Table I. Features of Demonstration Proposal**

<p><b>Included Population</b></p>	<p>Full benefit Medicare-Medicaid adults, including:</p> <ul style="list-style-type: none"> <li>• Individuals enrolled in the Elderly or Disabled with Consumer Direction Home and Community Based (HCBS) Waiver (see Attachment A for a description of DMAS' HCBS waivers);</li> <li>• Medicaid Works program participants<sup>1</sup>;</li> <li>• Individuals residing in a nursing facility;</li> <li>• Auxiliary grant recipients (these individuals reside in Assisted Living Facilities (ALFs) or Adult Foster Homes). Auxiliary grant recipients cannot receive long-term care services and supports.</li> </ul>
<p><b>Excluded Population</b></p>	<ul style="list-style-type: none"> <li>• All children &lt; 21 years old;</li> <li>• Individuals enrolled in the Title XXI CHIP program;</li> <li>• Individuals in the following HCBS Waivers: <ul style="list-style-type: none"> <li>○ Individual and Family Developmental Disabilities Support;</li> <li>○ Intellectual Disabilities;</li> <li>○ Technology Assisted Waiver;</li> <li>○ Day Support; or</li> </ul> </li> </ul>

<sup>1</sup> Medicaid Works is Virginia's Medicaid Buy-In work incentive program that enables workers with disabilities to gain greater independence, higher income and retain more resources than is usually allowed by Medicaid.

	<ul style="list-style-type: none"> <li>○ Alzheimer's Assisted Living.</li> <li>● Money Follows the Person participants;</li> <li>● Individuals who are in State mental hospitals, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDs), Residential Treatment Facilities, or long stay hospitals);</li> <li>● 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);</li> <li>● Individuals enrolled in Hospice at the time of program implementation;</li> <li>● Individuals enrolled in the Family Planning Program;</li> <li>● Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare.</li> </ul>
<b>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide</b>	110,634
<b>Total Number of Beneficiaries Eligible for Demonstration</b>	65,415 <sup>2</sup>
<b>Geographic Service Areas</b>	<ul style="list-style-type: none"> <li>● Central Virginia, Northern Virginia, Tidewater and Western/Charlottesville, encompassing eighty (80) Virginia localities in Year One of the Demonstration.</li> <li>● Roanoke region in Year Two of the Demonstration, encompassing twenty-four (24) localities.</li> </ul>
<b>Summary of Covered Benefits</b>	<ul style="list-style-type: none"> <li>● Medicare Parts A, B, and D benefits (see Attachment B);</li> <li>● Majority of Medicaid state plan primary and acute care services, including behavioral health and transportation services (see Attachment E for a list of services that will be included in the capitation rate those provided through fee-for-service);</li> <li>● EDCD Waiver services, including those utilizing the consumer direction option;</li> <li>● State Plan personal care services for persons enrolled in the Medicaid Works program.</li> <li>● Nursing Facility coverage;</li> <li>● Person-centered service coordination (new service).</li> <li>● Supplemental/enhanced services at the option of participating MCOs.</li> </ul>
<b>Financing Model</b>	Capitated Model
<b>Summary of Stakeholder Engagement/Input</b>	<ul style="list-style-type: none"> <li>● Stakeholder meetings: January-March 2012;</li> <li>● Dedicated website and e-mail box; and;</li> </ul>

<sup>2</sup> This number represents a monthly average of individuals who would have been eligible for the Demonstration had it been in effect during CYs 2010 – 2011.

	30-day public comment period for the draft Demonstration Proposal: April 13-May 13, 2012. <ul style="list-style-type: none"> <li>• Additional meetings and discussions with stakeholder groups on-going.</li> </ul>
<b>Proposed Implementation Date</b>	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 managed care programs (other than PACE). Dual eligible individuals receive services driven by conflicting federal rules and separate funding streams resulting in fragmented and uncoordinated care, and they 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 management and support for chronic conditions. Long-term services and supports (LTSS) are provided in a nursing facility or through a variety of home and-community-based services (HCBS) waivers with no assigned primary care providers or overall coordination between providers. This fragmented system encourages cost shifting between Medicare and Medicaid, contributes to a lack of accountability, sub-optimal quality and health outcomes, and unnecessary costs.

To address these problems, DMAS established the goal of developing service coordination programs and integrating acute and LTSS 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 LTSS system was set in motion. Legislation was enacted (Special Session I, 2006 Virginia Acts of Assembly, Chapter 3) which directed DMAS, in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated system. DMAS was directed to move forward with two different models for the integration of acute and LTSS: a community model and a regional model. DMAS successfully developed a community model by implementing a robust PACE program. There are currently ten PACE sites in the Commonwealth and it is anticipated that there will be an additional five PACE sites operating by 2014.

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, individuals enrolled in an MCO remain in the MCO for their primary and acute medical services after they are approved for HCBS LTSS (prior to this, these individuals were disenrolled from managed care).<sup>3</sup> Their HCBS waiver services, including transportation to the waived services, continue to be paid through the FFS program. Approximately 2,600 individuals are being served through the ALTC program. However, this

<sup>3</sup> ALTC excluded enrollees receiving Technology Assisted Waiver, nursing facility, and PACE services.

program neither addresses 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 a full-risk capitated model that would provide Medicaid covered primary, acute, and LTSS in an integrated, person-centered managed care system. Several barriers were encountered which affected program implementation, including:

- The new service 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.
- Challenges associated with federal review and approval of the §1915(b) waiver and §1915(c) waiver amendment. This also included inconsistencies and conflicting requirements between §1915(b) and §1915(c) quality and reporting requirements.
- The model did not include individuals in nursing facilities due to the concerns expressed by the nursing facility (NF) industry (a key stakeholder).

## **3. Response to Barriers**

Virginia leaders have continued to look for opportunities to implement integrated and coordinated service 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 C). 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. 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 services delivery program for individuals who receive Medicare and Medicaid services. Integrating and coordinating services across the spectrum of services should result in fewer gaps in service, as all health care and LTSS needs will be managed by one entity. Aligned quality measurement and reporting will facilitate a more efficient monitoring system and contribute to improved 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 quality of life, health outcomes and experience of services;
- Provide a seamless, one-stop system of care;
- Reduce service gaps with focused attention on individuals with complex needs, such as persons with serious mental illness;
- Deliver the services and settings that meet the needs of members with cognitive impairments, behavioral health needs, physical support needs and other special medical needs;
- Service coordination - the non-clinical but important functions of providing information and logistical help in navigating the service environment, assuring timely and effective transfer of information, and tracking referrals and transitions to identify and address barriers to accessing timely services and/or support;
- Case management-the more intensive service provided by health professionals, including Interdisciplinary Teams (ITs), to individuals at high-risk. Case management encompasses both referral/transition management and clinical services such as monitoring, self-management support and medication review and adjustment. Case management will integrate the medical and social models of care, ensure individual choice and rights, and include individuals and family members using a person-centered model;
- Disease and medication management, 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;
- The provision of behavioral health services as needed, including services for individuals residing in nursing facilities, in collaboration with the individual, the individual's family, and all others involved in the individual's care, including other agencies or systems;
- Coordination between covered physical health, behavioral health, and LTSS 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 EDCD Waiver and individuals residing in nursing facilities. Approximately 65,400 individuals will be eligible to participate in the Demonstration. The following individuals will be excluded:

- Children < 21 years old;
- Individuals enrolled in the following home and community based waivers:
  - Individual and Family Developmental Disabilities Support;
  - Intellectual Disabilities;
  - Technology Assisted;
  - Day Support; and,

- Alzheimer's Assisted Living.
- Money Follows the Person Demonstration participants;
- Individuals who are in State mental hospitals, ICF/IDs, Residential Treatment Facilities, and long stay hospitals;
- Individuals enrolled in a PACE program (PACE participants will not be passively enrolled, but they may choose to enroll in 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.

**Table II. Populations**

	Total Eligible Population	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings (EDCD waiver)	Individuals not receiving LTSS
Target Population	65,415	10,900	8,417	46,098
Individuals age 65+	40,694	9,351	6,297	25,046
Individuals under age 65 <sup>4</sup>	24,721	1,548	2,120	21,053
Individuals with serious mental illness (SMI) <sup>5</sup>	19,101	3,476	2,349	13,276

### C. Care Model Overview

#### 1. Proposed Delivery System

DMAS, in partnership with CMS, will contract with MCOs under a capitated model that will be responsible for the delivery of all Medicare benefits, all but a very few Medicaid benefits<sup>6</sup> and for the provision of case management and service coordination activities. Service delivery will be supported by Interdisciplinary Teams (ITs) tailored and personalized to meet individual needs. MCOs will be responsible for coordinating referrals for non-covered services, such as affordable 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 and would like the option to expand to the Roanoke region in Demonstration year two. (Attachment D lists the specific localities within each region that will be included. The specific localities within each region may change slightly, based on additional analysis of market

<sup>4</sup> Individuals < 21 years old will be excluded from the Demonstration.

