



**COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

600 East Broad Street, Suite 1300
Richmond, VA 23219

April 29, 2016

Dear Prospective Offeror:

The Department of Medical Assistance Services (DMAS or the Department) is soliciting proposals for Contractors to enter into fully capitated, risk-based contracts to administer a coordinated delivery system that focuses on improving quality, access and efficiency under the Department's new Managed Long Term Services and Supports (MLTSS) Program. MLTSS will build on the foundation of Virginia's Medicare-Medicaid enrollee financial alignment demonstration, Commonwealth Coordinated Care (CCC).

CCC was Virginia's first opportunity to coordinate care for the high-risk dually eligible population and CCC activities in the areas of systems integration, contract and quality monitoring, outreach, and program evaluation have been nationally recognized as best practices. Virginia seeks to strengthen this model through including additional populations and operating the program statewide. Virginia is seeking federal authority to mandate the enrollment of eligible individuals into selected managed care plans.

As detailed in the RFP, selected Contractors shall arrange for the provision of services for approximately 212,000 members, including children and adults with disabilities and complex needs. MLTSS will also include individuals who qualify for both Medicare and Medicaid. Individuals enrolled in the three home and community based services (HCBS) waivers that specifically serve individuals with intellectual and developmental disabilities (ID/D) will be enrolled in MLTSS for their medical, behavioral health, pharmacy, and transportation services. As such, ID/D waiver services will not be included in the MLTSS Contract at this time.

DMAS will implement a mandatory MLTSS Program beginning in the summer of 2017. DMAS anticipates that it will enter into contracts with no fewer than two (2) Contractors per region. DMAS will consider contracting with Specialty Plans as an effort to test innovative, person-centered models of care that align with MLTSS goals for transforming service delivery. Offerors may submit proposals for one or more MLTSS region(s).

Specific details about the RFP process are included in the enclosed RFP. A link to the MLTSS Databook is included in Attachment B. The MLTSS Databook provides expenditure data for the eligible population. Offerors must check eVA Virginia Business Opportunities (VBO) at <http://www.eva.virginia.gov> for all official addenda or notices regarding this RFP. While DMAS also intends to post such notices on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx, eVA is the official and controlling posting site. The Commonwealth will not pay any costs that any Offeror incurs in preparing a proposal and reserves the right to reject any and all proposals received.

Prospective Offerors are requested not to call the Department with questions. Instead all questions related to this RFP should be submitted in writing in MS Word format by email to the attention of Tammy Driscoll at RFP2016-01@dmas.virginia.gov. All questions must be submitted by 5:00PM EST on May 13, 2016. Responses to questions will be posted in a RFP addendum on the eVA and DMAS websites.

MANDATORY PREPROPOSAL CONFERENCE: A mandatory preproposal conference will be held on May 10, 2016, 2:00 P.M. EST at the Department of Medical Assistance Service, 600 E. Broad Street, Conference Room 7B, Richmond, VA 23219. The purpose of this conference is to allow DMAS an opportunity to clarify various facets of the RFP. DMAS will not respond to questions during the preproposal conference. Due to the importance of all Offerors having a clear understanding of the specifications/scope of work and requirements of this RFP, attendance at this conference will be a prerequisite for submitting a proposal.

Proposals will only be accepted from those Offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. No one will be permitted to sign the register after 2:15 P.M on day of conference. Due to space limitations, Offerors are limited to two (2) representatives each at the preproposal conference. To ensure adequate accommodations, Offerors need to pre-register with Tammy Driscoll by sending an email to RFP2016-01@dmas.virginia.gov stating the name of Offeror and Offeror's participating representatives. For planning purposes, Offerors should pre-register with Tammy Driscoll by 1:00PM EST the day before the conference. Offerors should bring a copy of the RFP to the conference. Any changes resulting from this conference will be issued in a written addendum to the RFP.

Sincerely,



Christopher Banaszak
DMAS Contract Manager

Enclosure

REQUEST FOR PROPOSALS
RFP 2016-01

Issue Date: April 29, 2016

Title: Managed Long Term Services and Supports Program

Period of Contract: An initial period of five (5) years from award of contract, with provisions for five (5) twelve-month renewal options.

Commodity Code: 95856

All inquiries should be directed in writing via email in MS Word format to the attention of Tammy Driscoll at RFP2016-01@dmas.virginia.gov.

Preproposal Conference: 2:00PM EST, May 10, 2016

Deadline for Submitting Inquiries: 5:00PM EST, May 13, 2016

Proposal Due Date: Proposals will be accepted until 10:00 AM E.S.T. on June 30, 2016

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

"RFP 2016-01 Sealed Proposal"
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: Christopher Banaszak

Facsimile Transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, § 2.2-4343.1 or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposal (RFP) and pursuant to all conditions imposed herein or incorporated by reference, the undersigned proposes and agrees, if awarded a contract, to furnish the services contained in its proposal.

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

Submit this completed form with Technical Proposal under Required Forms

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
REQUEST FOR PROPOSALS
FOR
MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)

RFP 2016-01
ISSUED: April 29, 2016

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SECTION 1.0 – BACKGROUND

The Department of Medical Assistance Services (DMAS) hereinafter referred to as the Department or DMAS, is the single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act. These programs are financed by both Federal and State funds and are administered by the State according to Federal guidelines.

DMAS is hereby soliciting proposals from Virginia licensed and qualified Contractors to enter into fully capitated, risk-based contracts to administer a coordinated delivery system that focuses on improving quality, access and efficiency under the Department's new Managed Long Term Services and Supports (MLTSS) Program which includes 212,000 eligible members.

On April 25, 2016 CMS published final rule overhauling regulations governing Medicaid Managed Care. DMAS will implement the MLTSS Program in accordance with these regulatory changes. The final rule can be found at <https://www.federalregister.gov/public-inspection>. CMS' materials are posted here: <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>.

DMAS intends to enter into contracts with selected Contractors to provide covered services to members for an initial five (5) years with the possibility of five (5), 12 month extensions. All terms and conditions will be finalized in the MLTSS Contract. All contracts and rates will be renewed annually and as needed, subject to CMS approval pursuant to 42 C.F.R § 438.6. Amendments will be issued on an as needed basis.

The MLTSS Program will operate in six regions and will be implemented statewide (see Attachment A for regions and localities). Implementation will be phased-in by region starting in the summer of 2017 for the majority of the MLTSS population. Individuals enrolled in the CCC program and the Medallion 3.0 ABD population will be transitioned starting in January 2018. Offerors shall assume full financial risk for delivering and managing a care delivery system that will administer or arrange for the provision of all covered services. The Department anticipates that it will enter into contracts with no fewer than two (2) Contractors per region.

The following populations shall be included in MLTSS.

1. Dual eligible individuals with full Medicaid and any Medicare coverage (Medicare A and/or B) who are currently excluded from the CCC program.
2. Non-dual eligible (including the Health and Acute Care Program ([HAP](#)) population enrolled in DMAS' Medallion 3.0 program) members who receive long term services and

supports (LTSS), either through an institution or through five (5) of DMAS' home and community-based services (HCBS) waivers¹:

- i. Day Support for Persons with Intellectual Disabilities (DS)
 - ii. Elderly or Disabled with Consumer-Direction (EDCD)
 - iii. Individual and Family Developmental Disabilities Support (DD)
 - iv. Intellectual Disabilities (ID)
 - v. Technology Assisted (Tech)
3. Individuals who have opted-out of the CCC program will transition to the MLSS Program beginning in July 2017
 4. Individuals enrolled in the CCC program will transition to MLTSS Program in January 2018, which is after the CCC program ends
 5. Remaining ABD population (non-duals and those who do not receive LTSS). The majority of this population will transition from DMAS' Medallion 3.0 program to MLTSS on January 1, 2018.

MLTSS Populations – Snapshot, as of March 31, 2016

LTSS Population	Dual Adult	Dual Child	Non-Dual Adult	Non-Dual Child	Total
Aged, Blind, and Disabled without LTSS*	0	0	59,591	19,444	79,035
Duals without LTSS	70,610	162	0	0	70,772
Elderly or Disabled with Consumer Direction (EDCD) Waiver	20,320	39	5,395	6,755	32,509
Intermediate Care Facility (ICF) Nursing Facility (NF)	14,313	0	1,702	74	16,089
Skilled Nursing Facility	2,027	0	28	32	2,087
Technology (Tech) Assisted Waiver	53	0	40	164	257
Day Support (DS) Waiver**	131	0	107	13	251
Intellectual Disabilities (ID) Waiver**	6,077	33	3,111	987	10,208
Individual and Family Developmental Disabilities Support (DD) Waiver**	255	5	336	255	851
TOTAL	113,786	239	70,310	27,719	212,059

***Approximately 76,000 ABD individuals will transition from Medallion 3.0 to MLTSS in January 2018**

¹ Alzheimer's Assisted Living (AAL) Waiver participants will be excluded from MLTSS Program.

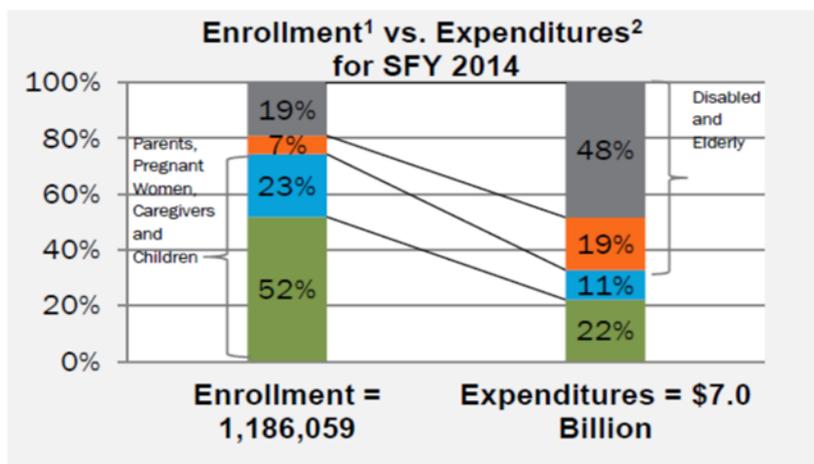
**Individuals enrolled in the DS, ID, and, DD Waivers will be enrolled in MLTSS for their non-waiver services only (e.g., acute, behavioral health, pharmacy, and non-LTSS waiver transportation services). These Waiver services are undergoing a major redesign and will be evaluated for inclusion after the transition period.

The Virginia Medicaid program covers approximately 1,000,000 individuals. Seventy-five percent of enrollees receive care through contracted health plans and twenty-five percent of enrollees receive care through a fee-for-service arrangement. The majority of enrollees in the Virginia Medicaid program are children, pregnant women, and caretaker adults. These enrollees tend to be relatively healthy. Virginia pays an average monthly capitated payment for each enrollees' services (a "per-member, per-month" (PMPM)) of \$234, translating to an annual payment of \$2,808. Under full risk contracts, the MCOs provide all Medicaid covered benefits and are responsible for a number of additional services, such as 24-hour nurse advice lines and 24-hour crisis lines for behavioral health emergencies; care coordination; maintaining an adequate provider network; processing provider claims; monitoring quality of care; and, participating in reviews conducted by the DMAS contracted External Quality Review Organization (EQRO).

Also included in Virginia's Medicaid population are over 200,000 individuals who are included in the Aged, Blind, and Disabled (ABD) coverage group. Out of the 200,000 individuals who are in the ABD group, 80,000 enrollees are in capitated health plans with an average monthly cost around \$1,100 PMPM, an annual payment around \$13,000. This spending amount for ABD enrollees, however, does not include costs for expensive long-term services and supports (LTSS) for this population and it does not include the subset of ABDs who are also enrolled in Medicare. Approximately 115,000 ABDs are Medicare-Medicaid enrollees where Medicare pays for the vast majority of their medical costs, and Medicaid pays for the majority of their long-term services and supports and behavioral health services through fee-for-service.

Long-Term Services and Supports

A disproportionate share of Virginia's Medicaid spending is allocated toward enrollees who receive long-term services and supports (LTSS). This population is only 7% of enrollment, yet accounts for almost 20% of total Medicaid expenditures. The majority of LTSS enrollees are also enrolled in Medicare, so the majority of this Medicaid spending is for LTSS - not



¹Coverage and enrollment numbers show the total annual unduplicated enrollments for Virginia's Title XIX program
²Expenditures represent claims expenditures for Virginia's Title XIX program

medical services. In 2015, 58% of Virginia's LTSS expenditures were for home and community-based services (HCBS). Two-thirds of Virginians accessing LTSS, now do so in the community. Virginia, however, still has a significant opportunity to improve its LTSS delivery system. In 2015, Virginia spent \$1Billion of its total \$8.2 Billion Medicaid spend on institutional care (public and private ICF/IDs and nursing homes).

Virginia operates six Home and Community Based Services (HCBS) waivers, ensuring that care is provided in the community. Virginia operates these waivers through §1915c waiver authority. The Alzheimer's Assisted Living Waiver, Elderly or Disabled with Consumer Direction (EDCD) waiver, Technology Assisted Waiver (Tech), Day Support (DS) Waiver, Developmental Disabilities Waiver (DD), and the Intellectual Disability Waiver (ID), are fully described on the DMAS long-term care and waiver services [webpage](#). Waiver slots for the ID, DD, and DS Waivers are allocated on an annual basis by the Virginia General Assembly. Over the past years, there has been growing support to enhance the availability and number of waiver slots. While there has been significant growth in the program over the last years, community capacity of providers and services is of concern. To that end, Virginia anticipates making a significant effort to strengthen the current capacity with the resources and authorities made available through MLTSS.

In March 2014, Virginia launched the Commonwealth Coordinated Care (CCC) program. CCC is a CMS Medicare-Medicaid Financial Alignment Demonstration. This demonstration is seeking to test models to integrate Medicare and Medicaid services, rules, and payments under one delivery system for individuals who are eligible for both Medicare and Medicaid (dual eligible individuals). CCC operates as a managed care program with three health plans and includes:

- a strong, person-centered service coordination/care coordination component
- integration with an array of provider types for continuity of care
- ongoing stakeholder participation, outreach and education
- the ability for innovation to meet the needs of the population

CCC will operate through December 31, 2017, in five regions of the state (Tidewater, Central Virginia, Northern Virginia, and the Roanoke and Charlottesville areas). As of March 2016, there were 69,003 Virginians eligible for CCC. Of those eligible, 29,510 are participating in the voluntary program. Virginia plans to leverage the successes of the CCC program, while expanding the program by both region and population.

CCC Program Population – Snapshot, as of March 31, 2016

MLTSS Region	CCC Eligible but Not Enrolled	CCC Enrolled	Total
Central Region	11,186	9,939	21,125
Charlottesville Western Region	3,184	2,790	5,974
Northern and Winchester Region	10,249	3,283	13,532
Roanoke/Alleghany Region	6,214	5,160	11,374
Tidewater Region	8,660	8,338	16,998
Total	39,493	29,510	69,003

Behavioral Health

Like many other states, building the infrastructure to deliver the highest quality behavioral health services in the community continues to be a challenge. Behavioral health services that are typically offered to a commercial population are currently offered through Virginia’s contracted health plans. Community-based behavioral health services – those services that are more typically accessed by the Medicaid population - are offered through a contracted behavioral health services administrator (BHSA). In the early 2000’s states began a strong effort to strengthen their home and community based services. Coupled with this move were federal policy shifts that required that Virginia’s behavioral health services be opened up to allow private providers the opportunity to administer services.

Ultimately, Virginia’s Medicaid funded behavioral health expenditures increased by 400% over 10 years. In a desire to ensure that individuals were getting high quality care, and providers were appropriately qualified, DMAS worked with the legislature and sister agencies to overhaul licensing qualifications and processes for providers and implemented a pre-screening requirement for select services to ensure a stronger program. Virginia also contracted with a BHSA to administer the community behavioral health services component of the Medicaid program. Virginia is just beginning to see improved outcomes as a result of the BHSA arrangement. As a result of the BHSA partnership, DMAS has seen a decrease in psychiatric inpatient admissions and an increase in follow up care upon discharge. Spending on institutional mental health services has remained relatively constant over the past five years, and in 2014, \$136 million was spent on these services (state and private psychiatric hospitals and Level C residential treatment centers). Virginia’s 2014 community-based mental health services spending was almost \$600 million.

Managed Long Term Services and Supports and the need for operational authority:

The 2013 Virginia Acts of Assembly directed DMAS to work towards the inclusion of all remaining Medicaid populations and services, including long-term care and home- and

community-based waiver services into cost-effective, managed and coordinated delivery systems.” (Item 307.RRRR.4. - <http://lis.virginia.gov/131/bud/hb1500chap.pdf>). The 2015 Virginia Acts of Assembly, (Item 301.TTT) directed DMAS to further principles of care coordination to all geographic areas, populations, and services under programs administered by the Department. Building off of the successes of the CCC demonstration previously mentioned, DMAS is meeting the stated objectives of the Virginia legislature by creating a mandatory managed care program, through the selection of Managed Care plans committed to being certified as a Dual Eligible Special Needs Plan (D-SNP) in Virginia.

DMAS is advancing the General Assembly’s directive for delivery system reform by seeking federal approval for a Delivery System Reform Incentive Payment (DSRIP) Program. DSRIP would enable Virginia to invest in infrastructure development, system redesign, and clinical outcome improvements. Alignment of MLTSS and DSRIP creates a powerful opportunity to strengthen and integrate Virginia’s Medicaid community delivery structure and accelerate a shift towards value-based payment. When approved, funding will be available for eligible providers to support care delivery transformation.

Throughout this RFP, MLTSS refers to the delivery of long-term services and supports, including HCBS and institutional-based services, behavioral health services, and acute and primary care services, through capitated Medicaid managed care plans. MLTSS programs provide an opportunity to create a seamless, integrated health services delivery program. Some of the goals of MLTSS include:

- Improved quality of life, satisfaction, and health outcomes for individuals who are enrolled
- A seamless, one-stop system of services and supports
- Service coordination that provides assistance in navigating the service environment, assuring timely and effective transfer of information, and tracking referrals and transitions to identify and overcome barriers
- Care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and includes individuals and family members in decision making using a person-centered model
- Support for seamless transitions between service/treatment settings
- Facilitation of communication between providers to improve the quality and cost effectiveness of care
- Arranging services and supports to maximize opportunities for community living and prevent or delay the need for long-term services and supports
- System-wide quality improvement and monitoring
- Alignment with DMAS’ Delivery System Reform Incentive Payment (DSRIP) initiatives

SECTION 2.0 – PROPOSAL INSTRUCTIONS

2.1 OVERVIEW

The proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of this RFP. Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the Offeror's capacity to provide the required services. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals should be organized in the order specified in this RFP. A proposal that is not organized in this manner risks a lower score or elimination from consideration if the evaluators are unable to find where the RFP requirements are specifically addressed. The Department and the evaluators are not obligated to ask an Offeror to identify where an RFP requirement is addressed, and no Offeror should assume that it will have an opportunity to supplement its proposal or to assist the evaluators in understanding and evaluating its proposal.

2.2 BINDING OF PROPOSAL

Proposals shall be clearly labeled "RFP 2016-01" on the front cover. The legal name of the organization submitting the proposal shall also appear on the cover.

The proposals shall be typed, bound, page-numbered, single-spaced no smaller than a 12-point font on 8 1/2" x 11" paper with 1" margins and printed on one side only. Offerors may use a larger size font for section headings and may use a smaller font size for footers, tables, graphics, exhibits, or similar sections, if necessary. The smaller font size must be legible. Larger graphics, exhibits, organization charts, and network diagrams may be printed on larger paper as a foldout if 8 1/2" x 11" paper is not practical. Each hard copy and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The Offeror shall submit one original and ten (10) copies of the bound proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked "RFP 2016-01." The Offeror shall also submit five electronic copies (thumb drives preferred) of their proposal in MS Word format (Microsoft Word 2010 or compatible format). In addition, the Offeror shall submit a redacted electronic copy in PDF of its proposal, in which the Offeror has removed proprietary and trade secret information. Please note that, as described below, merely redacting information is not sufficient to comply with *Code of Virginia § 2.2-4342(F)*.

2.3 TABLE OF CONTENTS

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

2.4 SUBMISSION REQUIREMENTS

All information requested in this RFP shall be submitted in the Offeror's proposals. By submitting a proposal, the Offeror certifies that all of the information provided is true and accurate. Offerors will be accountable for providing services and meeting requirements as described in their response to this RFP and in accordance with all terms and conditions.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act and subject to *Code of Virginia* § 2.2-4342. Confidential information shall be clearly marked in the proposal and reasons why the information should be confidential shall be clearly stated.

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

The proprietary or trade secret materials submitted shall be identified by some distinct method, such as highlighting or underlining, and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The electronic redacted copy of the technical proposal shall have the proprietary and confidential information removed or blocked out in its entirety so the content is not visible. The classification of an entire proposal document as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal. **Attachment G of this RFP shall be used for the identification of proprietary or confidential information submitted with the proposal.**

2.5 TRANSMITTAL LETTER

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

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

1. A statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
 - a) The Offeror must identify any contracts or agreements it has with any state or local government entity that is a Medicaid provider, plan, or contractor and the general circumstances of the contract. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest.
 - b) Offeror must be able to present sufficient assurances to the Commonwealth that the award of the contract to the Contractor will not create a conflict of interest between the Contractor, the Department, and its subcontractors.
 - c) The Offeror will meet all licensing and certification requirements to conduct business in the Commonwealth of Virginia.
2. An attestation that the Offeror has read, understands and agrees to perform all of the responsibilities and comply with all of the requirements and terms and conditions set forth in this RFP, any modifications of this RFP, the Contract and Addenda
3. The Offeror's general information, including the address, telephone number, and facsimile transmission number
4. Designation of an individual, to include their e-mail and telephone number, as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the resultant Contract
5. A statement agreeing that the Offeror's proposal shall be valid for a minimum of twelve (12) months from its submission to DMAS

2.6 SIGNED COVER PAGE OF THE RFP AND ADDENDA

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

2.7 PROCUREMENT CONTACT

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

Tammy Driscoll
Senior Programs Advisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Email: RFP2016-01@dmass.virginia.gov

All communications with DMAS regarding this RFP shall be directed to the principal point of contact or the DMAS Contract Management Officer named in the cover memo. All RFP content-related questions shall be submitted in writing to the principal point of contact. An Offeror or any of its representatives who communicates with any other employees or Contractors of DMAS concerning this RFP after its issuance may be disqualified from this procurement.

2.8 SUBMISSION AND ACCEPTANCE OF PROPOSALS

The proposals, whether mailed or hand delivered, shall arrive at DMAS no later than 10:00 A.M. EST on June 30, 2016. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals will not be accepted and will be automatically rejected from further consideration. The address for delivery is:

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

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

Hand Delivery or Courier to:

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

DMAS reserves the right to reject any or all proposals. Reference *Code of Virginia* § 2.2-4319. DMAS reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Offerors must check the eVA VBO at <http://www.eva.virginia.gov> for all official postings of addendums or notices regarding this RFP. DMAS also intends to post such notices on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx but the eVA VBO is the official posting site that Offerors must monitor.

2.9 POTENTIAL MEANS FOR FURTHER EVALUATION

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

- DMAS Review of Industry Publications and Literature
- Offeror Presentations
- Site Visits to Offeror

- Contacting Offeror's References
- Product Demonstrations by the Offeror
- Obtain a Dun and Bradstreet Report on the Offeror
- Obtain a Securities Exchange Commission Report on the Offeror
- Requesting Offeror to elaborate on and/or clarify specific portions of their proposals

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

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

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

2.10 PROPOSAL

The Offerors response shall contain all the documents required in this RFP including the signatory documents. These include the following:

1. RFP Cover Sheet
2. RFP Addenda (if issued)
3. Offeror's Transmittal Letter
4. Offeror's Technical Proposal Response including Network Submission File (Attachment C) and Mapped Version of Providers (Attachment D)
5. Proprietary/Confidential Information Identification Form (Attachment G)
6. Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process (Attachment H)
7. State Corporation Commission Form (Attachment I)

Offerors must respond to all sections of this RFP. This applies to Offerors submitting a proposal to operate as a Specialty Plan.

Offerors may submit proposals for one or more region(s). Offerors do not need to submit a separate proposal for each region; however, proposals shall clearly indicate in which region(s) the Offeror is proposing to participate and respond with region-specific detail as applicable. An Offeror's region-specific response shall clearly indicate to which region it applies. The Department anticipates that it will enter into contracts with no fewer than two (2) Contractors per region. Following evaluation of the proposals, and contingent upon passing the readiness review, the Department will enter into contracts with the selected Contractors for each region.

The Offeror’s Technical Proposal response should adhere to the page limits for each section or subsection identified in the chart below. If the Offeror is proposing to operate in multiple regions, the Offeror should adhere to the page limits detailed below.

Technical Proposal Response (RFP Section)	Page Limit	Special Instructions
3.0 Technical Requirements		
3.1 Executive Summary	3	
3.2 Corporate Overview	10	Financial statements not included in page count Resumes no more than 2 pages each
3.3 System of Care		
3.3.1 Covered Services	15	
3.3.2 Services ID/D Waiver Participants	3	
3.3.3 Model of Care		
3.3.3.1 Description of MLTSS Population	11	
3.3.3.2 Staff and Provider Training	3	
3.3.3.3 Provider Network Special Expertise in MLTSS	4	
3.3.3.4 Assessments	12	
3.3.3.5 Interdisciplinary Care Team	6	
3.3.3.6 Individualized Care Plan	10	
3.3.3.7 Care Coordination	10	
3.3.3.8 Care Transition Programs	6	
3.3.4 Community Partnerships	4	
3.3.5 Vignettes	18	Vignettes are limited to 3 pages each
3.3.6 Integrated BH Health Home	5	
3.3.7 Coordination with Medicare	3	
3.3.8 Consumer Directed Services	3	
3.3.9 High Utilizers	4	
3.3.10 Enhanced Benefits	2	
3.4 Relationships	10	
3.5 Operations		
3.5.1 Staffing	8	
3.5.2 Communications	4	
3.5.3 Quality	13	Auditor-Locked Interactive Data Submission Data (IDSS), most recent Adult and Child CAHPS report, and EQRO reports, QI description, plan, and annual evaluation results from two (2) states are not included in page count

Technical Proposal Response (RFP Section)	Page Limit	Special Instructions
3.5.4 Provider Recruitment Strategy	4	
3.5.5 Provider Network Adequacy and Submission	Unlimited	Submit Provider Network file Submit Mapped Version of Providers attachment
3.5.6 Ongoing Provider Support	2	
3.5.7 PCP Assignment	1	
3.5.8 NF Services	6	
3.5.9 Transportation	1	
3.5.10 Call Center	3	Process flow charts not included in page count
3.5.11 Program Integrity	5	
3.6 Technology	4	
3.7 Readiness	12	Work plan included in page count
3.8 Innovation		
3.8.1 Delivery System Reform	2	
3.8.2 Health Homes	2	
3.8.3 VBP	5	
4.0 Past Experience		
4.1 Overview of Relevant Experience	Unlimited	
4.2 Past Experience Examples and References		
4.2.1 Past Experience Examples	6	2 pages per Past Experience Example
4.2.2 Medicare Plan Quality & Performance Rating	Unlimited	
4.2.3 Stakeholder References	Unlimited	
4.3 Compliance History	Unlimited	

2.11 MISREPRESENTATION OF INFORMATION

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

2.12 SCHEDULE OF EVENTS

If it becomes necessary to revise any part of this RFP, or if additional data is necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be issued by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. Offerors must check the eVA VBO at

<http://www.eva.virginia.gov> for all official postings of addendums or notices regarding this RFP.

Proposals should be thorough but concise and include sufficient detail to allow DMAS to properly evaluate the Offeror’s capacity, capability and relevant experience and expertise to implement the requirements contained within this RFP. The RFP evaluation process will include a brief in-person presentation by each Offeror.

The schedule below represents the State’s anticipated timelines for this procurement. This schedule is subject to change.

MLTSS Program Milestones	Target Dates
State Issues RFP	April 29, 2016
Mandatory Preproposal Conference	May 10, 2016 @ 2:00PM EST
Proposal Questions Due	May 13, 2016 @ 5:00PM EST
Deadline for Submission of Proposals	June 30, 2016 @ 10:00AM EST
Offerors Presentations on Vignettes	July 2016
Offerors Selected for Negotiation; Readiness Review Begins	August 19, 2016
Notice of Intent to Award	December 9, 2016
MLTSS Contracts Signed	December 19, 2016
MLTSS Implementation Begins with Tidewater Region (other regions will be phased in)	July 1, 2017
CCC Participants Transition to MLTSS	January 1, 2018
ABD from Medallion 3.0 Transition to MLTSS	January 1, 2018
MLTSS Transition Complete	2018

MANDATORY PREPROPOSAL CONFERENCE: A mandatory preproposal conference will be held on May 10, 2016, 2:00 P.M. EST at the Department of Medical Assistance Service, 600 E. Broad Street, Conference Room 7B, Richmond, VA 23219. The purpose of this conference is to allow DMAS an opportunity to clarify various facets of the RFP. DMAS will not respond to questions during the preproposal conference. Due to the importance of all Offerors having a clear understanding of the specifications/scope of work and requirements of this RFP, attendance at this conference will be a prerequisite for submitting a proposal. Proposals will only be accepted from those Offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative’s signature on the attendance roster. No one will be permitted to sign the register after 2:15 P.M on day of conference. Due to space limitations, Offerors are limited to two (2) representatives each at the preproposal conference. To ensure adequate accommodations, Offerors need to pre-register with Tammy Driscoll by sending an email to RFP2016-01@dmass.virginia.gov stating the name of Offeror and Offeror’s participating representatives. For planning purposes, Offerors should pre-register with Tammy

Driscoll by 1:00PM EST the day before the conference. Offerors should bring a copy of the RFP to the conference. Any changes resulting from this conference will be issued in a written addendum to the RFP.

2.13 READINESS REVIEW

The Offeror must demonstrate to DMAS' satisfaction that the Offeror is ready and able to meet all MLTSS Contract requirements identified in the readiness review prior to the contract execution. In addition, the Offeror must provide DMAS or its designee with any corrected materials requested as part of the readiness review. Additionally, DMAS must determine that the Offeror has passed the readiness review prior to conducting any marketing or accepting any enrollment. Any changes required to the Offeror's processes as identified through readiness review activities shall be made by the Offeror prior to implementation. Costs associated with these changes shall be borne by the Offeror.

DMAS reserves the right to award contracts to all, or a subset of, the Offerors with which the Department enters into negotiations. If the Department determines through its review that there is a locality where only one (1) viable Offeror exists, the Department may consider postponing the program implementation for that locality or implementing an optional MLTSS participation arrangement until at least one additional Offeror is approved by the Department to operate in the locality.

DMAS will use the results of the readiness reviews to form its decision of which Offerors are ready to participate in MLTSS Program. Once this determination is made, DMAS will issue an Intent to Award Notice to announce which Offerors the Department intends to contract with for MLTSS services (following the standard timeframe for potential protests).

2.14 VIGNETTE PRESENTATION

DMAS plans to request Offerors to present vignettes in-person. Details on vignette presentations will be shared as an addendum.

SECTION 3.0 – TECHNICAL REQUIREMENTS

This section contains the technical program responses requested for this RFP. To be considered, Offerors must respond to all technical requirements, provide all applicable documentation requested in this section, and submit proposals in the format outlined in Section 2.0.

The Offeror shall provide detailed and succinct narratives for how it will define and perform each of the required tasks listed in this section. The Offeror's response must demonstrate its understanding of MLTSS populations, ability to perform tasks specified, and compliance with the requirements listed in this section. The response shall explain that the Offeror has considered all requirements and developed a specific approach to meeting the requirements to support a successful MLTSS Program. The Offeror shall provide all applicable documentation requested in this section. It is not sufficient to simply state that the requirements will be met.

Offerors are encouraged to present innovative in how the requirements outlined in this RFP are accomplished. The Offeror may propose alternate strategies to accomplish any of the requirements described below and how the alternate strategies will meet the DMAS requirements and objectives as appropriate.

The Offeror may perform all of the processes outlined in this RFP internally or involve subcontractors for any portion, but the Offeror must identify subcontractors by name and by a description of the services/functions they will be performing. The Contractor shall be wholly responsible for the performance of the resulting contract whether or not subcontractors are used.

3.1 EXECUTIVE SUMMARY

The Executive Summary response shall highlight the Offeror's:

1. Overall approach to the scope of work and a summary of the contents of the proposal (including proposed regions)
2. Qualifications and experience to serve as a Contractor for the MLTSS Program and plans to become a D-SNP in Virginia
3. Commitment to DMAS' goals for MLTSS and Medicaid delivery system and payment transformation

3.2 CORPORATE OVERVIEW

3.2.1 Corporate Structure

In response to this RFP, the Offeror shall submit an organizational chart and description of the Offeror's corporate structure. This must include the Offeror's parent organization, its subsidiaries, and businesses owned. It must also explain the relationships between these entities and how long each has operated under the Offeror's parent organization. The Offeror

shall also describe the major business services provided and any firewalls that exist to prevent any conflicts of interest and to maintain the highest level of security and program integrity.

The Offeror shall also submit:

1. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written
2. Federal Employer ID number
3. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers)
4. List of board members and their organizational affiliations
5. Legal status and whether it is a for-profit or a not-for-profit company

3.2.2 Licensure and Financial Participation Requirements

If currently operating in Virginia, the Offeror must submit a copy of their valid and current license (not under suspension or revocation) from the Virginia State Corporation Commission's Bureau of Insurance (BOI), and copies of quarterly and annual filings submitted to the BOI within the past two calendar years. These must be submitted prior to MLTSS contract signing (if selected).

If the Offeror does not have a valid and current license from the BOI to operate as a licensed health plan in Virginia, the Offeror must submit a copy of its last three (3) years of audited financial statements. In addition, the Offeror must submit its financial plan that details how it would raise the capital required by BOI to operate as a health plan in Virginia.

The Contractor must meet the solvency standards described in 42 C.F.R § 438.116 and shall retain the appropriate licensures at all times during the period of the contract, including licensure by the State Corporation Commission as set forth in the Code of Virginia §38.2-4300 through 38.2-4323, 14 VAC5-211-10 et seq. and any and all other applicable laws of the Commonwealth of Virginia, as amended.

3.2.3 Certification

Pursuant to §32.1-137.1 through §32.137.7 Code of Virginia, and 12VAC5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services they deliver.

If currently operating in a proposed region, the Offeror shall submit a copy of service area approval and certificate for each region(s) that the Offeror is proposing to operate. This approval is issued by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection.

If the Offeror is not currently operating in Virginia or in a proposed region, the Offeror must submit a copy of their service area approval and certificate prior to MLTSS contract signing (if selected).

3.2.4 Status as a Dual Eligible Special Needs Plan (D-SNP)

The Offeror shall submit verification (approved and current contract with CMS) of the Offeror's active status as a Medicare Dual Eligible Special Needs Plan (D-SNP) by locality in each region where the Offeror proposes to provide services under this RFP. The Contractor shall work with DMAS to align, whenever possible, enrollment of dual eligible members in the same plan for both Medicare and Medicaid services.

If the Offeror does not currently operate a D-SNP in the localities it proposes to provide services under this RFP, in response to this RFP the Offeror shall submit a plan, including timeframes for establishing and operating a D-SNP in those localities in accordance with CMS guidelines. The timeframe for receiving a D-SNP contract must be within two (2) years of being awarded an MLTSS Contract.

3.2.5 NCQA Accreditation

If Offeror is accredited for Virginia Medicaid business, in response to this RFP, the Offeror shall submit verification of the Offeror's accreditation by the National Committee for Quality Assurance (NCQA) for its Virginia Medicaid line of business and explain its ability to retain accreditation.

If the Offeror is not NCQA accredited for Virginia Medicaid business, in response to this RFP, the Offeror must explain its plan to meet DMAS' milestones as described below.

1. Participate in EQRO comprehensive onsite reviews at dates to be determined by the Department.
2. Attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to MLTSS members).
3. Obtain NCQA accreditation status of at least "Accredited" within 36 months of the onset of delivering care to MLTSS members.

3.2.6 Key Staff for Virginia Operations

In response to this RFP, the Offeror shall include a description of the proposed geographical locations of the central business office, billing office, and satellite offices, if applicable. In addition, the proposed hours of operation shall be noted for each office.

The Offeror shall propose the specific Virginia team responsible for delivery and operations of the MLTSS Program in the proposed regions. This team should have the ability to make rapid-cycle decisions. The Offeror shall describe the decision-making authority of the Virginia team to ensure timely and responsive decisions while enabling high-quality delivery.