<sup>5</sup> Approximately one-hundred and fifty ICD-9 diagnostic codes were utilized to identify individuals with SMI. The codes reflected numerous subcategories for Schizophrenia, Manic Disorder, Major Depressive Disorder and Bipolar Affective Disorder. Other codes were included such as Dependent Personality Disorder, Multiple Personality, Neurotic Depression, Shared Paranoid Disorder and Unspecified Affective Psychosis.

<sup>6</sup> See Attachment E for a full description of included and excluded Medicaid services.

characteristics, utilization patterns and discussions with stakeholders). DMAS selected these regions because they contain a large number of the eligible population, have well-developed health systems and have favorable market characteristics. MCOs will have the option of participating in one or more Demonstration region. It is anticipated that several current Medicaid MCOs, as well as MCOs that are new to the Virginia Medicaid market, will respond to the Request for Applications (RFA).

Enrollment - DMAS proposes to use passive enrollment with an opt-out option. DMAS is awaiting CMS guidance on details of a unified enrollment process, but will work with CMS, individuals, stakeholders and other partners to design and implement the process. If a dual eligible individual opts out of the Demonstration he/she will return to the FFS environment. DMAS is not requesting that individuals who opt out of the Demonstration be mandatorily enrolled in an MCO solely for Medicaid services.

Beneficiary protections will be mandated to ensure a smooth transition to the MCOs. Protections may include:

- Enrollment algorithms that maintain current individual-provider relationships;
- Automatic transfer of pre-authorizations for traditional Medicare-paid services that conform to Medicare Advantage and Medicare Part D timeframes and for six months for traditional Medicaid-paid services;
- Transition reports that alert MCOs to individuals with chronic conditions and those using LTSS;
- The performance of health risk assessments (HRA) within sixty (60) days of enrollment for individuals in the EDCD waiver and with chronic health conditions. HRA performed within ninety days (90) of enrollment for all other individuals; and,
- Requirements that MCOs allow individuals to indefinitely remain in the nursing facility in which they are residing at the time the Demonstration is implemented, unless the individual and/or their family agrees to a transition.

To support enrollment decisions, DMAS will ensure that individuals are educated on MCOs' benefits and provider networks, consumer protections, 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). To help facilitate enrollment choices, DMAS anticipates contracting with a neutral enrollment broker to (1) help educate individuals; (2) assist with enrollment and MCO selection; (3) operate a toll-free helpline; (4) assist with and track grievance resolutions; and, (5) possibly marketing and outreach.

DMAS is awaiting guidance from CMS on how enrollment in the Demonstration will be operationalized. However, it is anticipated that DMAS (or its contractor) will offer sufficient advance notice to help individuals either select a MCO in their geographic area or remain in the FFS environment (effectively opting out of the Demonstration). If an individual does not select a MCO within a prescribed time frame, DMAS or its contractor will assign the member to a Demonstration MCO using algorithms that connect individuals with MCOs based on past enrollment and provider networks when possible. DMAS or its contractor will confirm the MCO choice or assignment before coverage begins. Once members are enrolled, DMAS and the MCO

will take steps to maximize continuity of services as people transition to accessing services through the Demonstration. If individuals express a desire to change from one MCO to another in their geographic region or to opt out and return to the FFS environment, DMAS or the enrollment broker will provide information on how the 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 meet Medicare standards for benefits for which Medicare is the traditional primary payor and Medicaid standards for LTSS and other benefits for which Medicaid is the traditional primary payor. Determination of network adequacy for traditional Medicare-paid benefits will be facilitated through the Health Plan Management System (HPMS) Medicare Advantage and Part D process, while network adequacy for traditional Medicaid-paid services will be determined by DMAS with CMS.

Because the prevalence of behavioral health issues in the eligible population is high and behavioral health and substance abuse conditions are often co-occurring with physical and cognitive conditions, the inclusion of a range of behavioral health providers and services in the Demonstration is crucial. To the extent possible, DMAS intends to provide the flexibility for the establishment of behavioral health homes (BHHs) for individuals with serious and persistent mental illness (SPMI) using community providers, such as Community Services Boards (CSB), as BHHs. Using community behavioral health providers as BHHs will serve to maintain and expand the successful systems that are in place that serve individuals with complex behavioral and other health and social needs.

MCOs will enter into provider contracts for HCBS waiver services, including adult day health care, personal care, respite care, personal emergency response systems installation and monitoring, and will provide either directly, or through subcontracts, fiscal employer agent services and service facilitators for individuals using consumer directed services.

MCOs will enter into provider contracts with any willing nursing facility that has an active provider agreement with the Department. Payments to in-network nursing facilities will be no less than an equivalent FFS Medicaid amount as determined by DMAS.

MCOs' provider networks will be evaluated to assure a sufficient variety of available providers given the anticipated enrollment, geographic location of providers, distance, travel time and means of transportation, after hour availability, and physical accessibility (see [http://www.ada.gov/medicare\\_mobility\\_ta/medicare\\_ta.htm](http://www.ada.gov/medicare_mobility_ta/medicare_ta.htm), for example). Each MCO will be required to include in their networks providers with open panels who will accept new individuals.

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 established time and distance standards; (2) throughout the transition period according to Medicare and Medicaid

standards above; and, (3) provider do not furnish a covered service the client seeks because of moral or religious objections.

MCOs will be required to report regularly (such as monthly or quarterly) on their adherence to the established network adequacy 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, provider contract terminations, or insolvency.

MCOs will be responsible for management of their network and ensuring that providers are properly credentialed and re-credentialed according to current State and professional standards. MCOs must determine whether providers are licensed, certified, registered or otherwise credentialed by the State, 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 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. To the extent possible, MCO credentialing criteria and processes will not duplicate or add to other State and Federal requirements, if existing criteria are sufficient (e.g., can be used to meet NCQA standards).

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 ensure that all providers throughout the Demonstration are appropriately re-credentialed to assure that the providers and personnel under contract continue to be qualified to perform covered services.

*Hospital and Nursing Facility Transition Programs* - MCOs will work in a timely fashion with hospital discharge planners and nursing facility staff, individuals and family members to maximize community living with the use of natural supports. Additional detail about these programs appear below.

*Outreach and Marketing* - DMAS and CMS will develop unified marketing and outreach rules that include both Medicaid and Medicare requirements as appropriate. DMAS and CMS will review and approve all MCO marketing materials prior to use. To ensure effective communication, written documents must meet the sixth (6<sup>th</sup>) grade reading level and MCOs must offer materials and methods of communication to insure that effective communication is provided for individuals with disabilities (e.g., alternative formats). DMAS anticipates contracting with a neutral enrollment broker to increase awareness about the Demonstration and to inform enrollment choices through mailings, audio, or print and virtual media.

MCOs will be required to develop a comprehensive marketing plan and submit it to DMAS and CMS for initial approval and annually thereafter. MCOs' contracts will prohibit direct marketing to individuals who may potentially enroll and prohibit distributing marketing materials that have

not been pre-approved by CMS and DMAS, that are inaccurate or false, and that mislead, confuse, or defraud.

*Grievances and Appeals Process* – Medical necessity determinations for covered services will be based on Medicare standards for traditionally Medicare-paid services and prescription drugs and Medicaid standards for LTSS and other traditionally Medicaid-paid services. Areas of coverage overlap will be addressed by CMS and the state. DMAS and CMS will develop a grievance (complaint) and appeals process. Internal appeals processes will be governed by a unified set of requirements for MCOs that incorporate relevant Medicare and Medicaid requirements. DMAS will ensure individuals and their families are informed of their grievance and appeals rights within this program. The grievance and appeals processes will include a timeline and other provisions that are explained to individuals in language that is easily understood. Time frames and parameters for the continuation of benefits during an appeal will be outlined in the forthcoming RFA and in the MCOs' contracts.

*Quality Measurement and Performance Improvement* - 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 and 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 covered Medicare and Medicaid services for individuals enrolled in their plans. 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 and brings added value to individuals through service coordination, case management, medication therapy management and other optional enhanced benefits. MCOs will determine the utilization management tools, including prior authorization requirements, for all services, and will have procedures for determining medically necessary services.

The MCOs will manage and fully integrate the combined inpatient, outpatient, behavioral health, LTSS, and pharmacy services covered by Medicare and Medicaid in a seamless manner, eliminating administrative burden and delays for both individuals and providers in arranging for and accessing/delivering services. More specifically, all Medicare-covered Part A (i.e., inpatient, hospice, skilled nursing facility and home healthcare), Part B (outpatient services), Part D pharmacy services, and Medicaid LTSS and a large majority of Medicaid State Plan services will be included in the capitated payment to participating MCOs. While the majority of Medicaid State Plan services will be included in the Demonstration, a very small number of services, such as private duty nursing, targeted case management for individuals with intellectual disabilities, and abortions will be carved out of capitation and continue to be paid on a FFS basis. Attachment E summarizes which services will be carved in (included) and carved out (excluded) from the capitation payment. Carved in LTSS include:

- 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.