The Offeror must include its proposed organizational structure for the Virginia team with names of the MLTSS Project Director, MLTSS Project Manager, MLTSS Care Coordination Manager, and top leadership positions including individuals responsible for network recruitment, credentialing and management, medical oversight, behavioral health oversight, long-term services and supports oversight, pharmacy oversight, quality, financial management, claims payment, utilization management, and IT management.

The Offeror shall have a dedicated full-time Virginia MLTSS Project Director, MLTSS Project Manager, MLTSS Care Coordination Manager, Virginia licensed Medical Director, behavioral health lead, and long-term services and support lead. These key staff must be located in Virginia. Provider relations and care coordination staff shall be located within the Commonwealth of Virginia and preferably in the geographic region(s) where the Offeror proposes to operate.

The Offeror shall submit job descriptions and resumes outlining the qualifications of the MLTSS Project Director, MLTSS Project Manager, Virginia licensed Medical Director, and MLTSS Care Coordination Manager. In addition, the Offeror shall submit job descriptions and resumes, if available, for the other top leadership positions. Resumes must be limited to two pages. The resumes of proposed personnel must include qualifications, experience, relevant education, professional certifications, and training for the positions they will fill.

The MLTSS Project Director and the MLTSS Project Manager are expected to attend all required meetings as required by DMAS. Other key staff shall attend meetings as requested by DMAS.

The MLTSS Project Director shall be authorized and empowered to make contractual, operational, and financial decisions including rate negotiations for Virginia MLTSS business, claims payment, and provider relations/contracting. Additionally, the Virginia MLTSS Project Director must be directly employed by the Offeror.

The MLTSS Project Manager shall be able to make decisions about MLTSS program issues and shall represent the Offeror at the Department's meetings. The MLTSS Project Manager must be able to respond to issues involving information systems and reporting, appeals, quality improvement, member services, service management, pharmacy management, medical management, care coordination, and issues related to the health, safety and welfare of the member.

3.2.7 Prohibited Affiliations

Consistent with Federal disclosure requirements described in 42 C.F.R §§ 455.100 through 42 C.F.R §§ 455.106 and 438.610, the Offeror and its subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding the Offeror's owner(s) and managing employee(s). In response to this RFP, the

Offeror shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)*.

3.3 SYSTEM OF CARE

3.3.1 Covered Services

The Contractor shall promptly provide, arrange, purchase, or otherwise make available all covered Medicaid services as defined under the State Plan for Medical Assistance (State Plan) as amended, the §1115 waiver, written Department policies (including, but not limited to, contracts, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. Dual eligible individuals enrolled in MLTSS will receive their Medicare-covered services either through the Contractor's companion D-SNP, Medicare fee-for-service, or another Medicare Advantage plan. Some MLTSS members may have additional insurance coverage and require coordination of benefits.

In response to this RFP, the Offeror shall explain in detail a full understanding of the covered services and explain any experience providing these or similar covered services, including how these services will be provided to members as needed. The Offeror's response shall include the following service categories: acute and primary, institutional and community-based LTSS, behavioral health, and special Medicaid services as detailed in Attachment E and outlined below:

1. Early Intervention (EI)
2. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
3. Private Duty Nursing (PDN) Services for Children under Age 21
4. Services for Foster Care and Adoption Assistance Children

3.3.2 Services for Individuals Enrolled in the Intellectual Disabilities (ID), Day Support for Persons with Intellectual Disabilities (DS), and Individual and Family Developmental Disabilities Support (DD) Waivers

Individuals enrolled in the ID, DS, and DD Waivers will be enrolled in MLTSS for their non-waiver services only (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services). Their waiver services, including transportation to the waiver services, will be paid for through Medicaid fee-for-service as "carved out" services (transportation for non-waiver services will be the responsibility of the Offeror). Some individuals who are on the ID, DS, and DD Waiver waiting lists are enrolled in another waiver (e.g., EDCD Waiver) until an ID, DS, or DD Waiver slot becomes available.

In response to this RFP, the Offeror shall describe: how it proposes to manage individuals with ID or DD; how it will coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services with waiver services; and how it will identify and access appropriate community-based resources for these individuals.

3.3.3 *Model of Care*

The Offeror shall propose a Model of Care (MOC) that achieves the goals of the MLTSS Program. The goals and expectations of the MLTSS Program include:

- Improve quality of life and health outcomes for enrolled individuals
- Improve and maintain member satisfaction with the Contractor and provider services and performance
- Provide a seamless, one-stop system of services and supports
- Provide service coordination that provides assistance in navigating the service environment, assuring timely and effective transfer of information, tracking referrals and transitions, and outcomes to identify and overcome barriers
- Provide care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and includes individuals and family members using a person-centered model
- Improve support for seamless transitions between treatment settings
- Facilitate communication between providers to improve the quality and cost effectiveness of care
- Arrange services and supports to maximize opportunities for community living, community integration, and employment
- Provide system-wide quality improvement and monitoring

It is not sufficient for the Offeror to propose the same MOC that it may have submitted to CMS as part of its D-SNP application (if applicable) because Virginia has specific MLTSS requirements that must be addressed in the MOC. DMAS will neither consider the score that the NCQA gives to the Offeror as part of its D-SNP application (if applicable) nor will the NCQA score for the D-SNP MOC be incorporated into the total score for this section of this RFP.

The Offeror's MOC should be person-centered and tailored to meet the unique needs of the included populations as outlined in this RFP. The Offeror should reference the *Model of Care Assessment and Individualized Care Plan Expectations* table for further guidance on assessment, reassessment, and Individualized Care Plan (ICP) development timelines. The Offeror's MOC shall ensure all covered services are provided through a fully integrated delivery system. The Offeror's MOC must be responsive to member's needs and preferences, and take into account the health, safety, and welfare of members.

In developing the MOC, Offerors need to take into consideration that individuals enrolled in MLTSS may receive Targeted Case Management (TCM) services, such as mental health case management, substance use disorder case management, treatment foster care case management (for children under age 21 years), early intervention, high risk prenatal and infant case management, and/or ID and DD case management (ID/DD case management are carved out services). These services include but are not limited to assessments, the development of specific care plans, referrals and related activities, and monitoring and follow-up activities.

The required elements of the Model of Care include:

1. Description of the Plan-specific Target Population
2. Staff and Provider Training
3. Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols and Training
4. Assessments
5. Interdisciplinary Care Team
6. Individualized Care Plan
7. Care Coordination
8. Transition Programs

In response to the RFP, the Offeror shall:

- Describe its approach to the MOC elements, including a detailed description and examples of how it will address each MOC element. Examples should be varied to address the needs of the “Plan Specific Target Population” included in MOC Element 1
- Explain how its proposed MOC varies to meet regional needs
- Demonstrate that it has the staff, infrastructure, and systems in place to monitor the delivery of person-centered care coordination
- Submit for review any tools or flow charts that illustrate the proposed processes

3.3.3.1 Description of the MLTSS Target Population (MOC Element #1)

Populations identified in items a – m below are the MLTSS “Vulnerable Subpopulations”. The Offeror’s response to this MOC element must include all subpopulations of MLTSS members as follows:

- a. Individuals enrolled in the following Waivers: Technology Assisted, Elderly or Disabled with Consumer Direction, Day Support for Persons with Intellectual Disabilities, Intellectual Disabilities, Individual and Family Developmental Disabilities Support
- b. Individuals with intellectual/developmental disabilities (I/DD)
- c. Individuals with cognitive or memory problems (e.g., dementia)
- d. Individuals with brain injuries
- e. Individuals with physical or sensory disabilities
- f. Individuals residing in nursing facilities (skilled, custodial and specialized care) and other institutional settings
- g. Individuals with serious mental illnesses and serious emotional disturbances (institutional and community-based)
- h. Individuals with substance use disorders
- i. Individuals with end stage renal disease
- j. Individuals receiving hospice benefits
- k. Children in foster care or adoption assistance
- l. Women with a high risk pregnancy
- m. Individuals with other complex or multiple chronic conditions

- n. Individuals who have limited or no current medical, behavioral health, or long-term service and support (LTSS) needs, but may have needs in the future (*this group is referred to as Community Well*).

Offeror's response to this MOC element should take into account the fact that many enrolled individuals will have co-occurring conditions and could be included in more than one sub-population. In response to the RFP, the Offeror shall:

1. Describe its MOC approach for each of the subpopulations included in this MOC element. Include both children and adults, and dual eligible members
2. Explain how it will identify each subpopulation
3. Explain how its approach will vary to meet regional needs
4. Submit for review any tools or flow charts that illustrate the proposed processes

3.3.3.2 Staff and Provider Training (MOC Element #2)

The Offeror's response to this MOC element shall describe how it will train staff and providers to fulfill the requirements of the MLTSS Program. The Offeror shall:

1. Describe the types of training, including the frequency and modes of training the Offeror will provide to its care coordinators regarding the MLTSS program and all applicable federal and state requirements. Describe how and when trainings will be updated to reflect changes in policy, quality improvement strategies, member satisfaction, and evaluations of staff performance.
2. Describe specific information regarding the training to be provided to staff performing care coordination functions for the vulnerable sub-populations
3. Describe how best practices and information learned during DMAS delivered training will be incorporated into staff training.
4. Describe its provider education plan, inclusive of routine education sessions and tools to support continuity of care and seamless transition for members and providers new to managed care as well as comprehensive coordination of the full range of physical health, behavioral health, and LTSS benefits using a person-centered planning process. Include strategies for supporting traditional LTSS and Medicaid behavioral health providers in making the transition to MLTSS through training and technical support. Include information regarding strategies for educating and engaging providers in relation to the Integrated Care Team (ICT) expectations.
5. Describe the MOC training the Offeror will provide to its personnel and provider network, including the training strategy and plan on each MOC element to ensure appropriate staff, contractors and providers have the knowledge, skills, and abilities to fulfill the MOC requirements. The Offeror's response shall address the methodology for developing a training strategy and plan as follows:
 - a. How the organization will conduct initial, annual, and on-going model of care training including training strategies and content (e.g., printed instructional

materials, face-to-face training, web-based instruction, audio/video-conferencing, etc.)

- b. How the organization identifies personnel training needs
- c. How the organization will train on cultural competency
- d. How the organization assures and documents completion of training by the employed and contracted personnel (e.g., attendee lists, results of testing, web-based attendance confirmation, electronic training record, etc.)
- e. Who the organization will identify as personnel responsible for oversight of the model of care training
- f. Actions the organization will take when the required model of care training has not been completed (e.g., contract evaluation mechanism, follow-up communication to personnel/providers, incentives for training completion, etc.)

3.3.3.3 Provider Network having Specialized Expertise in the MLTSS Population and Use of Clinical Practice Guidelines and Protocols (MOC Element #3)

The Offeror's response to this MOC element shall:

1. Describe how the Offeror will ensure members receive the appropriate primary and acute medical care, including individuals who depend on device-based medical or nutritional support (e.g., ventilator, feeding tube, or tracheostomy) or those who reside in an institutional setting
2. Describe how the Offeror will ensure members or those who reside in an institutional setting receive appropriate behavioral health services
3. Describe how the Offeror will ensure members (e.g., "Vulnerable Subpopulations") receive the appropriate specialized care from providers such as neuropsychologists, infectious disease specialists, gerontologists, etc.
4. Describe how the Offeror assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols
5. Describe the Offeror's approach to monitoring the quality of services provided by its network providers and the quality of continuity of care/choice of providers, including during the implementation/transition to MLTSS
6. When a plan of care is required specific to the provision of a service (e.g., personal care and private duty nursing), describe the Offeror's approach to working with that service provider to develop the appropriate plan of care and to ensure the member receives the identified services

3.3.3.4 Assessments (MOC Element #4)

Health Risk Assessments (HRAs)

Offeror's response to this MOC element shall submit for review any other tools or flow charts that illustrate the proposed processes and:

1. Describe and submit all of the HRA tools the Offeror will use to identify the specialized needs of its members. At a minimum, HRA tools must encompass social (including housing and employment), functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains. The HRAs must identify member's primary care provider and specialists, strengths and goals, identify if the member utilizes TCM services, community resources used/available for the member, and the plan for care coordination.
2. Describe how the Offeror will use information from the Minimum Data Set(MDS) section Q and the HRA to identify members who may be appropriate for transition to community settings
3. Describe in detail, the identification strategy, including predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information that are used to prioritize the timeframes for when and how initial HRAs and annual Level of Care (LOC) reassessments are conducted for each member. Clearly define when the stratification is conducted (e.g., how far in advance of effective date and on an ongoing basis). Also describe how the results of the HRAs are used to confirm the appropriate stratification level.
4. Describe the personnel who review, analyze, and stratify health care needs.
5. If an initial brief screening tool will be used for member stratification and identification of needs, submit a copy of this tool. Describe in detail how it will be used, the qualifications of staff performing the screening, and how the information will be communicated to the care coordination team.
6. Describe how the Offeror will ensure that initial HRAs for those individuals who are enrolled in the program are conducted in accordance with the requirements outlined in the *Model of Care Assessment and Individualized Care Plan (ICP) Expectations* table below.
7. Describe how the Offeror involves members and family members/caregivers in the HRA process, including the Offeror's efforts to obtain documentation, including signatures, to signify that members and family members understand and consent to the HRA process. The Offeror must describe efforts for the different populations, including individuals residing in nursing facilities, individuals enrolled in the waivers, and best efforts for the community well population. Describe how the Offeror will accommodate the needs of individuals with communication impairments (e.g., speech, hearing and/or vision limitations) and individuals with limited English proficiency, in a culturally and developmentally appropriate manner and how the Offeror will consider an member's physical and cognitive abilities and level of literacy in the assessment process.
8. Describe how the Offeror will ensure that HRA reassessments to identify any changes in the specialized needs of its members are conducted as required in the *Model of Care Assessment and Individualized Care Plan (ICP) Expectations* table below.

Annual Level of Care (LOC) Reassessments

Offeror's response shall describe how it will ensure that annual LOC reassessments are conducted timely for EDCD and Tech Waiver participants (minimum within 365 days of the last annual LOC reassessment), including when a member experiences a change in status that could impact Waiver eligibility. For EDCD and Tech Waiver participants, describe how the Offeror will conduct annual face-to-face assessments (functional and medical/nursing needs) for continued eligibility for the Waivers.

3.3.3.5 Interdisciplinary Care Team (ICT) (MOC Element #5)

The ICT is led by the care coordinator. Offeror's response to this MOC element shall:

1. Describe how the ICT process will be used to empower and support the care team in proactively recognizing signs of emerging issues (e.g., depression, fall risk, etc.) and mechanism for follow-up on identified risks.
2. Describe in detail how the ICT process will interface with the development of a comprehensive ICP.
3. Describe the proposed strategies to engage and solicit input from all participants of the ICT. At a minimum the ICT must include: the member and/or their authorized representative, care coordinator, PCP. If applicable, ICT must include: LTSS providers (including the RN Supervisor of the provider agency for Tech Waiver participants, Services Facilitator, Adult Day Health Care Center staff, NF staff, etc.), behavioral health clinician, Targeted Case Management service providers, and pharmacist, unless specified otherwise by the member. The ICT must include other providers or individuals the member requests to participate, including family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.
4. Describe how the Offeror will ensure that required participants are invited, have input into, and actively participate in the ICT process.
5. Describe how the Offeror will enable the participation of the member, the member's designated representative, and other required participants whenever feasible. Include how the Offeror will accommodate member's needs and preferences related to location of ICT meetings.
6. Describe how the Offeror will coordinate with other existing ICT meetings, including but not limited to, those held in NFs, ADHC, CSB, etc. Include provider outreach and education regarding ICT requirements and expectations.
7. Describe how the Offeror will operate the ICT. Include processes for input from all participants, communication strategy and plan, and approach to accommodate the needs of the member and ICT participants.

3.3.3.6 Individualized Care Plan (ICP)(MOC Element #6)

The Offeror shall develop a person-centered ICP for each individual enrolled with the Offeror. The ICP will be tailored to individual needs. The ICP shall be updated with the member as part

of the ICT as outlined in the *Model of Care Assessment and Individualized Care Plan (ICP) Expectations* table. Offeror's response to this MOC element shall:

1. Describe the method of stratification, the person-centered and culturally competent ICP development process, and how Targeted Case Management providers (if applicable) will be incorporated into the ICP development process but not duplicate Targeted Case Management (if applicable).
2. Describe the essential elements incorporated in the ICP. Describe how the ICP is documented and where the documentation is maintained.
3. Describe how the ICP will be developed to meet the member's needs and preferences. Specify the approach for each MLTSS sub-population. Explain how the Offeror will incorporate and leverage external existing plans of care.
4. Describe which personnel (specify qualifications) develop the comprehensive, person-centered, culturally competent, ICP that is tailored to the member's needs and preferences.
5. Describe how the Offeror will ensure the member and family/preferred support system is engaged in the ongoing development of their ICP.
6. Describe how the initial ICP and any care plan revisions are communicated among the member, ICT, and other pertinent providers. Describe how the Offeror's communication structure accommodates the needs of individuals with communication impairments (e.g., hearing and vision limitations) and individuals with limited English proficiency.
7. Describe the Offeror's process to get members or their representatives to acknowledge the ICP by signing the initial ICP and all subsequent revisions. Describe the Offeror's process if the members or their representatives decline or are unable to sign.
8. Describe how the Offeror will identify triggering events and ensure that ICPs are revised based on triggering events.

In response to the RFP, the Offeror shall also submit for review any tools or flow charts that illustrate the proposed processes for this MOC element.

3.3.3.7 Care Coordination (MOC Element #7)

Offeror's response to this MOC element shall include the following:

For All Members

The Offeror shall describe how care coordinators will ensure member's ongoing care coordination needs are identified and met, using a person-centered approach.

The Offeror shall describe how it will provide care coordination functions for *all* members: At a minimum:

1. Provide a single, 24/7 toll-free number for assistance
2. Facilitate referrals that result in timely appointments

3. Provide communication and education regarding available services and community resources in a mode and manner that is culturally and developmentally appropriate and considers the member's physical and cognitive abilities and level of literacy
4. Assist in developing self-management skills to effectively access and use services

The Offeror shall describe how it will notify members of the following:

1. Name of assigned care coordinator
2. How to contact the care coordinator
3. When is the care coordinator is available
4. Alternative resources if the assigned care coordinator is unavailable
5. When there is a change to the member's assigned care coordinator

The Offeror shall describe how it will notify providers of the following:

1. Name of assigned care coordinator
2. How to contact the care coordinator
3. When is the care coordinator is available
4. Alternative resources if the assigned care coordinator is unavailable
5. When there is a change to the member's assigned care coordinator

The Offeror shall describe proposed strategies to:

1. Outreach to and engage individuals who are hard to contact/locate
2. Engage individuals who decline to engage in care coordination

Enhanced Care Coordination for Vulnerable Subpopulations:

The Offeror shall describe its proposed enhanced care coordination activities to meet the needs of the "Vulnerable Subpopulation" as described in MOC element #1.