EDCD Waiver participants who receive personal and respite care have the option of *consumer-direction*. Consumer direction allows the individual to serve as the employer of their personal care attendant(s). Under consumer direction, the individual is responsible for hiring, training, supervising, and firing the attendant. The consumer-directed model is chosen as an alternative to agency-directed care by the individual or someone acting on their behalf (e.g., spouse, parent, sibling, child of, other family members, etc.), if the individual is not able to direct their own services.

Individuals who use consumer direction also receive *service facilitation*. Service facilitators currently provide consumer directed employer support (e.g., initial comprehensive visit, training, routine on-site visits, etc.) to assist individuals in their role as employer. In addition, DMAS utilizes a contracted fiscal employer agent (FEA) to verify consumer directed service delivery, administer payroll and comply with Internal Revenue Service requirements. Under the Demonstration, MCOs will have the option of subcontracting or directly providing FEA services and service facilitation.

### **3. Service Coordination and Case Management**

Person-centered service coordination and case management will be added as new functions under the Demonstration. *Person-centered* refers to the practice of basing decisions on individual needs, preferences, and expectations. MCOs will be required to provide coordination and case management services that fill gaps in service; ensure effective linkages, support communication and coordination between providers; monitor transitions between levels of care; and, facilitate discharge planning.

In addition, DMAS is in communication with community behavioral health providers (Community Services Boards, or CSBs) regarding the development of a behavioral health home (BHH) model that could be embedded into the Demonstration. Several CSBs in the demonstration regions currently work with at least one MCO serving in a BHH role. DMAS is pursuing using and extending this capacity to serve individuals in the Demonstration that have intensive behavioral health needs (have serious and persistent mental illness). The community behavioral health providers have established the infrastructure to provide and coordinate a full array of services and multiple funding streams (in addition to Medicaid and Medicare payments), covering behavioral and physical health, social services, support services and housing, among others. DMAS will facilitate a workgroup to address operational aspects of this model, as well as other service coordination structures. In addition, Targeted Case Management for individuals with intellectual disabilities and serious mental illness will continue to be provided by the CSBs. The MCOs and CSBs will be responsible for communicating information and coordinating services used by these individuals.

MCOs will also have the flexibility to contract with other providers who currently perform service coordination/case management to individuals eligible for the Demonstration, such as adult day care centers and nursing facilities. MCOs will be required to describe in their Model of Care how they will work with other providers to coordinate services and ensure that coordination and management include person-centered values and practices. Effective coordination will include the following components:

Health Screenings and Risk Assessments - MCOs may conduct health screenings by telephone, telehealth or via electronic or written forms completed by the individual or their representative. Screenings will be followed with face-to-face health risk assessments (HRA) to best determine individuals' needs. MCOs will be required to conduct an initial HRA within sixty (60) days of enrollment for individuals in the EDCD waiver and those with chronic conditions, and within ninety (90) days of enrollment for all other individuals. MCOs' HRAs may vary and must be pre-approved by DMAS and CMS. HRAs will capture information including: medical, psychosocial, functional (ability to perform activities of daily living and instrumental activities of daily living), cognitive, behavioral health, and LTSS needs that will be used to produce health status profiles, risk scores and individualized service plans.

MCOs will ensure that all HRA information is communicated to primary care providers, the integrated team, other pertinent providers, individuals, family members, and others as needed. Reassessments will be performed within one year of last assessment or when warranted by a change in status (additional requirements for EDCD Waiver participants are described below). 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 service planning.

Eligibility for Long-Term Services and Supports (LTSS) – The Uniform Assessment Instrument (UAI) is a comprehensive, multidimensional, standardized questionnaire that assesses an individual's ability to perform activities of daily living, instrumental activities of daily living, cognitive ability and other dimensions. It has been used in Virginia to assess the LTSS needs of individuals and eligibility for NF and HCBS waiver since the 1990s. The UAI can be accessed through DMAS' web portal at <http://www.virginiamedicaid.dmas.virginia.gov>.

DMAS uses Pre-Admission Screening Teams (contracted through the Virginia Departments of Health and Social Services for community screenings) or an acute care hospital for hospitalized individuals to conduct the UAI. All UAIs must be signed by a physician. Under the Demonstration the Pre-Admission Screening Teams will continue to conduct the UAI to determine initial eligibility for long-term care services. To the extent possible, DMAS anticipates sharing the data collected from the UAI with the MCOs. The MCOs will be responsible for re-assessments.

Service Coordination - Service coordination is multifaceted and includes:

- Assessing needs and planning services;
- Linking individuals to services and providers in order to meet medical, behavioral, social and support services needs;

- Assisting individuals directly for the purpose of locating, developing or obtaining needed services and resources;
- Coordinating services and service planning with other agencies and providers;
- Enhancing community integration;
- Assessing ongoing progress and ensuring services are delivered; and,
- Education, counseling and developing a supportive relationship that promotes the service plan.

The goals of service coordination are to: ensure the delivery of high quality services; 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; identify opportunities that support recovery and independence in the community; improve management and stabilization of chronic conditions; monitor access to services; and ensure timely access to appropriate preventive services.

The MCOs will be required to develop a strategy to stratify individuals into different levels of service coordination/case management, based on information gathered from HRAs, UAI's (when applicable) and other sources. The MCOs' risk stratifications will result in individuals being assigned to a minimum of two levels of service coordination (e.g., basic and enhanced). DMAS will finalize expectations around service coordination with additional input from stakeholders that will be reflected in the RFA and MCO contracts. At a minimum, DMAS envisions the following:

- ***Basic service coordination*** will include:
  - A single point of contact at the MCO for all questions;
  - Assurance that referrals result in timely appointments and do not result in duplication or provision of inappropriate services;
  - Linkages to community-based services as necessary, including Aging and Disability Resource Centers and No Wrong Door contractors;
  - Communication and education regarding available services and resources;
  - Assistance developing self-management skills to effectively access and use services.
- ***Enhanced service coordination/case management*** will be available to members who have a need for more intensive monitoring and follow-up (e.g., have multiple chronic conditions, behavioral health needs, require assistance with performing activities of daily living, use LTSS, etc.). The goals of the enhanced service coordination include:
  - Ensuring that individuals receive needed medical and behavioral health services, medications, LTSS, and social services and enhanced benefits;
  - Improving and maintaining functional health status;
  - Enhancing coordination and transitions across specialties and settings;
  - Eliminating duplicate services;
  - Reducing avoidable medical complications, emergency department use and hospitalizations;
  - Arranging services that promote community living and help avoid premature or

- unnecessary nursing facility placements;
- Planning and coordinating with hospital and nursing facility staff for timely and appropriate discharges to the most integrated settings, and timely community-based and primary care follow-up post-discharge to prevent re-admissions;
- Nursing facility service coordination to prevent avoidable hospitalizations or further deterioration in functioning. MCOs will be encouraged to partner with physicians and NFs to implement models of care such as the Nurse Practitioner model of coordination over the course of the Demonstration. NF coordination will include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, coordination of services beyond the scope of the NF benefit, assessment of interest in transitioning to the community (in coordination with NF staff administering the MDS Section Q) and appropriate community referrals.

It is expected that MCOs will evaluate individuals with chronic health conditions, behavioral health needs, and persons meeting Level of Care criteria for LTSS for enrollment into enhanced service coordination/case management. Individuals with these conditions who are not enrolled in the enhanced level will be reevaluated periodically to assess if their needs have changed and to help avoid a worsening of their health and functional status. MCOs will include a plan for stratification and continued monitoring in their proposals, Medication Management Program and Model of Care which MCOs will be required to submit through CMS' HPMS process.

Interdisciplinary Teams - Coordination/case management will be delivered using an interdisciplinary team model as appropriate. Toward that end, individuals will be assigned to an Interdisciplinary Team (IT) led by a 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 individuals enrolled in the Demonstration. The composition of an individual's IT (e.g., primary care physician, specialist, social worker, behavioral health specialist, pharmacist, etc.) will depend upon each individual's need. For example, a gerontologist and LTSS providers may be involved in ITs for individuals who are EDCD Waiver participants, and a psychiatrist may be involved in ITs for individuals with serious behavioral health issues.