Care Coordination Staffing:

Offeror shall describe its Care Coordination function including the roles and responsibilities of all staff performing care coordination activities. The Offeror shall propose care coordination caseload ratio and explain its proposed ratio.

The Offeror shall propose care coordination caseload ratios for each of the following categories:

1. HCBS waiver participants
2. Individuals residing in nursing facilities
3. Other Vulnerable Subpopulations, as defined in the MOC
4. Community Well subpopulation

The Offeror's proposed ratios shall illustrate its understanding of the complex needs of the MLTSS population and the requirements of this RFP, most significantly the requirements outlined in the Model of Care. The Offeror shall also describe how it will ensure that an adequate number of care coordinators will be available to meet the proposed care coordinator caseload ratios.

The Offeror shall submit job descriptions for all staff members involved in care coordination activities.

3.3.3.8 Care Transition Programs (MOC Element#8)

The Offeror's response to this MOC element shall describe the goals, processes, and systems for ensuring smooth transitions between levels of care and care settings. Include how the Offeror will identify members approaching or in need of a transition of care. The Offeror's response shall address coordination with Medicare for dual eligible members. The response must include details on transition between the following care settings:

1. Hospitals (acute) discharge to:
 - a. Nursing facility (skilled or custodial)
 - b. Community with HCBS waiver
 - c. Community without HCBS waiver
2. Hospitals (psychiatric) discharge to:
 - a. Nursing facility (skilled or custodial)
 - b. Community with HCBS waiver
 - c. Community without HCBS waiver
 - d. Residential Treatment Facility
3. HCBS waiver transition to:
 - a. Hospital (acute or psychiatric)
 - b. Nursing facility
 - c. Residential Treatment Facility
4. Community without HCBS waiver transition to:
 - a. Hospital (acute or psychiatric)
 - b. Nursing facility
 - c. Community with HCBS waiver
 - d. Residential Treatment Facility
5. Long-term Institution transition to:
 - a. Community with HCBS waiver
 - b. Hospital and back to Nursing facility

Model of Care Assessment and Individualized Care Plan (ICP) Expectations²

	Initial Health Risk Assessment (for new members at program launch ³)	Initial ICP (for new members at program launch)	Initial Health Risk Assessment (for new members after program launch)	Initial ICP (for new members after program launch)	Reassessment and ICP Review	As Needed ICP Revised	Annual Level of Care Reassessment
Technology Assisted Subpopulation	Within 14 days of enrollment with Contractor (must be face-to-face) ⁴	Within 30 days of enrollment (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner. ⁵) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA.	Within 14 days of enrollment (must be face-to-face)	Within 30 days of enrollment	Every 6 months ⁶ (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Contractor conducts annual face-to-face assessment for continued eligibility for the Tech Waiver ⁷
EDCD Vulnerable Subpopulation	Within 30 days of enrollment with Contractor (must be face-to-face)	Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA.	Within 30 days of enrollment (must be face-to-face)	Within 30 days of enrollment	Every 6 months ⁸ (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Contractor conducts annual face-to-face assessment for continued eligibility for the EDCD Waiver
Nursing Facility	Within 60 days of enrollment with	Within 90 days of enrollment. (Contractor must honor all existing	Within 60 days of enrollment (must	Within 60 days of	Follow MDS guidelines/time	Upon triggering event such as a hospitalization	Contractor works with facility on annual

² This chart is subject to final revision pursuant to the MLTSS Contract.

³ “At Program Launch” means the first month that an MLTSS region goes live. The “clock” begins on the Contractor effective date. All days are calendar days.

⁴ The clock starts at the effective date of enrollment and days are measured in calendar days.

⁵ Prior authorizations will be provided in the enrollee’s transition report.

⁶ Contractors must comply with requirements for the Tech Waiver as established in 12 VAC 30-120-1700 et seq.

⁷ Local and Hospital Preadmission Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, Tech Waiver, and PACE).

⁸ Contractors must comply with requirements for the EDCD Waiver as established in 12 VAC 30-120-900 et seq.

	Initial Health Risk Assessment (for new members at program launch³)	Initial ICP (for new members at program launch)	Initial Health Risk Assessment (for new members after program launch)	Initial ICP (for new members after program launch)	Reassessment and ICP Review	As Needed ICP Revised	Annual Level of Care Reassessment
Vulnerable Subpopulation	Contractor (must be face-to-face and incorporate MDS)	ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA	be face-to-face)	enrollment	frames for quarterly and annual reassessment and ICP development	or significant change in health or functional status	assessment for continued nursing facility placement
Vulnerable Subpopulation⁹ (Excluding Tech, EDCD & nursing facility)	Within 60 days of enrollment with Contractor	Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA	Within 60 days of enrollment	Within 60 days of enrollment	By ICP anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Community Well	Within 90 days of enrollment with Contractor	Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA	Within 60 days of enrollment	Within 90 days of enrollment	By ICP anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A

⁹ Vulnerable Subpopulation is defined in Element #1 of the Model of Care.

3.3.4 Community-Based Partnerships

Community-based partners may include, but are not limited to, Centers for Independent Living (CILS), Community Services Boards (CSBs), Area Agencies on Aging (AAAs), and adult day health care centers. Inclusion of community-based partners is critical to the success of achieving goals of the MLTSS Program.

In response to this RFP, Offerors shall:

1. Describe their experience forming partnerships with community-based organizations to perform aspects of their care coordination functions
2. Describe its successes and lessons learned associated with current partnerships in Virginia or other states
3. Describe proposed innovative partnerships in delivering a care coordination program for the Virginia MLTSS Program
4. Describe the type and scope of the proposed partnership(s), including specific services and/or functions to be carried out through or in tandem with the partnership (e.g., care transitions), geographic area(s) proposed

3.3.5 Vignettes

Offeror shall include responses to each of the vignettes included in Attachment F. The RFP evaluation process also will include an in-person presentation, including a demonstration of the Offeror's care management technology system, by each Offeror on a minimum of two (2) of the vignettes. Additional details regarding the in-person presentation will be provided to respondents, but the presentation should demonstrate the Offeror's structural capacity and ability to excel at meeting the needs of the enrolled population. The standards outlined in the following paragraph will be used to evaluate the respondent's MOC structure and capabilities.

To complete this requirement, the Offeror shall describe how it would apply its MOC to provide services and supports to the individuals depicted in each vignette. Emphasis should be placed on how the Offeror would coordinate and integrate Medicaid and Medicare services for those individuals depicted as dual eligible members in the vignettes. Responses do not need to include all elements of the MOC. Rather, the Offeror should focus their responses on the elements that they deem most applicable. The timeframe addressed should begin at initial enrollment and include the next 18 months. Vignettes shall be a maximum of five pages per vignette, single-spaced. Responses to the vignettes shall be detailed, responsive to individual needs and preferences, and take into account the health, safety, and welfare of members. To respond to these vignettes, Offeror may use the information included to draw inferences about the individuals' needs.

3.3.6 Integrated Health Home Systems of Care

Behavioral Health Home: The Contractor shall work with DMAS and DBHDS to develop and implement behavioral health homes (BHHs) appropriate for individuals with serious mental illness (SMI) using CSBs and other community systems.¹⁰

The Certified Community Behavioral Health Clinic (CCBHC) model is a form of a BHH. When CCBHC becomes available in a region, the Contractor's BHH models shall include the CCBHC.

Goals of the BHHs align with the MLTSS program and include:

1. Improving health and behavioral health outcomes and opportunities for community integration for BHH members using evidence-based practices
2. Empowering medical and behavioral health providers to collaborate and exchange information for aligned care planning to provide person-centered care at the right time in the least restrictive environment/mode
3. Improving the experience of care, quality of life and consumer satisfaction and promote a seamless and timely experience for enrolled individuals
4. Improving access to primary and urgent care services, lowering the rates of hospital emergency department (ED) use, reducing hospital admissions and re-admissions and decreasing reliance on long term care facilities and other high cost services
5. Providing member education for medical, behavioral health, pharmacy and other community services, supports and needs, including principles of recovery and resiliency as defined by SAMHSA

In response to this RFP, the Offeror shall describe for each Offeror's MLTSS proposed region:

1. How it will partner with CSBs and other community partners/providers for individuals with serious mental illness (SMI) within the Offeror's proposed regions
2. How its BHHs will collectively serve as a comprehensive behavioral health management program across its proposed regions
3. How its BHHs will use a team-based treatment approach that integrates primary, acute, pharmacy, behavioral health, and substance use disorder services
4. How its BHHs will have staff and resources to improve overall health care delivery through a patient-centered interdisciplinary system for care coordination of comprehensive services (including bi-directional behavioral health and primary care services)
5. How it will rapidly respond and prevent acute episodes for individuals with SMI with quality driven services and supports.

¹⁰ Behavioral Health Homes will not be implemented under Section 2703 of the Affordable Care Act, so enhanced matching funds will not be claimed for these activities.

3.3.7 Coordination with Medicare

Dual eligible members enrolled in MLTSS may receive their Medicare benefits from the Contractor's companion D-SNP, Medicare fee-for-service, or through another Medicare Advantage (MA) Plan. The Contractor shall encourage its enrolled members to also enroll in their companion D-SNP for the Medicare portion of their benefits, in order to provide consistency and maximize the Contractor's ability to coordinate services for the individual. The Contractor also shall work with DMAS to align, whenever possible, enrollment of dual eligible members with the same Contractor for both Medicare and Medicaid services.

The Contractor shall remain responsible for coordinating care and services for individuals who do not participate in the Contractor's companion D-SNP. The Contractor also shall be responsible for coordinating payments for dual eligible members and shall be responsible for paying crossover claims as will be outlined in the MLTSS contract.

The Contractor shall respond to requests from DMAS for D-SNP operational, benefit, network, performance, financial, and oversight information that directly impacts the continued integration of Medicare and Medicaid benefits in order to maintain a seamless service delivery of Medicare and Medicaid benefits to dual eligible members. These requirements will be included in the contract between DMAS and D-SNPs as part of Medicare SNP application requirements per the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The Contractor also shall notify DMAS of significant changes in Medicare information to beneficiaries, benefits, networks, service delivery, oversight results, or policy that are likely to impact the continued integration of Medicare and Medicaid benefits under the MLTSS contract. DMAS shall notify the Contractor of MLTSS changes that could affect its CMS D-SNP contract.

In response to this RFP, the Offeror shall describe its:

1. Approaches and applicable experiences, including successes and challenges, coordinating with Medicare for dual eligible members
2. Approaches and applicable experiences when an individual is enrolled with the Offeror for both Medicare and Medicaid services and when an individual is enrolled with the Offeror for Medicaid but not for Medicare
3. Procedures and processes that will be in place for coordination of care with Medicare providers, consistent with Virginia's requirements in the MIPPA contract

3.3.8 Consumer-Directed Services

Personal care and respite services are offered through two different models: Agency-Directed and Consumer-Directed. Individuals may use the Consumer-Directed service option alone or in conjunction with Agency-Directed services.

Under consumer direction, the waiver member or their designee is the legal employer of record (EOR). The Contractor shall be responsible for covering the cost of personal care and respite care services provided through the Consumer-Directed service model.

In response to this RFP, Offeror shall describe its:

1. Experience with Consumer-Directed services either in Virginia or in other states
2. Proposed approach to Consumer-Directed service delivery including ensuring individuals are aware of their service delivery options and empowering individuals to make informed decisions
3. Proposed approach to service facilitation including details regarding its design and implementation
4. Best practices or innovations in Consumer-Directed service delivery that could potentially be applied to the MLTSS Program

3.3.9 Members with High-Utilization or Emerging High-Risk Factors

The Offeror shall describe quantitative methods it will use to identify and monitor members with high-utilization or emerging high-risk factors. The Offeror shall describe how it will use this information to improve care coordination. The Offeror shall provide an explanation of this process (including the personnel involved, the metrics for identification of high-utilizer trend analysis, etc.) and describe how the effectiveness of strategies implemented will be evaluated.

3.3.10 Enhanced Benefits

Enhanced benefits are services offered by the Contractor to members in excess of MLTSS covered services. The Contractor shall have the discretion to use the capitated payment to offer enhanced benefits, as specified in the member's ICP, as appropriate to address the member's needs. Offerors that are considering providing enhanced benefits shall include a list of the enhanced benefits they may offer, to whom the benefits would be available to (enhanced benefits do not have to be offered to individuals in every category of eligibility), the benefit limits, and criteria for the approval of requests for each enhanced benefit.

Examples of potential enhanced benefits include, but are not limited to, routine and preventive dental coverage, chiropractic care, environmental modifications and assistive technology, vision, hearing, and personal care services for individuals who do not meet a waiver level of criteria. If consumer directed personal care services will be offered as an enhanced benefit, the Contractor must contract with and reimburse the F/EA for the administrative costs associated with the F/EA functions, as will be specified in the MLTSS Contract. *If a Contractor elects to offer enhanced benefits, DMAS encourages the Contractor to include routine and preventive dental coverage for adults as part of their enhanced benefits.* No increased reimbursement shall be made for enhanced benefits provided by the Contractor.

3.4 RELATIONSHIPS

The Offeror shall describe its relationship management approach to key partners and stakeholders. Specifically, the Offeror shall describe its plan to deliver high-quality client service, engage stakeholders to build strong partnerships and trust, share knowledge, collaborate and solve problems, and be proactive, responsive, flexible, adaptable, and innovative throughout the life of the MLTSS Contract. The Offeror shall describe specific examples that demonstrate its relationship management approach. The key partners and stakeholders of particular interest include:

1. DMAS and other state agencies
2. Providers (primary, specialty and acute care, community based organizations (AAA, CILS, CSBs), NFs, health systems, community providers (community BH and LTSS providers)
3. Associations (provider associations, advocacy associations)
4. Social Supports (community care coordination models, others)
5. Other contractors that are part of the MLTSS Program
6. Members and Informal Supports (including self-advocates)

3.5 OPERATIONS

3.5.1 Staffing

The Offeror shall include the proposed staffing plan (key staff and all other staff members) including the total number of proposed Virginia MLTSS FTEs by position and region. The staffing plan shall provide details on all needed functions including all the administrative, care coordination, and clinical oversight functions. The plan shall also detail the number of staff to be employed and number of staff to be obtained through subcontracting arrangements. If the Offeror plans to subcontract some positions, the Offeror must explain the roles for which it plans to subcontract and the oversight and management plan to ensure high quality delivery. In response to this RFP, the Offeror shall include proposed Virginia MLTSS program organizational charts, dedicated staffing numbers by position (delineated by employer), job descriptions and staff qualifications, locations, subcontract descriptions, and its oversight and management plan.

In response to this RFP, the Offeror shall submit a staff training approach for initial onboarding and ongoing training. In addition to the training approach for the entire MLTSS program, the Offeror's training approach shall include in-depth training on long-term services and supports and Medicaid behavioral health. The Offeror shall also submit its knowledge transfer approach as new staff members are added to the Virginia team. This approach shall include a detailed plan on ensuring continuity of operations and provider relationships as staff members transition to new roles.

3.5.2 Communications

In response to the RFP, the Offeror shall describe the proposed overall communications structure, internal communications sharing and storage, and training and management on communications infrastructure. Offeror's response shall:

Overall Communications Structure:

1. Describe the Offeror's overall communication structure related to the entire MLTSS Program. In the Offeror's description, include how the communication structure connects the Offeror's internal staff, providers, members, public, and regulatory agencies. Provide details regarding accessibility of all systems of communication and the specific information available for each type of end-user.

Internal Communications Sharing and Storage:

2. Describe how the Offeror preserves communications as evidence of care and contacts.
3. Detail the specific internal processes used by the Offeror's staff for documentation of member contacts (e.g., customer service, care coordination, grievance and appeals, 24/7 nurse advice line, and any web-based telehealth approach) and how this information is integrated into the overall care coordination activities.

Training on Communication Infrastructure:

4. Describe how the Offeror will provide outreach, training, and technical assistance on how to use each of the Offeror's modes of communication.

Management of Communication Infrastructure:

5. Describe the Offeror's staff who have oversight responsibility for monitoring and evaluating communication effectiveness.

In response to this RFP, the Offer shall also submit for review any tools or flow charts that illustrate the proposed communications processes.

3.5.3 Quality

NCQA Accreditation Quality Management and Improvement: Offerors with Medicaid and/or Medicare plans that are accredited by NCQA in Virginia and/or other states shall provide the following (in a chart format for items #1 – 3):

1. Name of each health plan as it appears on NCQA's website and whether it is a Medicaid or Medicare product.

2. Current accreditation level (must include a copy of the most recent accreditation/re-accreditation confirmation letter). If the current accreditation level is different from the confirmation letter, an explanation must be included.
3. Any deficiencies noted within the previous three years by NCQA
4. A copy of the auditor-locked interactive data submission system (IDSS) from the most recent HEDIS audit.
5. A copy of the most recent Adult and child CAHPS report, if available

Medicaid Managed Care External Quality Reviews: Offerors with Medicaid only, Financial Alignment Demonstration, or MLTSS experience shall submit the most recent two (2) years of EQRO reports from up to two (2) states (if applicable). If the Offeror has MLTSS experience, it must submit MLTSS reports. The EQRO reports must include the most recent three mandatory external quality improvement activities per the Federal Managed Care Regulations (42 C.F.R § 438.358): a comprehensive operational systems review, performance measure validations, and performance improvement projects validations.

Medicaid Managed Care Annual Quality Improvement Plan and Evaluation: Offerors with Medicaid only, Financial Alignment Demonstration, or MLTSS experience shall submit its most recent QI description, plan and annual evaluation results from up to two (2) states (if applicable). If the Offeror has MLTSS experience, the Offeror shall submit MLTSS QI reports.

Medicaid MLTSS Quality Improvement and Assurance: Offerors with Financial Alignment Demonstration or MLTSS experience shall describe their experience with LTSS measurement, including but not limited to, HCBS member experience surveys, quality of life surveys, and collecting and reporting on §1915(c) waiver quality assurances.

Quality Activities Related to the MLTSS Model of Care (see Section 3.3.3): In response to this RFP, the Offeror shall describe:

1. How the Offeror will structure the quality management/improvement infrastructure to support the MLTSS model of care
2. How the Offeror will collect, analyze, report, and act on data to evaluate the model of care (e.g., specific data sources, specific performance and outcome measures, etc.)
3. Who will collect, analyze, report, and act on data to evaluate the model of care (e.g., internal quality specialists, contracted consultants, etc.)
4. How the Offeror will use the analyzed results of the performance measures to continuously improve the model of care (e.g., internal committee, other structured mechanism, etc.)

5. How the evaluation of the model of care will be documented and preserved as evidence of the effectiveness of the model of care (e.g., electronic or print copies of its evaluation process, etc.)
6. The personnel having oversight responsibility for monitoring and evaluating the model of care effectiveness (e.g., quality assurance specialist, consultant with quality expertise, etc.)
7. How the Offeror will communicate results of the model of care evaluation and improvements in the model of care to all stakeholders (e.g., a webpage for announcements, printed newsletters, bulletins, announcements, etc.), including members, advocates, providers, etc.

3.5.4 Provider Recruitment Strategy

The Offeror shall provide adequate resources to support a provider relations function to effectively communicate with existing and potential network providers. The Offeror shall also establish and conduct ongoing provider education and trainings to assist in contracting with willing and qualified providers that meet the Offeror's requirements and with whom mutually acceptable provider contract terms, including reimbursement strategies, are reached.

In response to this RFP, the Offeror shall describe the provider recruitment strategy, including, but not limited to:

1. Innovative approaches that the Offeror will use to develop and maintain its MLTSS provider network to ensure network adequacy standards and highest quality care
2. How the Offeror will work with various provider associations
3. Plans to train providers and educate them about the benefits of the MLTSS program
4. How the Offeror will assist providers who are hesitant about managed care delivery systems
5. Strategies to recruit providers in rural areas, if applicable
6. How the Offeror will ease the transition for providers, particularly LTSS and community behavioral health providers who are not accustomed to operating in a managed care environment

3.5.5 Provider Network Adequacy and Submission

The Offeror shall be solely responsible for arranging and administering covered services to enrolled members and must ensure that its delivery system will provide available, accessible, and adequate numbers of facilities, locations and personnel for the provision of covered services. The Offeror is not required to contract with all willing providers, however its network must meet network adequacy requirements.

In addition, the Offeror shall ensure that its provider network provides access that is consistent with routine patterns of utilization, including in localities that fall adjacent to another region. For example, Accomack is located in the Central region; however, for some parts of Accomack, member utilization patterns may require the Offeror to contract with providers located in the Tidewater region or bordering state.

In response to this RFP, the Offeror shall submit their preliminary provider networks to include: acute, primary, LTSS, behavioral health (all Community Service Boards in the proposed regions), and transportation in the format described in Attachment C. In addition, the Offeror must include a mapped version of providers reflected in their preliminary network as described in Attachment D. The Offeror shall include providers in its network submission who are specialized in and capable of meeting the unique needs of the MLTSS population. The Offeror's network submission must meet the Federal and State network standards described in 42 C.F.R § 438.206 and the requirements outlined in this RFP. These providers must cover all the services as referenced in Attachment E. Only providers who have either signed a letter of intent (LOI) or signed a contract may be submitted. The Offeror must indicate this distinction (LOI vs. signed contract) for each submitted provider. The Offeror does not need to provide actual copies of signed LOIs or contracts in response to this RFP. Final networks, including fully executed provider contracts, will be evaluated during the readiness review process.

The Offeror shall submit a provider network file to the Department in an electronic MS-Excel spreadsheet format. Additional instructions included in Attachment C and detailed in the *Provider Network Adequacy Data System (PNADS) Manual*, available on the DMAS MLTSS webpage. Submissions not meeting the network file requirements will be rejected and returned. DMAS will use this data to evaluate the Contractor's provider network in accordance with requirements described in this RFP. The Department or its designee shall be the sole determiner of network sufficiency.

3.5.6 Ongoing Provider Support

Ongoing provider support is important for continuous improvement and high-quality care. The Offeror's response shall describe its approach for:

1. Provider outreach and communications when programmatic changes are made
2. Ongoing provider training
3. Technical assistance, especially to community behavioral health and LTSS providers, and out of network providers during the continuity of care period
4. Issue resolution with providers

3.5.7 PCP Assignment

With the exception of dual eligible individuals, the Offeror shall ensure that each member has an assigned PCP at the date of enrollment with the Offeror. The Offeror must allow individuals (other than dual eligible members) to select or be assigned a new PCP when requested by the individual, when the Offeror has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding.

In response to this RFP, the Offeror must explain how it assigns PCPs to non-dual eligible members and how these individuals are assisted if a change in PCP assignment is requested or necessary. The Offeror shall also describe how it identifies dual eligible members' PCPs, including the use of Medicare and DMAS data and incorporates the PCP information into their individuals' medical records to improve care coordination.

3.5.8 Nursing Facility (NF) Services

The Offeror shall provide coverage for skilled and intermediate NF care, including for dual eligible members after the member exhausts their Medicare covered days. DMAS shall require contractual agreements between NFs and the Offeror. Payment for services shall be made to NFs directly by the Offeror.

The Offeror's response shall explain the following topics regarding nursing facilities:

1. Describe the credentialing process that the Offeror will use with NFs, if different from other provider types
2. Describe how the Offeror will identify and contract with physicians and ancillary providers who contract with NFs
3. Describe how the Offeror will work with NFs to promote adoption of evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the NF benefit
4. Describe the specific criteria and metrics, if any, the Offer will use to evaluate NF quality
5. Describe the results of innovative payment strategies the Offeror has implemented including in other states to drive quality improvement with NFs
6. Describe how the quality outcomes will impact payment, patient placement, referral, and case management
7. Describe the specific resources and assistance for alternate placement that will be provided by the Offeror

3.5.9 Emergency and Non-Emergency Transportation Services

The Offeror shall cover emergency, urgent, and non-emergency transportation to ensure that members have necessary access to and from providers of covered medical, behavioral health, dental, and LTSS services, per 42 C.F.R § 440.170(a) and 12 VAC 30-50-530. The Offeror shall

not be responsible for transportation to LTSS services for individuals enrolled in the DS, ID, and DD Waivers. Transportation to LTSS services for these individuals will be paid through Medicaid fee-for-service as “carved out” services.

The Offeror’s response shall describe:

1. How it intends to provide emergency, urgent and Medicaid non-emergency transportation under the MLTSS program including policies and procedures
2. Whether or not the Offeror will contract with DMAS’ fee-for-service non-emergency transportation Contractor. If so, the Offeror is not required to submit its non-emergency transportation provider network.
3. If the Offeror plans to provide transportation services either in-house and/or through another transportation vendor, a network submission must be submitted in the format reflected in Attachment C

3.5.10 Call Center

The Contractor shall operate a 24 hours per day, 7 days a week, toll-free call center (for members and providers) to respond to questions, concerns, inquiries, and complaints, in accordance with the requirements detailed in this RFP and as further defined in the MLTSS Contract resulting from this RFP. The Contractor's call center shall work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues. Further, the Contractor’s call center shall be adequately staffed with qualified personnel who are trained to accurately respond to member and provider questions, including questions and concerns that are specific to the Virginia MLTSS Program.

The Contractor’s member call center staff shall be trained to respond to the unique needs of the MLTSS populations including calls from individuals with cognitive, physical, or mental disabilities, or from individuals with limited English proficiency (including access to interpreter and translation services as necessary). The Contractor shall ensure that all calls from MLTSS members that require immediate attention, are transferred via a “warm transfer” when necessary to a medical or behavioral professional with appropriate clinical expertise to assist the individual, and to connect the member with their assigned care coordinator. These “warm transfer” calls shall be delineated separately in reports and metrics from other call center contacts.

The Contractor’s provider call center shall ensure that staff are trained to respond to questions regarding verification of member enrollment, covered services, provider contracting and credentialing, service authorization and claims payment and providers, including providers who are unfamiliar with managed care. Additionally, for a period of at least twelve (12) months following the last regional implementation phase of the MLTSS program, the Contractor shall

maintain a dedicated queue to assist LTSS and community behavioral health providers with enrollment, service authorizations, and reimbursement questions or issues and shall ensure that these providers are appropriately notified regarding how to access the dedicated queue for assistance. Such period may be extended as determined necessary by DMAS.

In response to this RFP, Offerors shall:

1. Describe its proposed member call center operations and provider call center operations to serve its MLTSS members and providers and how the Offeror's proposal complies with all DMAS call center requirements described in the Terms and Conditions section of this RFP
2. Detail the geographic locations of the proposed call center operations and the number of full-time equivalent staff dedicated to the Virginia MLTSS Program
3. Submit for review any process flows to describe its call center operations. These processes should also detail the call center Interactive Voice Response (IVR) process, issue escalation process, and call center quality assurance process

Further, the Offeror's proposal shall also explain the Contractor's plan for how it would demonstrate operational readiness for all elements of its plan's call center to the Department prior to MLTSS implementation.

3.5.11 Program Integrity

DMAS will include in the MLTSS Contract a minimum number of medical record audits to be conducted annually based on total dollars in medical claims expenditures. If the Contractor fails to meet this minimum standard, or is found through the Program Integrity Compliance Audit (PICA) to lack adequate program integrity controls, DMAS reserves the right to impose a corrective action plan on the Contractor. If the Contractor subsequently fails to implement corrective action, DMAS reserves the right to impose financial and non-financial penalties.

To provide Offerors with a point of reference for the volume and type of program integrity activity that will be expected to be performed under the MLTSS contract, a summary of the provider investigations conducted by DMAS on its fee-for-service expenditures in state fiscal year (SFY) 2015 is presented in the table below.

Provider Investigations Conducted by DMAS on FFS Expenditures, SFY 2015

Audit Type	Number of Provider Investigations Conducted	Overpayments Identified
DMAS Staff - General Provider Types	44	\$3,418,039
Contractor - Physician and Waiver Services	338	\$5,112,608
DMAS Staff – Behavioral Health	63	\$1,429,283
Contractor – Behavioral Health	70	\$1,333,219
DMAS Staff – Hospital Utilization Review	77	\$1,586,229
Contractor - Hospital DRG Review	92	\$6,394,998
Contractor - Pharmacy and Durable Medical Equipment	51	\$2,584,304
Total, DMAS Staff and Contractor Audits	678	\$22,210,821

The investigations presented in table above were conducted on \$3,444,063,728 in expenditures from 8,684,785 paid Medicaid claims. This means that DMAS conducted one audit for every \$5.1 million in prior year expenditures, or one audit for every 12,809 claims. While these may not be the specific rates of auditing that will be required under the MLTSS contract, DMAS will likely use its own audit rate as a starting point for creating the baseline requirements. It is worth noting that this rate is not necessarily consistent across provider types. For example, Hospital DRG reviews are conducted on a targeted sample of 7.5% of every hospital’s billings every year. As seen in the table above, DMAS also focuses its efforts in particular areas, such as pharmacies, durable medical equipment providers, behavioral health service providers, and waiver services. All of these audits include reviews of medical records to ensure that documentation supports the services as they were billed. In addition to post-payment reviews, DMAS also requires prior authorization of medical necessity for many services.

Some program integrity activities may identify issues that constitute potential fraud. DMAS and its Contractors are required to refer any cases of suspected fraud to the Virginia Medicaid Fraud Control Unit (MFCU). As a result of this requirement, DMAS made 335 referrals to the MFCU from SFY 2013-2015. The Contractor shall maintain the same level of diligence in their provider network, and cooperate fully with any request for information or technical support made by the MFCU to support their investigations. MFCU investigations may verify that some of these referrals constitute a “credible allegation of fraud.” In these instances, Contractors will be notified and shall suspend payments to those providers as set forth in 42 C.F.R § 455.23.

Pursuant to the DMAS memorandum of understanding with MFCU, any recovery, in whole or in part, or penalty recovered through the investigative efforts or litigation by the MFCU related to fraudulent provider conduct will be returned to the Commonwealth of Virginia and remain in the possession of the Commonwealth of Virginia.

Additional program integrity and oversight requirements will be outlined in the MLTSS contract.

The Offeror's response must:

1. Outline the program integrity activities it proposes to perform, including an estimate of the number and type of reviews that would be performed under the MLTSS Program (on a per member, per claims expenditure, and/or per claim basis.)
2. Describe the sampling methodology
3. Provide examples of program integrity reviews performed in the past, focusing on the size of the review(s) (claims/dollars/providers), specific overpayment amounts identified, and outcomes of these activities (including but not limited to, recovery of overpayments)
4. Describe the Offeror's oversight of subcontractor program integrity activities and direct investigations to verify the effectiveness of subcontractor program integrity

3.6 TECHNOLOGY

3.6.1 Interface and Connectivity to the Virginia Medicaid Management Information System (VaMMIS) and Medicaid Enterprise System (MES)

In response to this RFP, the Offeror must explain the ability to meet DMAS' requirements to interface with the VaMMIS and Medicaid Enterprise System.

3.6.2 Care Management Technology System

The Offeror shall have a care management technology system that maximizes the opportunity to share and integrate data and information among the Offeror, providers, members, and care managers in near real time. This system shall ensure coordination of care, follow members through episodes of care, and streamline care transitions to ensure positive health outcomes for members. The system should allow the appropriate Offeror's staff to have immediate access to the most recent case-specific information. The recommended data contained within the care management technology system includes the following: administrative data, call center notes, helpline notes, provider service notes, a member's care coordination notes, and any recent inpatient or emergency department utilization. The Offeror's care management technology system must also have the capability to make available relevant information (e.g., utilization reports, care treatment plans, etc.) with the member, member's provider(s), and care managers. The Offeror shall also be required to exchange relevant care coordination information with DMAS to facilitate effective care coordination and transitions of care.

The Offeror shall also have the capability to interface with DMAS' future Medicaid Enterprise System to exchange data to address challenges with the coordination and integration of care and to provide transparency and data needed to move Virginia to value-based payment. If requested, the Offeror shall actively engage with DMAS to inform the development of this care management technology system.

In response to this RFP, the Offeror shall:

1. Describe its care management technology system and how it meets the requirements in this RFP
2. Explain how its care management technology system facilitates communication among providers, Offeror's helpline, the member, and care managers
3. Describe the types of data stored in the care management technology system
4. Describe how information is fed into the system (e.g., real time, manual entry, etc.), how frequently (e.g., daily, weekly, etc.), and from what internal and external sources
5. Explain which providers and staff have access to the data, how they access the data, and for what purposes
6. Detail the Offeror's ability to communicate (send/receive) relevant information with DMAS for care coordination and monitoring purposes

Explain how data sharing will occur between the Offeror's care management technology system and other health plans' systems

3.7 READINESS

Contractor Readiness

As stated, based on the evaluation scores, DMAS will select Offerors that the Department will then enter into negotiations. These Offerors will go through an extensive readiness review process conducted by DMAS or its designee to evaluate each Offeror's ability to comply with the MLTSS requirements, including but not limited to, their ability to accurately process claims and enrollment information, accept and transition new members, provide adequate access to all covered services, meet Federal and state regulatory and contract standards, and meet MLTSS quality standards established by the Department. At a minimum, each readiness review may include a desk review and a site visit to the Offeror's headquarters and regional offices if applicable. The scope of the readiness review(s) will include, but not be limited to, review and/or verification of all areas listed in the table below.

Key Areas of Operational Readiness	
✓ Health risk assessments (person centered processes, etc.)	✓ Provider network composition and access to care; includes recruitment and development strategy, capacity, and access to care standards
✓ Care coordination and interdisciplinary care team (ICT) policies, procedures, processes	✓ Subcontractor contracts and capacity
✓ Member outreach and education	✓ Provider credentialing and contracting
✓ Confidentiality policy, procedures, and processes	✓ Provider manuals, training, and technical assistance
✓ Member protections including continuity of care and out of network provisions	✓ Fraud, abuse and program integrity policy and procedures
✓ Member materials and communications	✓ Systems capacity for member and provider enrollment, claims processing, claims payment, encounter processing, care coordination, and reporting. Includes examination of dataflow, integration, and security capabilities to support seamless care coordination across ancillary systems
✓ Utilization management policies, procedures, and processes	
✓ Financial solvency	
✓ Organization structure and staffing capacity	
✓ Performance and quality improvement	

Contractor’s Plan for Demonstrating Operational Readiness

DMAS intends to take full advantage of the competitive procurement process to identify health plans who demonstrate the superior ability to perform all administrative functions and to provide high-quality services to the Commonwealth’s most vulnerable populations.

In response to this RFP, the Offeror shall describe their comprehensive plan to achieve operational readiness as well as the process the Contractor plans to use to demonstrate readiness to the Department, especially for each of the areas listed in the table above, and that includes the following supportive documentation:

1. For each proposed region, the Offeror shall provide a detailed project work plan with timelines, responsible parties, milestones, and dependencies, and that explains how the Offeror will effectively prepare for MLTSS launch and scale its operations to meet the Department’s readiness and implementation requirements.

The Offeror’s detailed project work plan shall:

- a. Explain how it will assist providers toward readiness (through technical assistance, etc.) and how it will demonstrate that its providers are operationally ready for MLTSS implementation.
- b. Include the Offeror’s proposed infrastructure development plan including call center operations, enrollment systems and other administrative supports.
- c. Describe how it will prepare all ancillary programs to be operational for implementation (disease management, 24 hour nurse line, translation services, program integrity, compliance monitoring, etc.).

- d. Detail how the Offeror will demonstrate its ability to incorporate Virginia MLTSS program operations into its current business structure/processes and shall demonstrate that it has the capacity to effectively manage additional lives (i.e., MLTSS populations).
 - e. Include a plan for development, implementation, and operations of behavioral health homes and any other health homes.
 - f. Describe the plan for securing regional community support such as community based organizations, provider and advocacy associations, and non-contracted safety net providers.
 - g. Include the implementation plan for care coordination.
 - h. Explain its plan to establish its quality program.
 - i. Include a comprehensive outreach and education plan for members and providers (both short and long-term).
2. The Offeror shall include a regional risk assessment including any provider contracting barriers or challenges.
 3. The Offeror must explain how it will ensure its network has sufficient capacity across all regions to be served in the Commonwealth and across all lines of business (i.e., other Medicaid programs, Medicare, commercial business, etc.).
 4. The Offeror must list its subcontractors and how the Offeror will demonstrate its subcontractors' readiness to effectively meet the needs of the MLTSS Program and contract.
 5. The Offeror shall describe its plan to recruit, hire, and prepare staff needed to meet the MLTSS Program requirements.