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

Individualized Service Plans - MCOs will be required to work with individuals and their family and/or caregivers to develop a comprehensive person-centered, individualized service plan (ISP). The ISP must incorporate identifiable goals that take into account individuals' needs, preferences

and unique requirements and use evidence-based strategies to achieve goals. Based on the needs and preferences identified in the health risk assessment, the ISP should include:

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

Individualized service plans will be developed in consultation with a variety of providers that are integral to the individual's care (e.g., LTSS providers for dual eligibles who are also Waiver participants). Individuals and/or their caregivers will be encouraged to direct and actively engage in the ISP development process, including determining which providers will be included in the process. Each ISP will be reviewed, monitored, and modified by appropriate staff during contact with the individual, as the individual's health status changes, or at least annually. For Waiver participants, monitoring of the ISP will include ensuring choice of LTSS provider(s), including consumer directed; the effectiveness of back-up plans (e.g., cases in which providers do not show up); and, the health, safety, and welfare of participants. MCOs will have mechanisms to document and maintain the ISPs 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 (NF) Transition Programs - MCOs will be required to operate transition programs in hospitals and nursing facilities. The transition programs in hospitals will ensure the appropriateness of admissions and lengths of stay and adequate discharge planning, with the goal of reducing the need for hospital re-admissions and emergency department visits after discharge. MCOs will also be required to have an adequate network of providers specializing in the needs of individuals residing in nursing facilities, including behavioral health providers. As part of the transition programs in NFs, MCOs will conduct onsite services 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 (including behavioral health) and coordination. In addition, MCOs will work with nursing facility staff to ensure that individuals who wish to transition into the community (identified through MDS Section Q or other means) are referred to local contact agencies in order to facilitate a transition. Individuals who enroll into the Money Follows the Person program will be disenrolled from the Demonstration.

Information Technology - DMAS and CMS will seek participation by MCOs that have the information technology capacity to assist with service coordination that includes a clinical information system (e.g., secure, web-based portal) to track referrals, service authorizations and services delivered. The information technology will be used by providers and the teams to monitor provider/individual communication, individual profiles (e.g., goals, service plan adherence, service delivery, lab results, etc.), and inbound and outbound contact, among other things. MCOs will describe their systems for communication in the Model of Care submitted

through the CMS HPMS system. MCOs will ensure the privacy of health records and provide for access to such records by individuals upon request.

DMAS will also seek participation by MCOs that facilitate and support the use of telemedicine and electronic health records and/or a secure, web-based application that facilitates communication between providers, provides general information, health history, service plans, service use and other information.

Other Requirements - In addition to providing the coordination services outlined above, MCOs will be required to assure access to quality services 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 timely confirmation of eligibility and service authorizations and a nurse advice line.
- Health Education - MCOs must offer health education programs to educate individuals 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 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; personal care services for individuals who do not meet the level of criteria for the EDCD Waiver, or a service whereby a “coach” goes into members’ homes at critical times to prepare the individuals’ and their environments for conditions they may soon experience (e.g., discharge from hospital for hip replacement, an individual with a visual impairment). 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 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, coronary heart disease, clinical pharmacy reviews, etc. MCOs must implement disease management programs that use evidence-based clinical guidelines and methods and employ evidence-based programs for persons with serious mental illness, such as Assertive Community Treatment. Rigorous evidence is not available to inform all health decision making, and individuals with complex needs may require flexibility in

treatment approaches. In developing person-centered service plans, evidence-based practice will be appropriately balanced by an approach that takes individuals' needs into account.

## **5. Context of Other Initiatives**

Current Waivers and/or State Plan Services Available to the Population - Under the Demonstration, individuals who are enrolled (or who become enrolled) in the §1915(c) EDCD Waiver will continue to be enrolled in the waiver and will access HCBS services through participating MCOs.

Existing Managed Long-Term Services and Supports 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 eligible individual is determined to need LTSS, the individual 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 - In Virginia's current Medicaid MCO program (Medallion II), inpatient and outpatient behavioral health and substance abuse services (e.g., inpatient psychiatric hospitalization, outpatient individual therapy, outpatient family therapy, etc.) are covered by the Medicaid MCOs. Non-traditional community and residential based behavioral health and substance abuse services (psychosocial rehabilitation, crisis stabilization, mental health support services, etc.) are carved out of the Medicaid MCOs' contracts and are covered by DMAS on a fee-for-service basis. DMAS recently released a Request for Proposals for a non-risk Behavioral Health Services Administrator (BHSA) to provide service coordination for behavioral health and substance abuse services. When awarded, the BHSA will be responsible for coordinating and preauthorizing all behavioral health and substance abuse services for individuals in the fee-for-service program and non-traditional community and residential based behavioral health and substance abuse services for individuals enrolled in the current Medicaid MCO (Medallion II) program. The contract is anticipated to be awarded in 2012.

Under the proposed Demonstration, participating MCOs will provide all Medicaid and Medicare covered behavioral health and substance abuse services for enrolled dual eligible individuals, including the Medicaid-covered inpatient and outpatient behavioral health and substance abuse services and the non-traditional community and residential based mental health rehabilitative services (e.g., psychosocial rehabilitation, mental health and substance abuse crisis intervention, crisis stabilization, mental health support services, etc.). In addition, MCOs may work with the CSBs in providing a BHH model as described above. However, dual eligibles who opt out of the Demonstration and remain in the fee-for-service environment will continue to receive Medicaid covered behavioral health and substance abuse services in the fee-for-service environment managed and coordinated 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 LTSS are provided in the community

centered on an adult day health care model using combined Medicaid and Medicare funds. There are currently ten PACE sites in the Commonwealth, and plans are underway for five additional sites. Because of the age overlap between PACE and the Demonstration, 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 Medicare Special Needs Plans (SNP) that operate in a few of the demonstration localities. The SNP contracts do not include Medicaid services. Individuals enrolled in the SNPs will be disenrolled from the SNPs and enrolled in the Demonstration MCOs, unless they choose to opt out. In addition, individuals enrolled in a Medicare Advantage and/or Part D plan will be passively enrolled into the Demonstration, unless they 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 individuals by redirecting services away from long-term institutional settings and helping individuals return to the community. Demonstration MCOs will be encouraged to develop payment policies and practices that align payment with outcomes and share accountability with primary care providers and settings.

## **D. Stakeholder Engagement and Individual 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 the Demonstration. Since January 2012, DMAS has engaged with a variety of stakeholder groups and individuals and continues to engage them on an ongoing basis. Specific meeting dates and topics discussed at each meeting appear in Table III below.

In March 2012, DMAS conducted a series of stakeholder meetings with providers, health plans, nursing facilities, hospitals, state agencies, advocacy groups, associations, and individuals, among others<sup>7</sup>. All of the March meetings were open to the public, but some of the meetings focused on specific aspects of the Demonstration that were most relevant to targeted groups. Presentations from the March meetings can be accessed at [http://dmasva.dams.virginia.gov/Content\\_pgs/altc-enrl.aspx](http://dmasva.dams.virginia.gov/Content_pgs/altc-enrl.aspx).

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<sup>7</sup> There are no recognized Indian tribes in Virginia.

**Table III. Stakeholder Meetings**

Date	Stakeholders	Topics
January 4, 2012	Representatives from six Medicaid MCOs	Demonstration design elements
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, LTSS and behavioral health providers, contracts, other state agencies, and advocates)	Demonstration overview – input from attendees
March 21, 2012	Public meeting, but focused on aspects relevant to nursing home and hospital representatives	Potential impacts of the Demonstration, design recommendations and input from attendees
March 23, 2012	Public meeting, but focused on aspects relevant to community LTSS and behavioral health providers	Potential impacts of the Demonstration, design recommendations and input from attendees
March 26, 2012	Public meeting, but focused on aspects relevant to Managed Care Organizations/Health Plans	Potential impacts of the Demonstration, design recommendations and input from attendees
March 28, 2012	Public meeting, but focused on aspects relevant to dual eligible individuals, families and advocates	Potential impacts of the Demonstration, design recommendations and input from attendees
March 28, 2012	Public meeting, but focused on aspects relevant to 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 Facility operators on issues important to these providers.
May 9, 2013	MCO Workgroup Meeting	Update on design changes, discuss Nursing Facility industry issues.
May 16, 2012	Optima Health Plan	Discuss operational and policy issues relevant to MCOs.
May 16, 2012 and May 22, 2012	Virginia Association of Community Services Boards (CSB) and CSB executive directors	Impact of Demonstration on individuals with serious behavioral health issues; use of behavioral health home model.
May 17, 2012	Virginia Adult Day Health Services Association	Met with twelve Adult Day Care administrators to provide Demonstration overview and receive comments.

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 service 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' service coordination and case management; the unmet need for behavioral health services for persons 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, vision and hearing supplemental benefits; the need to reduce paperwork and the number of payers with whom individuals must interface; 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 service authorizations and 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 individuals 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](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](mailto: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.

As mentioned previously, DMAS continues to meet with specific provider and advocacy groups on an ongoing basis and will schedule a series of workgroup meetings to obtain input on operational aspects of the Demonstration, such as enrollment, service coordination, beneficiary protections, educational materials, grievances and appeals, etc. In addition, DMAS complied with CMS requirements regarding public comment on the draft Demonstration proposal. The draft proposal was posted on [http://dmasva.dams.virginia.gov/Content\\_pgs/altc-enrl.aspx](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 received comments from approximately thirty groups or individuals. DMAS reviewed all comments and incorporated them, as appropriate, into the Demonstration proposal, but some comments that were received are more appropriately addressed in the forthcoming MOU, RFA and MCO contracts than in this proposal.