3.8 INNOVATION

3.8.1 Delivery System Reform

On January 19, 2016, DMAS submitted a §1115 Waiver application to CMS seeking authority for the MLTSS program and a Delivery System Reform Incentive Payment (DSRIP) program in Virginia (VA 1115 Waiver Application January 19 2016). DSRIP can provide financial resources to states to achieve Medicaid delivery system transformation through infrastructure development, system redesign, and clinical outcome improvements. If approved, funding will be available for eligible providers to support care delivery transformation.

Virginia's DSRIP proposal focuses on three key improvements areas: (i) increasing delivery system efficiency, (ii) improving care delivery for Medicaid members- especially those with complex physical, behavioral health, and social needs, and (iii) implementing payment reform and transitioning Virginia's Medicaid to a system of value-based payment. DMAS is still in the

early stages of its DSRIP design and looks to contracted health plans to be integral partners in the design, implementation, and success of DSRIP's provider transformation.

In response to this RFP, the Offeror shall:

1. Explain how it plans to contribute to the implementation of DSRIP in Virginia
2. Describe its plans to leverage Virginia's proposed DSRIP model, including the formation of Virginia Integration Partners (VIPs), to achieve the goals of MLTSS

3.8.2 Health Homes

Health Homes (HH): Contractors are encouraged to establish health homes for individuals with complex health conditions. Health homes should leverage existing community systems that serve individuals with complex health and social needs. Examples may include, but are not limited to, health homes for individuals with dementia utilizing area agencies on aging, rural health clinics, adult day health care centers, or other community providers.

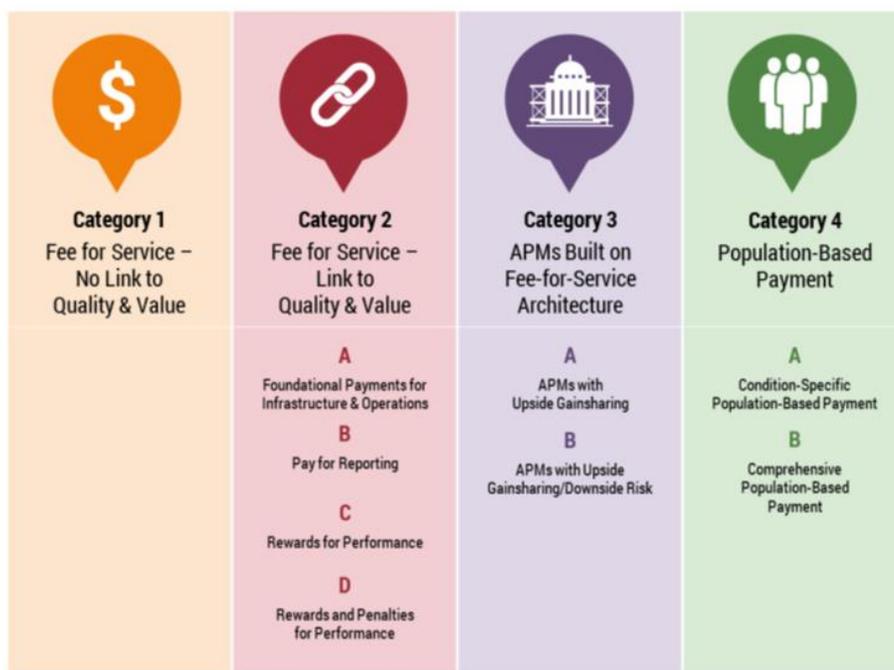
In response to this RFP, the Offeror shall describe:

1. How it will partner with community partners/providers across the continuum of care within the Offeror's proposed regions
2. How the Offeror's HHs will collectively serve as a comprehensive health management program in its proposed MLTSS region(s)
3. How its HHs will use a team-based treatment approach that integrates services: primary, acute, pharmacy, behavioral health, and long-term services and supports
4. How its HHs will have staff and resources to improve overall health care delivery through a patient-centered interdisciplinary system for care coordination of comprehensive services.
5. How it will rapidly respond and prevent acute episodes for individuals with quality driven services and supports

3.8.3 Value-Based Payments (VBP)

VBP is a broad set of payment strategies that link financial incentives to providers' performance on a set of defined measures of quality, cost and/or resource use to help transform health care. The Offeror's VBP proposed strategy shall follow the Alternate Payment Method (APM) framework in the Final White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with a special emphasis on categories 3 and 4. The White Paper can be accessed at <https://hcp-lan.org/2016/01/final-apm-framework-white-paper/>.

Figure 1. APM Framework (At-A-Glance)



DMAS will also use measurement methodologies developed by HCP-LAN. See <https://hcp-lan.org/groups/apm-fpt/national-apm-data-collection-effort/>.

Although the HCP-LAN APM data collection excludes LTSS, DMAS will use the measurement methodologies as the framework for VBP. Annually, each Contractor shall complete the Medicaid APM data collection tool. The draft data collection tool is at <https://hcp-lan.org/workproducts/Medicaid-Category-Metrics.pdf>.

After the first year, DMAS will set targets in the annual contract for all VBP (categories 2-4) and Alternative Payment Models (categories 3-4). There will be separate targets for acute care, behavioral health and LTSS. There will be separate VBP targets for dual eligible members and

non-dual eligible members as appropriate. Successful bidders should expect the targets to increase by at least 5 percentage points each year. DMAS will establish population-based performance targets such as reducing potentially preventable events, effectively managing episodes of care or keeping members in the community rather than institutions. Meeting these VBP and population-based targets will be considered for the quality withhold and/or quality incentive program described in Section 6.7.6 in this RFP. The Contractor shall work with DMAS as the Department sets expectations and benchmarks.

Offerors with Virginia Medicaid, Commercial, and/or Medicare contracts must separately and explicitly identify their use of APMs in their VA provider network lines of business when responding to this series of questions on value-based payment. Offerors without Virginia contracts and Offerors without a Medicaid contract must be explicit about the State(s)/lines of business used to respond to these questions. DMAS is specifically interested in the Offeror's ability to implement APM approaches in Virginia, in Medicaid, and for the following populations: Medicaid aged, blind and disabled populations not eligible for Medicare and dually-eligible persons.

Offeror shall indicate/describe:

1. All APMs it currently is using with its provider network, by provider type and line of business and the HCP-LAN APM framework category/sub-category in which the APM best fits (e.g., 2, 3, or 4)
2. For the APM models identified in one above, the percentage of the plan's total (and Medicaid) medical expenses expected to be paid under each type of APM model in the current calendar year or fiscal year, including what methodology and number the plan is using for the numerator and denominator and the types of services (e.g., primary and acute, behavioral health, LTSS, and others) included in Offeror's relevant APM experience
3. Up to three APM strategies expected to be most effective for services and populations most relevant to this RFP based on Offeror's experience, including how the APMs will serve to improve member outcomes and experience

Offeror shall propose a VBP plan for using APM and implementation strategy in Virginia, clearly indicating what steps would be in place by Contract execution, after the first full contract year and after the second full year of the contract. The Offeror's VBP approach must include:

1. Development of provider readiness for VBP
2. Relationship to its commercial VBP strategy and/or other payers such as Medicare in the Virginia health care marketplace

3. Methods and frequency for collecting and providing quality performance data from providers
4. Specific objectives for APM implementation, including scope, provider performance, and a timeline for implementation related to each of the proposed APM model approaches

3.8.4 Specialty Plan

DMAS will consider Offeror proposals to operate regional Specialty Managed Care Plans (Specialty Plans) as an effort to test innovative, person-centered models of care that align with MLTSS and DSRIP goals for transforming service delivery. The Specialty Plan will be at full-risk for all MLTSS covered services for its enrolled population. DMAS reserves the right to determine population assignment to Specialty Plans.

Specialty Plans shall provide all MLTSS covered services with a focus on meeting the needs of specific vulnerable sub-population(s). In addition, Specialty Plans must be able to serve any MLTSS member. Specialty Plans shall offer member care coordination and cover the same services as outlined in the MLTSS Contract.

Specialty Plans shall offer members a specialized managed care option with expertise, community connections, and particular focus on care for a specific diagnosis or condition (e.g. , institutional or community LTSS, SMI/SED and/or SUD, chronic disease management, dementia care, etc.). Specialty Plans may include more of certain types of specialty providers or primary care physicians in their provider network, based on the needs of the designated population.

Members eligible to join the Specialty Plan in their area will have choice of plans available in their region and can choose to enroll in the available Specialty Plan if desired.

An Offeror's submission of Specialty Plan proposal does not guarantee that DMAS will accept or implement the proposal. In addition, DMAS reserves the right to implement a specialty plan at any time during the course of the contract resulting from this procurement.

The Offeror's response must describe how its proposed Specialty Plan differs from the rest of the Offeror's response to this RFP.

1. Overview of Specialty Plan model
2. Proposed population
3. How the population would be identified (detailed criteria)
4. Proposed care coordination plan and care coordinator ratios for this population
5. Anticipated enhanced services
6. Proposed utilization of Community Services Boards, FQHCs, HUD, and/or other community providers
7. Proposed/proven strategies to enhance and support Nursing Facilities with their MSP members

8. Proposed strategies to engage other supports (for example the criminal justice system and/or school system)
9. Any other information that is relevant based upon the Offeror's experience
10. The Offeror should include any best practices utilized in Virginia or other markets as well as examples of innovations and proven strategies for the proposed population that provided positive, quantitative outcomes

4.0 PAST EXPERIENCE

4.1 OVERVIEW OF RELEVANT EXPERIENCE

The Offeror shall provide a description of the Offeror’s experience working with Medicaid enrollees, including dual eligible members, non-dual eligible members who receive LTSS either through an institution or through HCBS services, and other vulnerable subpopulations. Responses must include a table with columns indicating experience operating Medicaid programs, MLTSS programs, Financial Alignment Demonstrations, and D-SNPs or other Medicare products containing the following information (see table below for an example):

1. Programs/product lines (e.g., Medicaid only, Financial Alignment Demonstration, MLTSS, Medicare Advantage, D-SNP, etc.);
2. Location (statewide or geographic region(s) covered);
3. Timeframe for operating the program (e.g., the year) and duration (e.g., months/year(s) operating the program);
4. Average program enrollment size by city/county within the region(s) the Offeror operates;
5. Whether enrollment in the program is/was mandatory or voluntary;
6. Populations included (Document using the “MLTSS Target Populations” included in Element #1 of the MOC);
7. Age range of enrollees;
8. General type of services covered (e.g., acute and primary, nursing facility, home and community-based waiver services, behavioral health, etc.); and,
9. Prevalent conditions of the enrolled population.

Example-Relevant Experience

1. Programs/product line	D-SNP
2. Location	Virginia-statewide
3. Timeframe and Duration	2012-present; 2.5 years
4. Average program enrollment size	1,200 individuals
5. Enrollment (mandatory or voluntary)	Voluntary
6. Populations included	a-c
7. Age range of enrollees	21 years old and older
8. General types of services covered	Acute and primary; nursing facility, behavioral health
9. Prevalent conditions of enrolled population	Chronic conditions, behavioral health issues

4.2 PAST EXPERIENCE AND REFERENCES

4.2.1 Past Experience Examples

Offeror shall provide three (3) past experience examples which demonstrate experience with the following: rebalancing, value-driven care, care transitions, Value-Based Payments design and implementation, integration of behavioral health and acute care, and social determinants of health, and needs of Medicaid population. For each past experience example, Offeror's response shall include:

1. Contract name
2. Client name and contact information (title, address, phone, email)
3. Description of scope of services performed (covered lives, population types, services, provider types, geography, etc.)
4. Contract period of performance and duration
5. Contract type
6. Annual value of contract
7. Contract size (# of providers served,# of participants served, etc)
8. Description of key strategies and innovations implemented (system of care, staff, operations, technology, and relationship management, etc.)
9. Number of Contractor staffed assigned to contract
10. Description of risks and issues
11. Description of results and value achieved
12. Description of lessons learned
13. Any legal or adverse contractual actions against the Offeror related to the project

4.2.2 Medicare Plan Quality and Performance Rating

The Offeror shall submit its annual Medicare Star Ratings developed by CMS and posted on the Medicare.gov website for the last 3 performance years.

4.2.3 Stakeholder References

Offeror shall provide 10 total references from this group of stakeholders:

1. State & Local Government (required)
2. Federal Government
3. Providers (required and include VBP experience)
4. Community Based Organization (required)
5. Advocacy Organization (required)
6. Member (required)
7. Contractor/Partner
8. Subcontractor

For each reference, the Offeror's response shall include:

1. Name
2. Contact Information (address, phone, email)
3. Type of stakeholder (from list above)
4. Nature of relationship
5. Time period of relationship

4.3 COMPLIANCE HISTORY

DMAS will perform a comprehensive evaluation of each Offeror's compliance with Medicaid and Medicare program rules.

In response to this RFP, the Offer must report areas of non-compliance across Medicaid and Medicare lines of business. The Offeror shall include the average number of lives covered by the organization, parent organization, or sibling organization during the 36 month prior to proposal submission. DMAS reserves the right to disqualify an Offeror, if an Offeror is under sanction.

Offeror must include non-compliance for itself, its parent organization, and sibling organizations for the time period of 36 months of the prior to the proposal submission.

For each item listed below, outline in a chart the type of non-compliance issued (e.g., letter, fines), date issued, the reason, the entity that issued it, the state(s) in which the Offeror was providing services for which the non-compliance was issued, and the actions taken by the Offeror to address the non-compliance.

- a. Compliance Letters – Includes Warning Letters, Notices of Non-Compliance, Corrective Action Plans (CAPs) or similar state notices, and letters
- b. Failure to maintain fiscally sound operations – Negative net worth or financial loss greater than half of the applying Offeror's total net worth. The Offeror also shall indicate if a claim was made on a payment or performance bond. If so, the Offeror shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.
- c. Adverse financial audits – All contracts that receive adverse audit opinions or disclaimed audit reports during the 36-month performance period
- d. Performance audits – All contracts failing more than 50% of the audit elements during the audit performance period
- e. Exclusions enforcement actions– Imposed by CMS as an intermediate sanction
- f. Termination and non-renewals –Three types of contract, or partial contract, termination include (i) Federal and/or State Imposed, (ii) Disruptive Mutual (i.e. members were

transitioned to other providers in the absence of significant time and transition planning),
(iii) Non-Disruptive Mutual. Indicate type of contract and type of termination

g. Significant compliance concerns not otherwise captured above

The Offeror shall use the following timeframe in its response to this RFP:

- Non-compliance or poor performance in either the Medicaid or Medicare program must have either occurred or been identified within 36 months of the proposal deadline.
- Non-compliances that occurred in prior years but were not identified or addressed until sometime during the 36 month period shall be included.
- Non-compliances that occurred during the 36 month period but are not identified until after the end of the RFP review period and prior to contract signing are included in the assessment and must be reported to DMAS per the proposal contact instructions.

5.0 PROPOSAL EVALUATION CRITERIA

5.1 EVALUATION OF MINIMUM REQUIREMENTS

DMAS will evaluate the Proposals received in response to this RFP in accordance with the Virginia Public Procurement Act (Va. Code § 2.2-4300, *et seq.*).

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the proposal. Proposals shall comply with the instructions contained throughout this RFP. Failure to comply with the instructions may result in a lower score or elimination from further consideration. Reference Agency Procurement and Surplus Property Manual (APSPM) § 7.3(b). DMAS reserves the right to waive minor irregularities.

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

Signature Sheets:

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

These forms shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section 2.0 before the closing of acceptance of proposals in the number of copies specified.

Additional Condition: Attendance at the Mandatory Preproposal Conference for this RFP as described in Section 2.0.

5.2 PROPOSAL EVALUATION CRITERIA

Offerors must demonstrate an understanding of all of the technical requirements as specified in the RFP. Offerors also must demonstrate that they have the capacity, capability, and relevant experience and expertise to perform the requirements specified in this RFP. Proposals will be evaluated using a numerical scoring system consistent with the following factors:

Factors	Weights
1. Technical Response	85%
a) Corporate Qualifications and Key Staff	
b) System of Care	
c) Relationship Management Approach	
d) Operations & Technology	
e) Readiness Plan	
f) Innovations and Experience with Value-Based Payment Strategies	
2. Past Experience	15%

5.3 NEGOTIATION AND AWARD

After the due date and time of proposal submission, the proposals received in response to the RFP will be screened to ensure compliance with Section 5.1, Evaluation of Minimum Requirements. Evaluators may request further information from Offerors to help determine those fully qualified and best suited. Offerors will be selected based on the strength of their proposals and two or more of the top ranked Offerors for each region will then be selected for negotiations.

During negotiations, the Offerors will go through an extensive readiness review process conducted by DMAS or its designee to evaluate each Offeror's ability to comply with the MLTSS readiness requirements. At a minimum, each readiness review may include a desk review and a site visit to the Offeror's business operations location(s). The Offeror must demonstrate compliance to the readiness review and that the Offeror is ready and able to meet all MLTSS requirements identified in the readiness review prior to the contract execution. In addition, the Offeror must provide DMAS or its designee with any corrected materials requested as part of the readiness review. During the readiness review, the MLTSS capitation rates will be finalized.

After negotiations have been conducted with each Offeror so selected, DMAS shall select the Offerors, in its opinion, which have made the best proposal and provides the best value. DMAS anticipates that it will select no fewer than two (2) Offerors per region. See Section 6.9.2 in the RFP for more details.

Once this determination is finalized, DMAS will post a Notice of Intent to Award (NOIA) to announce the Offerors with which the Department has selected to execute MLTSS Contracts. DMAS reserves the right to award contracts to all, or a subset of, the Offerors.

6.0 TERMS AND CONDITIONS

6.1 CORPORATE

6.1.1 Base of Operations

The Contractor may utilize subcontracts with third party administrators (TPAs) for the purpose of processing claims, “back office,” and other purely administrative functions. All contracts between the Contractor and its chosen TPA must be submitted to the Department for initial approval ten (10) days prior to execution, and then annually or upon amendment thereafter.

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a TPA for additional services beyond those referenced above, or when there is a change in an existing or new TPA relationship. Assurances must include an assessment, performed by an independent Contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard. The Contractor and TPA must provide assurances that all service level agreements with the Department will be met or exceeded. Contractor staff must be solely responsible to the single entity contracted with the Department.

6.1.2 Disclosure of Ownership and Control

The Contractor shall disclose to the Department information on its ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B [42 C.F.R. 455.104, 455.105, 455.106]. The Contractor shall maintain such disclosed information in a manner which can be periodically reviewed by the Department. In addition, the Contractor shall comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A), 42 C. F. R. § 438.610 and 42 C.F.R. § 455.436.

6.1.3 Prohibited Affiliations

The Contractor shall comply with the requirements described in 42 C.F.R. §§ 438.610 and 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at <http://www.cms.gov/smdl/downloads/SMD061208.pdf>).

Consistent with Federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. §§ 455.106 and 438.610, the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal

conviction regarding the Contractor's owner(s) and managing employee(s). Annually, the Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)*.

The Contractor shall require its MLTSS providers and all subcontractors, at the time of application, credentialing, and/or recredentialing, to disclose the required information in accordance with 42 C.F.R. § 455 Subpart B as related to ownership and control, business transactions, and criminal conviction for offenses against Federally related health care programs including Medicare, Medicaid, or CHIP programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any program under Medicare, Medicaid, or CHIP.

6.1.4 D-SNP

The Contractor shall begin operating a D-SNP within two (2) years of being awarded a contract for MLTSS. At DMAS' discretion, failure to comply with this requirement may deem the Contractor non-compliant and subject to MLTSS Contract termination.

6.1.5 Accreditation

The Contractor must adhere to all requirements based on the most current version of NCQA Standards and Guidelines for the Accreditation. The standards categories include: Quality Management and Improvement, Standards for Utilization Management, Standards for Credentialing and Recredentialing, Standards for Members' Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Contractors must adhere to the following timeline of milestones for NCQA Accreditation set forth by the Department and provide documentation upon completion of each milestone:

- Participate in EQRO comprehensive onsite reviews at dates to be determined by the Department.
- Attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to MLTSS members).
- Obtain NCQA accreditation status of at least "Accredited" within 36 months of the onset of delivering care to MLTSS members.

Denial or revocation of NCQA accreditation status or a status of "Provisional" may be cause for the Department to impose remedies or sanctions to include suspension, depending upon the reasons for denial by NCQA.

6.1.6 Provider Agreements

The Contractor must comply with the requirements specified in 42 C.F.R. § 438.214 which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. The Contractor shall utilize credentialing and recredentialing standards outlined by NCQA and in the requirements outlined in the MLTSS Contract for network development and maintenance. The Contractor shall also comply with the requirements detailed at 42 C.F.R. § 455.436, requiring the Contractor to, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE) and other federal databases; (1) at least monthly for its providers, (2) before contracting with providers, and (3) at the time of a provider's credentialing and recredentialing.

The Contractor shall not include in its provider contracts any provision that directly or indirectly prohibits, limits, or discourages network providers, through incentives or other means, from participating as network or non-network providers with any other Contractor participating with the Department for Medicaid and CHIP enrollees.

In accordance with 42 C.F.R. § 438.206, the Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide timely and adequate access to all services covered under the MLTSS Contract.

The Contractor shall not require as a condition of participation/contracting with physicians, etc. in their Medicaid network to also participate in the Contractor's commercial managed care network. However, this provision would not preclude a Contractor from requiring their commercial network providers to participate in their Medicaid provider network.

The Contractor shall not require as a condition of participation/contracting with physicians, etc. in the Medicaid network a provider's terms of panel participation with other Contractors.

The Contractor must require that all providers rendering services under the MLTSS Contract have a National Provider Identifier (NPI) number. The NPI is provided by the CMS which assigns the unique identifier through its National Plan and Provider Enumeration System (NPPES).

The Contractor must have the ability to determine whether providers are licensed or certified by the State and have received the proper certification and/or training necessary to perform the services agreed to under the contract. The Contractor's standards for licensure and certification also shall be included in its participating provider network contracts.

The Contractor shall enter into provider contracts for the provision or administration of covered primary, acute, behavioral health, and LTSS. LTSS services include hospice, NF, EDCD, and Tech Waiver covered services (*individuals enrolled in the DS, ID, and DD Waivers will be enrolled in MLTSS for their acute, behavioral health, pharmacy, and non-LTSS waiver transportation*

services only). EPSDT services are also required. These providers must be reflected in the networks submitted in the format outlined in Attachment C. Provider qualification requirements for MLTSS covered LTSS services can be found in the DMAS regulations and manuals.

Coverage responsibility for behavioral health services shall be the responsibility of the Contractor. There are two categories of covered services: (1) traditional and (2) non-traditional or community behavioral health and substance use treatment services. The Contractor shall cover traditional and non-traditional behavioral health services as defined in Attachment E. Behavioral health service providers must meet DMAS' qualifications as outlined in the most current DMAS behavioral health provider manuals, including the community mental health rehabilitative services, mental health clinic, and psychiatric services provider manuals found at: <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

The Contractor shall contract with the Department's BHSA for the provision of non-traditional services within the Department's established coverage criteria and guidelines until such time that the DMAS BHSA contract expires (no later than November 30, 2018). The Contractor may negotiate either a fully insured risk-based or an administrative services only (ASO) contract for the non-traditional services. The Contractor may also contract with the Department's BHSA for traditional behavioral health services, if the Contractor so chooses. Regardless of the type of contractual arrangement the Contractor establishes with the BHSA, the Contractor shall be at full-risk for all behavioral health services covered as outlined in the MLTSS Contract.

When DMAS' contract with the BHSA expires, the Contractor shall remain responsible for meeting the network adequacy standards and for the provision of the full scope of traditional and non-traditional services covered in the MLTSS Contract. To meet these standards, the Contractor may (1) continue to contract with DMAS' BHSA; (2) contract with a different BHSA; or (3) provide the full scope of required services through the Contractor's own network of behavioral health providers. Upon DMAS notification, the Department will review and approve the Contractor's complete BHSA behavioral health provider network and transition plan.

The Contractor shall manage non-traditional and traditional behavioral health services under the MLTSS Program. The Contractor will contract with DMAS' BHSA for the provision of non-traditional services. This requirement does not: (1) require the Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees (e.g., the Contractor can define the network and use a narrower network of providers as long as it is consistent with and meets the requirements outlined in the MLTSS Contract); (2) preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty (except for mental health case management); or (3) preclude the Contractor

from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

Residential Treatment Center (RTC) services are administered through the Department's BHSA for fee-for-service individuals. Any child admitted to an RTC will be temporarily excluded from MLTSS until after they are discharged. The Department is currently restructuring the RTC services. At the completion of this restructure, RTC services will be transitioned to the MLTSS Program and the Contractor (depending on the timing, the Department may require that the Contractor provide coverage for RTC services through DMAS' BHSA until that contract expires).

To alleviate emergency department visits, Contractors shall be required to have a network of providers to cover after-hours urgent care services for members. Transportation to these services shall be required if medically necessary.

The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in trauma informed care and working with the medical/psychiatric aspects of caring for survivors and perpetrators of physical abuse, neglect, trauma, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of abuse, neglect and domestic violence.

The Contractor shall cover emergency, urgent, and non-emergency transportation services to ensure that members have necessary access to and from Medicaid-covered services in a manner that seeks to ensure the member's health, safety, and welfare. Per 12 VAC 30-50-530, modes of transportation include, but are not limited to, emergency and non-emergency air ambulance, emergency and non-emergency ground ambulance, public transit, stretcher vans, wheelchair vans, mini-vans, sedans, taxis, and volunteer drivers. With prior approval, family and friends shall also be able to transport members and receive gas reimbursement. The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatments set forth in 42 C.F.R. § 440.170(a). Transportation for covered waiver services shall be provided door-to-door when indicated. At times, covered Medicaid services may include transportation services to and from out-of-state medical facilities for treatment that is not available in Virginia and is approved in advance by the Contractor, DMAS agents, or DMAS' Medical Support Unit. The Contractor must honor authorizations (as will be outlined in the MLTSS Contract) in place for out-of-state treatment, including transportation services. The Contractor shall maintain an adequate transportation network to cover all approved transportation requests. The Contractor is encouraged to enter into contracts with taxis and commercial carriers as well as public agencies, non-profit and for-profit private agencies, and public carriers.

6.2 SYSTEM OF CARE

6.2.1 Covered Services

Contractor must have care managers and staff familiar with all carved out services including ID, DD, and DS Waiver services. The Contractor must have the ability to refer and communicate with DMAS, DBHDS, waiver services provider staff, and other formal and informal supports to ensure coordination of care. The Contractor must ensure that the carved out services are included in the Individualized Care Plan (ICP) in order to most effectively coordinate services for the individual. See Attachment B and applicable provider manuals available on the DMAS web portal at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal> for additional information on each of these waivers and services.

During the course of the MLTSS Contract, DMAS reserves the right to change the populations and/or services included in the program on a statewide or pilot basis. For example, DMAS may transition the ID/DD/DS Waiver services, ICF/ID or psychiatric residential treatment level C (PRTC) services into the MLTSS program when the redesign of these systems/services is complete.

The Contractor shall assume responsibility for all covered medical conditions of each member as of the effective date of coverage under the MLTSS Program, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions. MLTSS members will be exempt from cost sharing other than for any patient pay established by DSS towards LTSS services.

6.2.2 Prenatal and Postpartum Services

The Contractor shall cover prenatal and postpartum services to pregnant enrollees, in accordance with 12 VAC 30-50-280 and 12 VAC 30-50-290.

6.2.3 Early Intervention (EI)

The Contractor shall cover early intervention services, in accordance with EI coverage criteria and guidelines in 12 VAC 30-50-131 and the Early Intervention [Program Manual](#) (billing codes and coverage criteria).

EI services, authorized through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d), will be covered under MLTSS. Children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay are eligible for EI services. EI services are designed to address developmental delay in one or more areas (physical, cognitive, communication, social or emotional, or adaptive). EI services are provided in accordance with the child's Individualized Family Service Plan (IFSP), developed by the

service provider, which addresses the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family centered treatment. Services are performed by EI certified providers in the child's natural environment, to the maximum extent possible. Natural environments can include the child's home or a community based setting in which children without disabilities also participate.

6.2.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

In accordance with 42 C.F.R. § 441 Subpart B (Sections 50 – 62), the EPSDT program is Medicaid's comprehensive and preventive child health benefit for individuals under the age of 21. Contractors will be responsible for providing EPSDT services. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and includes periodic screening, vision, dental, and hearing services and other support services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to the child to correct, maintain or ameliorate a condition, even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan. Additional information regarding EPSDT can be found in the [EPSDT Manual](#) on the DMAS website and the [CMS website](#).

Medicaid children who are denied services that do not meet the Contractor's general coverage criteria must receive a secondary review to ensure that the EPSDT provision has been considered. The Contractor's secondary review process for medical necessity must consider the EPSDT criteria that services correct, maintain (prevent the condition from worsening or causing additional problems) or ameliorate the condition for which they are prescribed. The Department must approve the Contractor's second review process for EPSDT prior to implementation or when requested by DMAS. Denial for services to children cannot be given until this secondary review has been completed

6.2.5 Private Duty Nursing (PDN) Services for Children under Age 21

The Contractor shall cover medically necessary PDN services for children under age 21, in accordance with the Department's criteria described in the DMAS EPSDT Manual, and as required in accordance with EPSDT regulations described in 42 C.F.R. §§ 441.50, 440.80, and the Social Security Act §§1905(a) and 1905(r) I. Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing which provides for short-term, intermittent care where the emphasis is on member or caregiver teaching. Under EPSDT PDN, the individual's condition must warrant continuous nursing care, including but not limited to, nursing level assessment, monitoring, and skilled interventions.

Examples of individuals that may qualify for PDN coverage include, but are not limited to those with health conditions requiring: tube feedings or total parenteral nutrition (TPN); suctioning;

oxygen monitoring for unstable saturation levels; catheterizations; blood pressure monitoring (i.e., for autonomic dysreflexia); monitoring/intervention for uncontrolled seizures; or nursing for other conditions requiring continuous nursing care, assessment, monitoring, and intervention. Another example of individuals who may qualify for PDN includes members waiting to be screened for the Tech Waiver. The Contractor shall use the Department's criteria, as described in the DMAS EPSDT Manual, when determining the medical necessity for PDN services. The Contractor may use an alternate assessment instrument which must be approved by the Department; however, the Department's established coverage guidelines must be used as the basis for the amount, duration, and scope of the PDN benefit.

6.2.6 Services for Foster Care and Adoption Assistance Children

The Contractor shall cover services for children in foster care and those that receive adoption assistance if they meet the MLTSS eligibility criteria outlined in the MLTSS Contract. Coverage must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, including services that are accessed out of the Contractor's service area, Foster Care and Adoption assistance children shall be considered one of the MLTSS vulnerable Sub-populations. Reference the "*Model of Care Assessment and Individualized Care Plan Expectations*" table for further guidance on assessment, reassessment, and ICP development timelines. The Contractor shall work collaboratively with DMAS and Departments of Social Services in meeting the federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care.

6.2.7 Process for Foster Care and Adoption Assistance Children Enrolled in MLTSS

The Contractor shall cover services for MLTSS enrolled foster care and adoption assistance children (aid category designation codes 076 and 072, respectively).

- For decisions regarding the foster care child's medical care, the Contractor may work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance child's medical care, the Contractor shall work directly with the adoptive parent.
- The social worker will be responsible for all changes to Contractor enrollment for foster care children. The adoptive parent will be responsible for all changes to Contractor enrollment for adoption assistance children. An enrollment change can be requested at any time that the child is placed in an area not serviced by the Contractor.
- Out of network coverage shall not be limited to emergency services and must extend to all medically necessary services, including EPSDT or required evaluation, and treatment services of the foster care program.

- If the Contractor finds that the foster care child has been placed in an area other than the one where the Contractor participates, the Contractor may contact the social worker to request a change in MLTSS Contractor.
- The Contractor must work with DSS in all areas of care coordination.
- Foster care children are not restricted to their Contractor selection following the initial 90 day enrollment period, as outlined in the MLTSS Contract.

Regardless of the reasons described above, if a child moves out of the service area, the child remains the responsibility of the Contractor for all contractually covered services until disenrollment occurs.

6.2.8 LTSS Provided Through the Elderly or Disabled with Consumer-Direction (EDCD) and Technology Assisted (Tech) Waivers

The Contractor shall cover all services provided through the EDCD and Tech Waivers for individuals who are enrolled in these waivers (see Attachment E).

The EDCD Waiver covers a range of community support services to individuals who are elderly or who have a disability and would otherwise require a nursing facility level of care. EDCD Waiver services include: adult day health care, personal care (agency and consumer-directed), personal emergency response systems and medication monitoring, respite care (agency and consumer-directed), transition services, and transition coordination. See 12 VAC 30-120-900 through 12 VAC 30-120-995 and the EDCD Waiver provider manual available on the DMAS web portal at www.virginiamedicaid.dmas.virginia.gov for additional information on the EDCD Waiver.

Individuals enrolled in the Tech Waiver are chronically ill or severely impaired, have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care to avert further disability or death. Tech Waiver services include: skilled private duty nursing (RN and LPN), skilled respite care, assistive technology, environmental modifications, agency-directed personal care (participants must be 21 years of age or older) and transition services. The Tech Waiver uses different qualifying criteria for adults and children (<21 years of age). Everyone enrolled in the Tech Waiver must receive skilled private duty nursing services. Skilled private duty nursing services and skilled respite care services can be provided as either individual or congregate services. See 12 VAC 30-120-1700 through 12 VAC 30-120-1770 and the Tech Waiver provider manual available on the DMAS web portal at www.virginiamedicaid.dmas.virginia.gov for additional information on the Tech Waiver.

6.2.9 Behavioral Health Services

Coverage responsibility for behavioral health services including mental health and substance use disorder (SUD) services shall be the responsibility of the Contractor. There are two

categories of behavioral health covered services: (1) traditional and (2) non-traditional and these cross inpatient (acute and subacute), outpatient, and community based levels of care.

The Contractor shall cover traditional mental health services and traditional and non-traditional SUD services as outlined in Attachment E, including: inpatient (acute and subacute), outpatient (individual, family, and group), temporary detention orders, and emergency custody order services. The Contractor may propose to establish its own medical necessity criteria for behavioral health services. The contractor's medical necessity criteria shall be consistent with Federal, State, and DMAS program guidelines. The contractor's SUD criteria shall be consistent with the American Society for Addiction Medicine (ASAM) criteria. As provided in 42C.F.R. 438.2.10 (a)(4)(i), the Contractor's medical necessity criteria shall not be more restrictive than DMAS' criteria. Contractors shall ensure that they comply with the Mental Health Parity Act and that services meet Federal EPSDT coverage requirements.

Furthermore, as outlined in the requirements of this RFP, the Contractor shall contract with the Department's BHSa for the provision of non-traditional mental health services within the Department's established coverage criteria and guidelines (see Attachment E) until such time that the DMAS BHSa contract expires. When the DMAS contract with the BHSa expires, the Contractor shall continue to be responsible for the full scope of behavioral health services, as part of the MLTSS contract, whereby the Contractor may manage these services in-house or through the Contractor's contracted behavioral health services administrator. DMAS reserves the right to review and approve the Contractor's in-house services or subcontracted behavioral health services administrator agreement to ensure necessary services are provided and are seamless when the DMAS' contract with the BHSa expires.

The Contractor shall also provide coverage for transportation and pharmacy services necessary for the treatment of **all** behavioral health conditions. As will be addressed in the MLTSS Contract, the Contractor and the BHSa shall work together to coordinate services in a manner that fully supports timely access to appropriate person-centered services through a seamless continuum of care that is based on the individual clinical needs of the member. The Contractor shall also work with the Department and the BHSa on SUD system transformation initiatives to improve benefits and service delivery of behavioral health services per the MLTSS Contract.

6.2.10 Medicaid Substance Use Disorder (SUD) Services

DMAS is working in collaboration with CMS, DBHDS, VDH, DHP, [the Governor's Task Force on Prescription Drug and Heroin Abuse](#), and community stakeholders to improve Virginia Medicaid service benefits and delivery systems for individuals with SUD. Through the SUD initiative DMAS has identified key areas for SUD reform, especially in relation to SUD benefits, coverage criteria, provider requirements and capacity, and reimbursement strategies that reward quality outcomes, and features necessary to ensure high quality and program integrity. Virginia SUD

system goals include ensuring that a sufficient continuum of care is available to effectively treat SUD.

The Contractor shall implement all SUD system requirements and improvements as directed by DMAS. The Contractor shall work with DMAS and interested stakeholders to ensure that the Contractor's SUD system is fully implemented as outlined in the MLTSS Contract.