## **2. On-going Stakeholder Meetings and Input**

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

- Convene workgroups to address operational and design issues, such as enrollment, service coordination, behavioral health homes, timely authorization standards, transition programs, communications between providers, etc.

- Continue to hold public stakeholder meetings.
- Maintain the dedicated website [http://dmasva.dmas.virginia.gov/Content\\_pgs/altc-enrl.aspx](http://dmasva.dmas.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.
- Inform Pre-Admission Screening Teams of the Demonstration, including state and local Departments of Social Services, including eligibility for the program and how Teams can help individuals enroll.
- Conduct periodic trainings and develop notices and related materials about the Demonstration that will be sent directly to individuals and/or their representatives.  
Develop meaningful consumer input processes into MCO ongoing operations, for example, convening governing or advisory boards that include sufficient numbers of enrolled individuals and representatives.

Once the Demonstration is implemented, individual 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. Individual Protections**

DMAS carefully designed the Demonstration to include rights and protections to ensure health, safety and access to high quality health care and supportive services through various methods. Protections include requirements regarding choice of providers, family participation in choosing treatment options when desired, 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 that MCOs ensure that individuals have a choice of primary, acute, behavioral and LTSS providers and access to a broad array of specialists who have experience in serving populations with diverse and complex health conditions. MCOs will be required to establish provider networks that meet DMAS and CMS' standards related to travel time and distance and ensure that individuals have adequate access to a choice of nursing facilities, within a reasonable distance from their homes. MCO provider networks will be required to have sufficient breadth and depth to ensure adequate access to all covered services. MCOs will provide access to out of network providers based on criteria that will be established in the RFA process.

*Continuity of Services* To the extent possible, MCOs must employ a process to ensure continuity of services that allows individuals to maintain relationships with their existing providers when possible. Section C describes these and other features of the delivery model that constitute protections related to individuals' choice of providers. During the transition period, MCOs will honor service authorizations according to Medicare and Medicaid criteria. In addition, individuals residing in a nursing facility at implementation will be allowed to remain in the facility indefinitely, unless they and/or their families agree to move to a different facility.

Grievances (Complaints) and Appeals Process - Through contract requirements with MCOs and in agreement with CMS, DMAS will ensure that individuals 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 individuals 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: timing and notification to individuals and providers; authorized appeal representatives; DMAS and external appeal entities; criteria for type of appeal (expedited or standard); levels of appeal (internal and external); and, continuing services and reimbursement.

Customer Service - The MCOs will maintain and staff a toll-free Member or Customer Services function to be operated 24 hours per day, seven days a week and to be responsible for the following: explaining the operation of the MCO, including the role of the PCP and what to do in an emergency or urgent medical situation; assisting in the selection of a PCP and other providers; assistance with making appointments and obtain services; arranging medically necessary transportation for enrollees; and, handling inquiries and grievances. The MCOs will also be responsible for:

- Making oral interpretation services available free-of-charge in all non-English languages spoken by individuals, including American Sign Language;
- Maintaining the availability of services, such as TTY services or comparable services for individuals who are hearing impaired;
- 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 individuals with the means to identify their disability to the MCO;
- Maintaining employment standards and requirements (e.g., education, training, and experience) for services department staff and providing a sufficient number of staff to meet defined performance goals;
- Ensuring that customer service department representatives, upon request, make available to individuals and potential enrollees information on the following:
  - The identity, locations, qualifications, and availability of providers;
  - Individual 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 Protections* - DMAS will implement protections that ensure privacy of records, access to culturally and linguistically appropriate services, access to providers who can serve individuals with mobility and other impairments, and involvement of caregivers, guardians and other 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 services they deliver, reward high quality and improved health outcomes, link payment incentives with quality metrics, and reduce health services spending;
- Support a delivery system that integrates and coordinates comprehensive services and incorporates robust quality measurement;
- Reduce cost shifting between Medicare and Medicaid. 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 do 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 services for dual eligible individuals. 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 incentives to provide high quality, coordinated services that will reduce overall costs. The blended capitation payment structure is expected to provide plans with the flexibility to utilize the most appropriate cost effective services and eliminate incentives to shift costs between Medicare and Medicaid. DMAS will encourage MCOs to extend payment reform models, such as pay-for-performance and accountable care organizations/medical homes to network providers. 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 will include expenses associated with medical, behavioral health, and LTSS, as well as the non-medical expenses required to provide and coordinate those services.

*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.

*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 populations using managed LTSS 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. As a CMS requirement of the demonstration, participating plans will be subject to an increasing quality withhold over the three-year period. 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 key to improving outcomes, DMAS shall explore the option of passing a portion of earned withholds on to providers whose services lead 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 LTSS programs. DMAS will build upon this experience to ensure that the services provided to individuals enrolled in the Demonstration are of high quality and are cost effective. DMAS will work with CMS and stakeholders to finalize a list of quality measures that are the most feasible and meaningful to a significant portion of individuals that will be served by the Demonstration and that meet the federal requirements associated with the 1932(a) State Plan

Amendment and the §1915(c) waiver requirements. Where feasible, quality and outcomes monitoring and measurement will build upon and leverage existing systems and infrastructure, such as results from state and federal nursing home surveys, in order to avoid duplication and reduce administrative burden to providers and the MCOs. Examples of potential quality activities and reporting requirements that the MCOs will conduct and report to DMAS on a periodic basis include:

- A Quality Improvement Plan that includes a written description of the MCO's ongoing quality assessment and performance improvement program.
- Satisfaction surveys and Healthcare Effectiveness Data and Information Set (HEDIS) measures, such as:
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys;
  - Breast cancer screening via mammogram;
  - Vaccinations (influenza and pneumococcal);
  - Comprehensive Diabetes Care;
  - Cholesterol Management for Patients with Cardiovascular Conditions;
  - Pharmacotherapy of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation;
  - Controlling High Blood Pressure;
  - Antidepressant Medication Management;
  - Follow-up After Hospitalization for Mental Illness;
  - Ambulatory Care;
  - Annual Monitoring for Patients on Persistent Medications;
  - Potentially Harmful Drug-Disease Interactions in the Elderly; and,
  - Use of High Risk Medication in the Elderly.
- Other measures may include:
  - Measures related to customer service (e.g., wait/hold times, call abandonment rates, etc.);
  - Measures related to service coordination (e.g., number of completed HRAs, etc.);
  - Quality of life measures;
  - Hospital admission and readmission rates;
  - Appropriate and thorough hospital discharge plans;
  - Follow-up contact by a primary care physician or service manager within seven days of a hospital discharge;
  - Emergency department utilization;
  - Percent of individuals on multiple atypical antipsychotics;
  - Percent of individuals meeting self-defined goals in their individualized service plans;
  - Percent of individuals receiving facility-based services who want to transition to the community and have a plan to do so;
  - Number of transitions from a nursing facility to the community;
  - Nursing facility admissions;
  - Performance measures currently being used in the EDCD Waiver, such as maintenance of functional abilities. 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 G 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 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 individuals referred for UAI assessments (for NF and waiver services);
  - Prompt payment compliance reports; and,
  - Grievances, appeals and inquires.

The MCOs must comply with §1915(c) waiver quality assurance standards and performance measure requirements. Section 1915(c) requirements are extensive, and DMAS will 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 individuals enrolled in the Demonstration. For example, DMAS would like to explore with CMS the feasibility of using the quality measures required under the PACE program, which are not as extensive as those required under the §1915(c) waiver. The PACE measures include: (1) influenza immunization; (2) pneumococcal immunization; (3) grievances and appeals; (4) enrollments and disenrollments; (5) prospective enrollment; (6) hospital readmissions; (7) emergency care; (8) unusual incidents; and (9) deaths.

## **2. Potential Improvement Targets**

DMAS will finalize the quality measures that will be used 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 Applications and in the MCO contracts. However, it is important to note that it will take time for the service coordination activities to achieve measurable results; therefore, DMAS asserts that performance measures tied to payment withholds in the first year should be based on realistic expectations and involve process measures.

### **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 individuals from one service or setting to another, based on payer source. Furthermore, services are 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 Medicaid savings, as savings would largely be on Medicare-paid services.

Virginia's eligibility criteria for NF and HCBS waiver services require that individuals have a high acuity level; individuals must need assistance in performing at least four activities of daily living and have a medical need. Therefore, it is expected that Medicaid savings in the Demonstration will be a result of delaying the need for NF admission and LTSS, and from maintaining optimum health status 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 service coordination/case management and transition coordination and savings on Medicaid-paid services resulting from better outpatient services that helps to keep people in the community for longer periods of time.

Virginia's nursing facilities, in particular, are sensitive to how the Medicare and Medicaid reimbursement systems impact their businesses and are seeking assurances of rate protection in the capitation reimbursement model. Due to the high acuity level of individuals residing in NFs in Virginia, DMAS does not expect that large numbers of individuals who are in NFs for non-skilled care when the Demonstration is implemented will be able to transfer to the community (although DMAS supports this goal and continues to work towards transitions whenever possible). DMAS is sensitive to the need to maintain access to NF beds, the financial challenges NFs face in serving dual eligible individuals, and their concerns about transitioning to a capitated environment. NF representatives have expressed the need for timely authorizations and payment; the need to not increase administrative burden; their desire for payment floors that match Medicare and Medicaid payment levels and mix; their wish for new funds to pay for increased service coordination and prevention activities; and, their wish for performance-based bonuses. DMAS is committed to addressing the concerns of NF providers and determine policies and practices that balance their needs with the needs of individuals in the Demonstration, participating MCOs and CMS.

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 Demonstration, 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 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 in Virginia.

Throughout the Demonstration, DMAS' Agency Director and Deputy Directors will provide executive oversight and guide the policies of the program. DMAS intends to create a new subdivision (Office of Integrated Care) with a dedicated director and will also utilize 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. In addition, DMAS will designate staff to manage stakeholder relations, in order to ensure that stakeholders are involved to the greatest extent possible. DMAS divisions involved in the project will include:

- 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. This HCS Division will play an integral role in the demonstration given its responsibility for program implementation, monitoring, and oversight of the contracted MCOs. The HCS Division also provides oversight of the (1) contracted enrollment broker that operates a helpline and assists eligible individuals enroll in MCOs and other programs, 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 Demonstration.
- The Provider Reimbursement (PR) Division is responsible for 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 contracted 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 H.

## 2. Expected Use of Contractors

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

- MCOs - A procurement process will be used to select a minimum of two, and a maximum of three MCOs in each of the four Demonstration regions. The proposal review process will be conducted jointly with CMS and will result in the negotiation of three-way contracts.
- Actuary - DMAS will contract with an actuary (DMAS' current actuary is PricewaterhouseCoopers (PwC)) 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 DMAS' acute and long term care integration efforts. 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 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 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 education, enrollment and MCO selection, operating a toll-free service helpline, assistance with and tracking of grievance resolution, and possibly marketing and outreach.
- Mailing Contractor - DMAS anticipates using a mailing contractor for notification mailings.
- Center for Health Care Strategies (CHCS) - DMAS receives technical assistance from the CHCS on the integration of LTSS and the Dual Demonstration. DMAS has received technical assistance from CHCS in the past and has benefited greatly from their national and state-specific knowledge of integrated models.

During the planning and design process, project staff will evaluate the potential impact of the dual eligible demonstration on other DMAS contracts (e.g., non-emergency transportation and pharmacy) and amend them as needed.<sup>8</sup>

### **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 DMAS' actuary for analyzing Medicaid 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 individuals. In addition, the crossover, FFS claim and MCO encounter files are sent to the Department's actuary to develop capitation payment rates for PACE and the previously proposed acute and long term care

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<sup>8</sup> 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.

integration program. PwC also develops capitation rates annually for managed care programs largely based on encounter data.

DMAS has requested Medicare files from CMS and will seek information on Medicare administrative expenses, in order to accurately estimate the costs for providing and managing the combined Medicare/Medicaid services. Medicaid/Medicare data linkage will be performed by PwC staff, drawing on their past experience in working with Medicaid data, with consultation and review provided by DMAS and the selected MCOs.

**Other data:** DMAS shall accept and process uniform person-level beneficiary data, as may be necessary for the purposes of program eligibility, payment, or evaluation purposes. Sources may be based upon an initial and ongoing assessment process which includes ICD-9 (and ICD-10, as appropriate) diagnoses codes, Health Outcomes Survey for individuals who are able to self-report, Functional Status elements of the Minimum Data Set (MDS), and/or any other data elements deemed necessary by CMS and the State. In addition, DMAS will collect encounter data from participating MCOs on all services provided. DMAS has collected encounter data from the Medallion II MCOs for many years and will use existing systems to extend this reporting to the Demonstration MCOs.

#### **4. Overall Implementation Strategy and Anticipated Timeline**

DMAS' overall strategy is to build off its past experience and seek assistance from stakeholders, CMS, and the Integrated Care Resource Center to develop, implement, and evaluate an integrated model that provides: (1) Medicare and Medicaid-covered services; (2) person-centered service coordination; and, (3) ensures individual health and safety and access to high quality physical and behavioral health services and LTSS. DMAS will develop a financial model that has the potential to achieve 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 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 continued stakeholder input on the policies, design, implementation, and evaluation of the Demonstration;
- Conduct data analysis on the dual eligible population to assess their costs and service use, and other characteristics. The data analysis will help drive key decisions about the model;
- Finalize program design elements;
- Sign a Memorandum of Understanding with CMS;
- Develop capitation rates in conjunction with CMS;

- Develop §1932(a) State Plan Amendment and §1915(c) waiver applications for CMS' approval;
- Identify and implement needed systems changes;
- Prepare regulation changes;
- Procure health plans and execute three-way contracts;
- Execute contract modifications with all of DMAS' impacted contractors (e.g., enrollment broker, EQRO, service authorization, non-emergency transportation broker, etc.);
- Prepare, disseminate, and conduct individual and provider communications and trainings;
- Conduct a readiness review;
- Implement the Demonstration;
- Monitor the Demonstration; 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 programs for dual eligibles. DMAS' anticipated high-level project timeline, including key tasks, dates, and responsible parties, appears in Table IV below.

**Table IV. Proposed High Level Project Plan**

<b>Tentative Timeframes</b>	<b>Key Activities/Milestones</b>	<b>Responsible Parties</b>
February 2012-ongoing	Stakeholder engagement	DMAS
April 13, 2012	Draft proposal public comment period	DMAS
May 13, - May 31, 2012	Incorporate public comments, revise proposal as appropriate	DMAS
May 31, 2012	Submission of proposal to CMS	DMAS
June- July 2012	CMS makes proposal publicly available for comment	DMAS & CMS
July-September 2012	MOU development	DMAS & CMS
June 2012-July 2013	Rate setting process	DMAS, CMS
August - September 2012	State submits draft §1932(a) SPA and §1915(c) waiver amendment needed for Medicaid authority to enroll dual eligible beneficiaries into integrated program	DMAS
September 2012-August 2013	IT/systems changes	DMAS
March-October 2012	RFA for health plan selection developed	DMAS & CMS
October 2012	RFA released	DMAS
February-June 2013	State/CMS plan RFA submission review	DMAS, CMS
June-July 2013	Promulgate regulations	DMAS
June-September 2013	Three-way contract documents finalized	DMAS, CMS, MCOs
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	Open 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 in the past, 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* – during previous efforts at care integration, interested MCOs believed that they would not be able to operate a program within the capitation rates offered, and they were concerned about recovering their considerable start-up costs. Furthermore, MCOs were concerned that the cost of service coordination would not be 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 service coordination load that they will find realistic. Health plans have demonstrated a strong interest in participating in the Demonstration. All six of the current Virginia Medicaid MCOs, in addition to several health plans that do not currently participate in the Virginia Medicaid market, have submitted letters to DMAS indicating their intent to respond to the request for applications. DMAS will work with CMS and the Department’s actuary 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 payors, to an arrangement where 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 a change. DMAS will work very closely with providers and advocates to address issues and concerns related to the transition to the managed care environment. Some of the issues that have been identified include, eliminating the Medicare three-day hospital stay requirement for skilled nursing facility care; increasing the number of providers who will visit individuals in a NF, especially behavioral health providers; prompt service authorization decisions and claims payment; meaningful transition coordination; and, potential changes to the mix of nursing facility reimbursement levels. DMAS is committed to working with providers and is meeting regularly with stakeholders to find solutions. In addition, DMAS has strong support from the Commonwealth’s Secretary of Health and Human Services and Governor for including LTSS

and behavioral health services for dual eligible individuals in a coordinated 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 programs.

Enrollment - DMAS proposes to use passive enrollment with an option for voluntary opt out. Under passive enrollment, if an eligible individual does not opt out of the Demonstration within the prescribed pre-enrollment time frame, he/she will be passively enrolled into the Demonstration. Individuals who become Medicare or Medicaid eligible retroactively will not be retroactively enrolled into the Demonstration.

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

Other Challenges – In the past, DMAS developed and submitted a joint §1915(b) and §1915(c) waiver application. 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 an integrated program. DMAS will pursue §1932a authority in conjunction with a §1915(c) waiver application for the Demonstration. CMS has communicated that they are working to develop a responsive authority review and approval process.

## **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 service 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 service coordination model for dual eligibles upon federal approval and prior to the completion of any regulatory process. DMAS intends to pursue a §1932(a) State Plan Amendment to operate the Demonstration in conjunction with §1915(c) waiver authority to provide home and community-based services.

## **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. In addition, DMAS intends to hire a new program director to lead the project.

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 individuals they serve (e.g., non-emergency transportation, FEA and the 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**

DMAS anticipates successfully implementing an innovative and effective Demonstration that can be replicated across the Commonwealth. DMAS has successfully used this approach in other managed care programs. Specifically, managed care was first implemented in 1996 in seven localities. Since that time, the program has experienced multiple 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 and primary care services. In addition, the foster care population is in the process of being folded into the managed care program on a regional basis with statewide coverage anticipated in 2014.

As indicated, DMAS plans to pilot the Demonstration in four geographic regions in the first year 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 several stakeholders (see separate Attachment I).

##### **I. Additional Documentation**

DMAS will provide additional documentation at CMS' request.

##### **J. Interaction with other Health and Human Services/Centers for Medicare & Medicaid Services Initiatives**

DMAS will work with HHS and CMS to coordinate and build upon their initiatives aimed at improving health and health services 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 transitions. The proposed Demonstration seeks to reduce hospital admission rates by addressing many of the elements of safe, effective, and efficient transitions identified by the Partnerships for Patients. Under the Demonstration, all beneficiaries will develop person-centered service plans to ensure services are responsive to their needs and social situation and will be managed by an integrated team that coordinates services among providers in all settings. The integrated team will provide a service coordination and linkage role to ensure standardized, accurate and timely information exchange among providers. Two of DMAS' current MCOs which have expressed interest in the Demonstration 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 service 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, individuals will have access to culturally competent and appropriate services. 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 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 service planning process, individuals and their integrated 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.

*Money Follows the Person (MFP)* – as noted above, Virginia operates a MFP program which is scheduled to end during the mid-point of the Demonstration. Due to the incomplete temporal overlap of the two programs, DMAS will not require that the MCOs establish the capacity to administer MFP services; therefore, individuals enrolled in the MFP program will be excluded from the Demonstration.

## **K. Workplan/Timeline Template**

See Section G.4 above.

## Attachment A: DMAS' Home and Community-Based Waivers

Virginia provides a variety of services under home and community-based waivers to specific individuals. Each waiver provides specialized services to help eligible individuals remain in their communities. DMAS' six waivers include:

**Alzheimer's Assisted Living (AAL) Waiver** – is available to individuals who live in an Assisted Living facility, receive services through DSS, are Auxiliary Grant (AG) recipients, and have a diagnosis of Alzheimer's disease or a related dementia with no diagnosis of mental illness or intellectual disability. **Alzheimer's Assisted Living Waiver participants will be excluded from the Demonstration.**

**Day Support (DS) Waiver** – provides home and community-based services to individuals with intellectual disabilities who require the level of care provided in an ICF/ID and are on the waiting list for the MR/ID waiver. Services include: day support; pre-vocational services; and supported employment. **Day Support Waiver participants will be excluded from the Demonstration.**

**Elderly or Disabled with Consumer Direction (EDCD) Waiver** - provides services in the community for individuals who are elderly or have a disability. There is no age limit. Individuals must meet nursing facility level of care criteria. The EDCD Waiver is unique because it does not have a wait list and it can be used for persons who qualify for other Medicaid HCBS waivers and are on a waiting list. For that reason, some individuals on the EDCD Waiver have intellectual disabilities and are waiting to be enrolled in the Intellectual Disabilities (ID) Waiver (described below). EDCD Waiver services include: personal care (consumer and agency directed); respite care (consumer and agency-directed); adult day health care; personal emergency response system and medication monitoring; transition coordination; and, transition services. **Full benefit dual eligible individuals enrolled in the EDCD waiver will be included in the Demonstration. An individual who is in the EDCD Waiver because he/she is on the ID Waiver waitlist will be disenrolled from the Demonstration when he/she is enrolled in the ID Waiver.**

**Individual and Family Developmental Disabilities Support (IFDDS) Waiver** - provides services in the community rather than in an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) The IFDDS Waiver serves individuals 6 years of age and older who: (1) meet the ICF/ID level of care criteria; (2) are determined to be at imminent risk of ICF/ID placement; and, (3) are determined that community-based services under the Waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/ID. There is a wait list for the IFDDS Waiver. Services include: adult companion services (agency-directed); assistive technology; case management; crisis stabilization; crisis supervision; day support; environmental modifications; family/caregiver training; in-home residential support (not group homes); personal care (agency-directed and consumer-directed); personal emergency response system (PERS); prevocational training; respite care (agency-directed and consumer-directed); skilled nursing; supported employment; therapeutic consultation; and transition services. **IFDDS Waiver participants will be excluded from the Demonstration.**

**Mental Retardation (MR)/Intellectual Disabilities (ID) Waiver** - provides services in the community rather than in an intermediate care facility for persons with intellectual disabilities (ICF/ID) for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have an intellectual disability. The waiver is administered jointly by the Department of Behavioral Health and Developmental Services (DBHDS) and DMAS. There is a waiting list for the waiver. Services include: adult companion care (agency-directed and consumer-directed); assistive technology; congregate residential; crisis stabilization; crisis supervision; day support; environmental modifications; in-home residential; medication monitoring (can only be received in conjunction with PERS); personal emergency response system (PERS); personal care (agency-directed and consumer-directed); prevocational services; residential support; respite care (agency-directed and consumer-directed); skilled nursing (RN and LPN); supported employment; therapeutic consultation; and transitional services. **MR/ID Waiver participants will be excluded from the Demonstration.**

**Technology Assisted Waiver** - provides services in the community for individuals who are dependent upon technological support and require substantial, ongoing nursing care. Individuals under 21 years old must be determined to otherwise require acute care hospitalization and meet criteria based on various methods of respiratory or nutritional support needs (tracheotomy, oxygen, tube feeding). Individuals 21 and older must be eligible for adult specialized care placement and be dependent at least part of each day on a mechanical ventilator or meet complex tracheotomy criteria. Services include: assistive technology; environmental modifications; PERS; personal care (agency-directed option); private duty nursing (RN and LPN); skilled private duty nursing; respite care; and, transition services. The waiver does not have a wait list. **Technology Assisted Waiver participants will be excluded from the Demonstration.**

**Waiver Enrollment Numbers**

Waiver	Total Waiver Enrollment (Includes Dual and Non-Dual Individuals)	Number of Full Benefit Dual Eligible Individuals in each Waiver	Number of Full Benefit Duals Eligible for the Demonstration in the Four Proposed Geographic Areas
Alzheimer's Assisted Living	35	33	0; waiver excluded from Demonstration
Day Support Waiver	256	110	0; waiver excluded from Demonstration
Elderly or Disabled with Consumer Direction	22,684	14,336	8,417
Individual and Family Developmental Disabilities Support Waiver	703	155	0; waiver excluded from Demonstration
Mental Retardation (MR)/Intellectual Disabilities Waiver	8,679	5,067	0; waiver excluded from Demonstration
Technology Assisted Waiver	356	58	0; waiver excluded from Demonstration

## Attachment B: 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 does not cover, such as some of the services of physical and occupational therapists, some home health care and some drugs

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

## Attachment C: 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 D: Proposed Regions and Localities for Demonstration**  
 (Region configuration is subject to change based on additional analysis and discussions with stakeholders.)

**Central Virginia**

<b>FIPS</b>	<b>Locality</b>
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**

<b>FIPS</b>	<b>Locality</b>
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**

<b>FIPS</b>	<b>Locality</b>
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**

<b>FIPS</b>	<b>Locality</b>
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

**Southwest/Roanoke**

<b>FIPS</b>	<b>Locality</b>
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

### Attachment E: 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	Carved in (Included) or Carved out (Excluded) of Demonstration	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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved out	<b>The MCO is not required to cover services for abortion. This service will be covered through a carve out.</b> 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.
Case Management Services for Participants of Auxiliary Grants	12 VAC 30-50-470 12VAC30-10-320 Chapter IV of the Assisted Living Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved out(pursuant to 12VAC30-10-320)	<b>The MCO is not required to cover this service. This service will be covered through a carve out.</b>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Case Management Services for the Elderly	12 VAC 30-50-460 Chapter 4 of the Elderly Case Management Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved out	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.
Targeted Case Management for Individuals with Intellectual Disabilities	12 VAC 30-50-440 Chapter IV of the Mental Retardation/Intellectual Disability Community Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved Out	The MCO is not required to cover this service. This service is provided by the Community Services Boards.
Chiropractic Services	12 VAC 30-50-150	Carved out	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	Carved out	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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in	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	Carved in	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	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Court Ordered Services	Code of Virginia Section 37.1-67.4	Carved in (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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved out, except for certain circumstances. See notes.	<b>This service will be covered through a carve-out.</b> 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- 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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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 individual'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.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Emergency Services - Post Stabilization Care	42 C.F.R. 422.100(b)(1)(iv) 42 CFR § 422.113(c)	Carved in (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.
Experimental and Investigational Procedures	12 VAC 30-50-140 Chapter IV of the Physician Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved out	<b>This service is not a Medicaid covered service.</b>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Family Planning Services	<p>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  <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a></p>	Carved in (pursuant to 12VAC30-10-320)	<p>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 individual's choice of provider for family planning services or supplies, and the MCO shall cover all family planning services and supplies provided to its individuals 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.</p>
General Obstetrical Hospital Services	<p>12 VAC 30-50-100            Chapter IV of the Physician Manual  <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a></p>	Carved in (pursuant to 12VAC30-10-320)	<p>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.</p> <p>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.</p>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
High-Risk Prenatal Services	<p>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  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	Carved in (pursuant to 12VAC30-10-320)	<p>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:</p> <ol style="list-style-type: none"> <li>Assessment to determine participants' needs which includes psychosocial, nutrition, and medical factors.</li> <li>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.</li> <li>Coordination and referrals that will assist the client in arranging for appropriate services and ensure continuity of care.</li> <li>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.</li> </ol>
HIV Testing and Treatment Counseling	<p>Code of Virginia Section 54.1-2403.01  Chapter IV of the Physician Manual  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	Carved in (pursuant to 12VAC30-10-320)	<p>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 individual shall be advised of the value of testing for HIV infection as set forth in 12 VAC 30-50-510 and shall request of each such pregnant individual consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Any pregnant individual shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the individual's medical record.</p>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Home Health Services	12 VAC 30-50-160 Chapter IV of the Home Health Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (pursuant to 12VAC30-10-320)	<p>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 individual'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. <b>The MCO is not required to, but may at their option, cover</b> 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.</p> <p><b>The MCO is required to cover this service.</b></p>
Hospice Services	12 VAC 30-50-270 Chapter IV of the Hospice Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in	

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Inpatient Hospital Services	<p>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  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	Carved in (pursuant to 12VAC30-10-320)	The MCO shall cover inpatient stays in general acute care and rehabilitation hospitals for all individuals. 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	<p>12 VAC 30-50-200 and  12 VAC 30-50-225  Chapter IV of the Rehabilitation Manual  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	Carved in (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	<p>12 VAC 30-50-120  Chapter IV of the Independent Laboratory Manual  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	Carved in (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	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Mammograms	12 VAC 30-50-220 Chapter IV of the Independent Laboratory Manual & Chapter IV of the Physician Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (pursuant to 12VAC30-10-320)	The MCO shall cover low-dose screening mammograms for determining presence of occult breast cancer for female individuals 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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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. The MCO shall cover nurse-midwife services as allowed under State licensure requirements and Federal law.
Nurse-Midwife Services	12 VAC 30-50-260	Carved in (pursuant to 12VAC30-10-320)	

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Nursing Facility	<p>12VAC5-215-10  12 VAC 30-50-130  Chapter IV of the Nursing Facilities Manual  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	<p>Carved in  (pursuant to 12VAC30-10-320)</p>	<p>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 individuals.</p>
Obstetric and Gynecologic Services	<p>Chapter IV of the Physician Manual  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	<p>Carved in  (pursuant to 12VAC30-10-320)</p>	<p>The MCO shall permit any female individual 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.</p>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	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	Carved in (pursuant to 12VAC30-10-320)	<p>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) individuals 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 individual from the MCO, if applicable, if the transplant is scheduled to occur concurrently with the participant's enrollment with the MCO.</p>
Outpatient Hospital Services	12 VAC 30-50-110	Carved in (pursuant to 12VAC30-10-320)	<p>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.</p>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Pap Smears	12 VAC 30-50-220 Chapter IV of the Physician Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Podiatry	12 VAC 30-50-150 Chapter IV of the Podiatry Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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.
Pregnancy-Related Services	12 VAC 30-50-220 12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-410	Carved in (pursuant to 12VAC30-10-320)	<p>The MCO shall cover services to pregnant women, including:</p> <ul style="list-style-type: none"> <li>a. Pregnancy-related and postpartum services for sixty (60) calendar days after the pregnancy ends, as set forth in 12 VAC 30-50-290;</li> <li>b. Services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290;</li> <li>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;</li> <li>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.</li> </ul> <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	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Prescription Drugs	<p>12 VAC 30-50-210  12 VAC 30-50  §38.2-4312.1 of the Code of Virginia  Chapter IV of the Pharmacy Manual  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	<p>Carved in  (pursuant to 12VAC30-10-320 and in coordination with Medicare Part D)</p>	<p>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 under fee-for-service. 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.</p>
Private Duty Nursing	<p>42CFR441.50 and 1905(a) of Social Security Act  EPSDT Nursing Manual  (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	<p>Carved out</p>	<p>Private Duty Nursing is not a Medicaid covered benefit for adults,</p>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220 Chapter IV of the Physician Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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 males for prostate cancer.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120 Chapter IV of the Prosthetic Devices Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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 individual regardless of the individual'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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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	Carved in (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	Carved in (Included) or Carved out (Excluded) of Demonstration	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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved out	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	Carved in (pursuant to 12VAC30-10-320)	The MCO shall provide coverage for a second opinion when requested by the individual 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 individual to obtain one outside the network, at no cost to the individual. 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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
<p>Temporary Detention Orders (TDOs) &amp; Emergency Custody Orders (ECOs)</p>	<p>42 CFR 441.150 and Code of Virginia 16.1-335 et seq. Code of Virginia § 37.2-808 and the Appropriations Act of 2006 - 2008, Item 300, B Appendix B of the Hospital Manual (<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>)</p>	<p>Carved in (pursuant to 12VAC30-10-320)</p>	<p>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.</p>

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 Chapter 4 of the Transportation Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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.
Vision Services	12 VAC 30-50-210 Chapter iv of the Vision Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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 individuals, shall be allowed at least once every two (2) years.

BEHAVIORAL HEALTH SERVICES			Notes
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (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 individuals. 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	Carved in (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 individuals, 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. <b>The MCO is not required to cover this service.</b> This service will be covered through the DMAS fee-for-service system. Notify DMAS of all individual admissions to state mental hospitals.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Carved out	

**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 \$2 visits, and 26 visits per year following the first year of treatment. Medication management visits are not to be counted against the number of outpatient psychiatric visits.

Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Psychiatric Diagnostic Exam	12VAC30-50-180 12VAC30-50-140	Carved in (pursuant to 12VAC30-10-320)	****
Individual Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (pursuant to 12VAC30-10-320)	****
Group Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (pursuant to 12VAC30-10-320)	****
Family Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual	Carved in (pursuant to 12VAC30-10-320)	****

	<a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a>		
Electroconvulsive Therapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****
Psychological/Neuropsychological Testing	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****
Pharmacological Management	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****

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

Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Community Mental Health Services	12VAC30-50-130 12VAC30-50-226 12VAC30-50-420 through 12VAC30-50-430 \Chapter 4 of the Community Mental-Health Rehabilitation Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in	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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved out	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			Notes
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	
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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in (pursuant to 12VAC30-10-320)	The MCO shall cover substance assessment and evaluation and outpatient services for substance abuse treatment for individuals enrolled in the Dual Demonstration. Emergency counseling services, intensive outpatient services, day treatment, opioid treatment, and substance abuse case management services are <b>carved-out</b> of this contact 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 ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in	The MCO shall cover Residential Treatment for Pregnant Women.
Day Treatment for Pregnant Women	12VAC30-50-510 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual ( <a href="https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual">https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual</a> )	Carved in	The MCO shall cover Day Treatment for Pregnant Women.

## Attachment F: Description of 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.

## **Attachment G: CMS Assurances for the EDCD Waiver**

### **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;
  - Between agency and consumer-directed waiver services; 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.

## Attachment H: Proposed Staffing for Demonstration

Agency Division	Role Title	Role
<b>Administration</b>	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
<b>Policy &amp; Research</b>	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
	Program Director - Office of Integration – New Position	Once hired will become project lead
	Senior Policy Analysts – Jeff Nelson & Rhonda Newsome	Data Analysis Design and Reporting
	Behavioral Health Services Manager- Sandy Brown	Behavioral Health & Substance Abuse Services
<b>Budget &amp; Contract Management</b>	Division Director – Seta Vandegrift	Executive Budget Oversight
	Planning & Forecast Manager – Tanyea Amos	Budget Manager
<b>Health Care Services</b>	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 – Kayla Anderson	Policy Analyst
<b>Provider Reimbursement</b>	Division Director – Bill Lessard	Executive Oversight
	Provider Reimbursement Manager – Nick Merciez	Manager & Actuary, Capitation Rates
	Reimbursement Analyst – Robert Miller	Analyst, Capitation Rates
<b>Long-Term Care</b>	Division Director – Terry Smith	Executive Oversight
	Program Administration Manager – Steve Ankiel	Program design, LTC Services
<b>Information Management</b>	Director – Sylvia Hart	Executive Oversight
	Systems Analyst – Mary Korsun	MMIS Systems Changes