6.2.11 Critical Elements of the Contractor's SUD System of Care

- 1. Comprehensive Evidence-based Benefit Design:** The Contractor's SUD system of care shall include recognized best practices in the SUD field, including a robust array of services and treatment methods to address the immediate and long-term physical, mental and SUD care needs of the individual. The Contractor's system of care shall include recognized best practices in the SUD field, including screening, brief interventions, and referral to treatment (SBIRT) for substance use problems, withdrawal management, medication assisted treatment (MAT), care coordination, and long-term recovery services and supports. The Contractor's SUD benefit design shall also include support services from qualified, Certified Peer Providers who are certified by DBHDS and services as defined by DMAS. The Contractor shall provide coverage for services at the most appropriate level of care, including in licensed SUD acute and subacute treatment facilities. DMAS is also pursuing delivery opportunities for short-term acute and residential SUD treatment in a substance abuse treatment facility that meet CMS' definition of an institution for mental disease (IMD), as defined in 42 C.F.R. § 435.1010, for adults age 21-64. As directed by DMAS, the Contractor shall also provide coverage in IMD settings as appropriate for individuals between the ages of 21 through 64. These coverage rules will be further defined in the MLTSS Contract.
- 2. Appropriate Standards of Care:** The Contractor's SUD coverage criteria shall be consistent with the American Society for Addiction Medicine (ASAM) criteria.
- 3. Strong Network Development Plan:** The Contractor's SUD network shall ensure member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care.
- 4. Care Coordination Design:** The Contractor shall ensure seamless transitions and information sharing between varied levels and settings of care, consistent with federal and state confidentiality requirements.

5. **Integration of Physical Health and SUD:** The Contractor shall implement viable strategies for coordinating physical health, including primary care, behavioral health, and pharmacy services to implement a fully integrated care model.
6. **Program Integrity Safeguards:** The Contractor shall ensure that its SUD providers enter into participation agreements pursuant to 42 C.F.R. § 431.107, and that there is a process in place to address billing, clinical concerns, and other compliance issues.
7. **Benefit Management:** The Contractor shall work collaboratively with the Department's BHSA Contractor to accomplish the DMAS SUD benefit management strategy, to demonstrate compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), and to coordinate services in a manner that fully supports timely access to appropriate person-centered services through a seamless continuum of care that is based on the individual clinical needs of the member.
8. **Community Integration:** The Contractor shall ensure compliance with CMS established person-centered planning and community based setting requirements in its service planning and service delivery efforts including for SUD benefits.
9. **Strategies to Address Prescription Drug Abuse and Opioid Use Disorder:** The Contractor's system of care shall include on-going efforts to train its health care providers regarding best practices for opioid prescribing, pain management, use of Virginia's Prescription Monitoring Program (PMP), and identification and treatment of individuals at risk of substance abuse through screening, intervention, and referral tools.
10. **Services for Adolescents and Youth with SUD:** The Contractor shall ensure timely access to the full scope of coverage available to children under age 21, pursuant to the EPSDT benefits.
11. **Reporting of Quality Measures:** The Contractor shall have a comprehensive strategy in place to collect, maintain, and report the quality measures for SUD as required by CMS, DMAS and DMAS' evaluation contractor. These requirements will be further described in the MLTSS Contract.
12. **Collaboration with DMAS, DBHDS, and Interested Stakeholders:** The Contractor shall work collaboratively with DMAS, DBHDS, providers, DMAS contractors, relevant local, state, tribal, and social services agencies and other interested stakeholders to provide the

infrastructure to support successful SUD treatment and to ensure that the Contractor's SUD system is fully implemented as outlined in the MLTSS Contract.

13. **Implementing Innovative Payment Models:** The Contractor shall work with SUD providers to develop and implement SUD value-based payments that drives high-quality care and improves member outcomes.

6.2.12 Interventions to Prevent Controlled Substance Use

The Contractor must submit an annual report that describes its interventions targeted to prevent controlled substance use. The report must describe actions taken by the Contractor to prevent the inappropriate use of controlled substances, including but not limited to, any clinical treatment protocols, a detailed definition of what, if any substances the Contractor targets that are not scheduled substances under the Controlled Substances Act (21 U.S.C. § 801 et seq.) but may place an individual at higher risk for abuse, authorization requirements, quantity limits, poly-pharmacy considerations, and/or related clinical edits.

6.2.13 Prescription Drugs and Formularies

The Contractor shall be responsible for covering all Food and Drug Administration (FDA) approved drugs for members, as set forth in 12 VAC 30-50-210, and in compliance with § 38.2-4312.1 of the *Code of Virginia*. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of §1927 of the Social Security Act (OBRA 90 §4401), shall not be covered.

The Contractor is required to maintain a formulary to meet the unique needs of the members they serve; at a minimum, the Contractor's formulary must follow the DMAS Preferred Drug List (PDL) available at <https://www.virginiamedicaidpharmacyservices.com>. The Contractor can add additional medications to their formulary in each drug class but their formulary must include all medications included on the DMAS PDL as "preferred drugs." Members cannot be required to try other drugs on the Contractor's formulary before being prescribed the "preferred drug" from the DMAS PDL.

The DMAS PDL is not an all-inclusive list of medications for DMAS members. Contractors are required to cover all medically necessary, clinically appropriate, and cost-effective medications that are federally reimbursable.

The Contractor's formulary must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee. The Contractor must submit their formulary to DMAS annually after review by its P&T Committee and inform DMAS of changes to their formulary by their P&T Committee.

The Contractor must have an updated link to their formulary available on their website.

The “preferred drugs” included on the DMAS PDL may still be subject to edits, including, but not limited to, service authorization requirements for clinical appropriateness as determined by the DMAS P&T Committee. The Contractor shall assure that access to all “preferred drugs” from the DMAS PDL is no more restrictive than the DMAS PDL requirements applicable to the “preferred drug” and that no additional service authorization criteria or clinical edits are applied. In addition, the Contractor must comply with the CMS requirement that health plans may not use a standard for determining medical necessity for a “preferred drug” that is more restrictive than is used in the state plan.

If DMAS makes any changes to the PDL at P&T Committee meetings or between meetings, the Contractor will have 60 days after notification of the changes to the PDL to comply with the DMAS changes.

The Contractor may not impose co-payments on any medications.

The Contractor shall have in place procedures to ensure continuity of care for members with established pharmacological treatment regimens. The Contractor shall ensure that members can continue treatment of any medications prescribed or authorized by DMAS or another Contractor (or provider of service) for at least ninety (90) days or through the expiration date of the active service authorization. This would not preclude the health plan from working with the individual and his treatment team to resolve polypharmacy concerns.

The Contractor shall have in place authorization procedures to allow providers to access drugs outside of the formulary, if medically necessary. This includes medications that are not on the Contractor’s formulary, and especially in relation to the Attention-Deficit/Hyperactivity Disorder (ADHD) class of medications (e.g., safeguards against having individuals go back through the Contractor’s step therapy program when pre-authorizations end). The Contractor shall follow prior authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2 and incorporate the requirements into its provider contracts.

The Contractor may require service authorization as a condition of coverage or payment for a covered outpatient drug. The Contractor shall follow service authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2 and comply with the requirements for prior authorization for covered outpatient drugs in accordance with section 1927 of the Social Security Act. The Contractor will incorporate the requirements into its provider contracts.

If the Contractor denies a request for service authorization, the Contractor must issue a Notice of Action within 24 hours of the denial to the prescriber and the member. The Notice of Action must include appeal rights and instructions for submitting an appeal in accordance with the requirements outlined in the MLTSS Contract.

Pharmacy services that are denied for children must comply with EPSDT requirements as outlined in the MLTSS Contract.

If needed, a 72-hour emergency supply of a covered pharmacy service shall be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in his/her professional judgement consistent with the current standards of practice, determines that the member's health would be compromised without the benefit of the drug.

The Contractor must have policies and procedures for general notifications to participating providers and member of revisions to the formulary and service authorization requirements. Written notification for changes to the formulary and service authorization requirements and revisions must be provided to all affected participating providers and members at least 30 calendar days prior to the effective date of the change.

The Contractor shall have a P&T Committee that serves in an evaluative, educational and advisory capacity to the Contractor's staff and participating providers in all matters including, but not limited to, the pharmacy requirements of the MLTSS Contract and the appropriate use of medications. Membership of the P&T Committee must include (i) a representative of DMAS, (ii) a provider licensed in the Commonwealth as a psychiatrist, (iii) a physician whom specializes in care for the aging and (iv) Virginia licensed pharmacist with expertise in the clinically appropriate dispensing and monitoring of covered outpatient drugs. The Contractor shall require all members of the P&T Committee to complete a financial disclosure form annually.

The Contractor will be responsible for developing and maintaining Drug Utilization Review (DUR) programs including prospective and retrospective DUR that will comply with §1927 of the Social Security Act.

The Contractor must exclude coverage for the following:

- Drugs used for anorexia or weight gain;
- Drugs used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
- DESI (Drug Efficacy Study Implementation) drugs considered by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
- Drugs which have been recalled;
- Experimental drugs or non-FDA-approved drugs; and

- Drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate Program.

The Contractor shall implement a MTM program. The MTM program shall include participation from community pharmacists, and include in-person and/or telephonic interventions with trained pharmacists.

Reimbursement for MTM services provided by participating pharmacists shall be separate and above dispensing and ingredient cost reimbursement.

The Contractor's MTM program shall be developed to identify and target members who would most benefit from these interactions.

6.2.14 Dental and Related Services

Under MLTSS, DMAS' contracted dental benefits administrator (DBA) will continue to cover diagnostic, preventive, restorative/surgical procedures, for MLTSS children and pregnant women as well as orthodontia services for MLTSS children. The DBA also will provide coverage for limited medically necessary oral surgery services for adults (age 21 and older). (see http://www.dmas.virginia.gov/Content_pgs/dnt-home.aspx). However, the Contractor shall be responsible for transportation and medication related to covered dental services.

In addition, the Contractor shall be responsible for medically necessary procedures for adults and children, including but not limited to, the following:

- CPT codes billed for dental services performed as a result of an accident.
- Medically necessary procedures, including but not limited to, preparation of the mouth for radiation therapy; maxillary or mandibular frenectomy when not related to a dental procedure; orthognathic surgery to attain functional capacity; and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.
- Coverage for anesthesia and hospitalization for medically necessary dental services.
- In accordance with § 38.2-3418.12 of the *Code of Virginia*, the Contractor shall cover anesthesia and hospitalization services when deemed medically necessary to effectively and safely provide dental care. The Contractor shall work with the DMAS DBA to coordinate coverage for these services.
- Coverage is required for children under the age of 5, persons who are severely disabled, and persons who have a medical condition that requires admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the member's treating physician that such services are required to effectively and safely provide dental care. The Contractor shall honor anesthesia and hospitalization

authorizations for medically necessary dental services as determined by the DMAS DBA and as further defined in the MLTSS Contract.

At their option, the Contractor may cover routine and preventive dental services for adults as an enhanced benefit.

6.2.15 Telemedicine Services

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. Telemedicine may also include 'store and forward' technology, where digital information, (such as an X-ray) is forwarded to a professional for interpretation and diagnosis. The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access to and/or enhance existing services, and increase timely interventions. The Contractor also shall encourage the use of telemedicine to promote community living and improve access to health services.

The decision to participate in a telemedicine encounter will be at the discretion of the enrollee and/or their authorized representative(s), for which informed consent must be provided, and all telehealth activities shall be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and DMAS program requirements. Covered services include:

- Store and Forward Applications: The Contractor may also reimburse for Store and Forward Applications, including but not limited to: (1) tele-dermatology; (2) tele-radiology; and, (3) tele-retinal imaging to assess for diabetic retinopathy.
- The ability to cover remote patient monitoring, especially for enrollees with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases or the need for anticoagulation. Examples of remote patient monitoring activities include transferring vital signs such as weight, blood pressure, blood sugar, and heart rate.
- The ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the enrollee's primary care physician.

All telemedicine services shall be provided in a manner that meets the needs of vulnerable populations and consistent with integrated care delivery.

6.2.16 Medical Necessity

The Contractor shall provide services to enrollees in accordance with medical necessity requirements set forth in 42 C.F.R. 438.210, Coverage and Authorization of Services. The Contractor's medical necessity criteria shall be no more restrictive than the State Medicaid

program as indicated in state statutes and regulations, State Plan, and other State policy and procedures, including all DMAS Program Memos and Manuals.

- The Contractor's medical necessity guidelines, program specifications and service components for services must, at a minimum, be submitted to DMAS annually for approval no later than 30 days prior to the start of a new Contract Year, and no later than 30 days prior to any change.
- LTSS shall be provided to support a participant in their ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The Contractor shall cover appropriate LTSS based on needs identified through the Uniform Assessment Instrument (UAI), other comprehensive assessments, and subsequent level of care evaluations, as specified in DMAS regulations and program manuals.

6.2.17 Continuity of Care Provisions

To ensure there is no interruption of covered services for enrollees, the Contractor must develop policies and procedures to ensure continuity of care for all enrollees that include the information below. During the time period set below, the Contractor shall maintain the enrollee's current providers at the Medicaid FFS rate and honor service authorizations (SAs) issued prior to enrollment for the specified time period.

Current Providers: The Contractor must allow an enrollee to maintain his or her current providers (including out-of-network providers) for 90 days. During the 90-day transition period, the Contractor may change an enrollee's existing provider only in the following circumstances: (1) the enrollee requests a change; (2) the provider chooses to discontinue providing services to an enrollee as currently allowed by Medicaid; (3) the Contractor or DMAS identify provider performance issues that affect an enrollee's health or welfare; or (4) the provider is excluded under state or federal exclusion requirements.

Within the first 90 days of an enrollee's membership with a Contractor, the Contractor shall make reasonable efforts to contact out-of-network providers who are providing services to enrollees during the initial continuity of care period, and provide them with information on becoming credentialed, in-network providers. If the provider does not join the network, or the enrollee does not select a new in-network provider by the end of the 90-day period, the Contractor shall choose one for the enrollee (with the exception of NF residents). The Contractor must offer single-case agreements to providers who are not willing to enroll in the Contractor's provider network and under special circumstances that will be outlined in the MLTSS Contract.

Individuals in NFs at the time of MLTSS enrollment may remain in that NF as long as they continue to meet DMAS criteria for nursing facility care, unless they or their families prefer to

move to a different NF or return to the community. The only reasons for which the Contractor may require a change in NF is if (1) The Contractor or DMAS identify provider performance issues that affect an enrollee's health or welfare; or (2) the provider is excluded under state or federal exclusion requirements.

When it is determined that a NF is not able to safely meet the needs of an enrollee (e.g., due to dangerous behaviors) or because the enrollee no longer meets the NF level of care requirement, the Contractor shall continue to pay the facility until the member is transitioned to a safe and alternate placement.

In the event of a NF closure, or as necessary to protect the health and safety of residents, the Contractor shall arrange for the safe and orderly transfer of all Enrollees and their personal effects to another facility. In addition to any notices provided by the facility, the Contractor shall provide timely written notice inclusive of the required elements in C.F.R. 483.75 (r) and work cooperatively with the Department of Social Services including the local departments of social services, the Long Term Care Ombudsman and other state agencies in arranging the safe relocation of residents. The care manager shall coordinate the relocation plan and act as a resource manager to other agencies and as a central point of contact for Enrollee relocations.

Service Authorizations (SA): The Contractor shall honor SAs issued by the Department or its Contractors as provided through DMAS transition reports and DMAS' contracted entities for the duration of the SA or for 90 days from enrollment, whichever comes first.

If, as a result of the HRA and ICP development, the Contractor proposes modifications to the enrollee's SAs, the Contractor must provide written notification to the enrollee and an opportunity for the enrollee to appeal the proposed modifications.

The Contractor shall transfer SA, HRA, ICP, and other pertinent information necessary to assure continuity of care to another Contractor, to DMAS, or its designated entity for enrollees who transfer to another Contractor or back to Fee-For-Service. The information shall be provided within three (3) business days from receipt of the notice of disenrollment to the Contractor in the method and format specified by DMAS. The Contractor shall work with the Department to develop and implement an automated process for sharing and honoring SAs for members who transition between the fee for service and MLTSS programs and from one MLTSS contractor to another. The Contractor shall share the necessary data in a HIPAA compliant format as directed by DMAS.

6.2.18 Member Healthy Incentives

The Contractor may offer non-cash incentives or discounts to their enrolled members for the purposes of rewarding healthy behaviors (e.g., immunizations [EPSDT, flu, shingles, pneumonia, etc.], prenatal visits, provider visits, or participating in disease management, HEDIS or HEDIS

related measures/activities, etc.). The Contractor shall also ensure that incentives are made available in equal amount, duration, and scope to the Contractor's membership in all localities served. Incentives shall be limited to a value of no more than \$50.00 for each medical goal, unless otherwise approved by DMAS. Incentives over \$50.00 per medical goal must be approved by DMAS prior to implementation; DMAS reserves the right to deny healthy incentive initiatives that do not align with DMAS or CMS policy. Non-cash incentives may include gift cards or discounts for services. The Contractor must have assurances that gift cards cannot be redeemed by the business (Wal-Mart, Target, etc.) for cash; cash incentives are not permitted.

Annually the Contractor shall report its healthy incentives plan annually and prior to implementation of new initiatives, including the various incentives that will be offered to its members. The report must describe how the Contractor will measure the success of the incentives offered and shall provide anticipated outcomes and return on investment. The Contractor shall maintain a database and track incentives by member and must provide information to the Department upon request. Additionally, as part of the Contractor's annual report to DMAS, the Contractor shall report the value /impact of the Contractor's healthy incentive initiatives on member health outcomes.

6.2.19 Enhanced Benefits

Enhanced benefits offered by Contractors will be listed in the Department's MLTSS comparison charts. Comparison charts are revised once annually. Any changes to enhanced services occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Revisions to enhanced services shall be made only at open enrollment. However, the Contractor may revise enhanced services at any date, if the Contractor accepts the cost of revising and printing comparison charts.

The Contractor must be able to provide to the Department, upon request, data summarizing the utilization of and expenditures for enhanced benefits provided to enrollees during the contract.

The Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to the member except for additional health-related services which have been added by the Contractor and approved by the Department.

DMAS strongly encourages Contractors to work with Department of Aging & Rehabilitative Services (DARS) to cover innovative services like the Chronic Disease Self-Management Program ([CDSMP](#)), as it aligns with the Department's priorities to empower individuals to take steps to improve their overall health and maintain an active and fulfilling lifestyle.

6.2.20 State Plan Substituted Services (In Lieu of Services)

After prior written approval by DMAS, non-state plan services may be offered by the Contractor as substitutes (in lieu of) for state plan services, if the substituted service will achieve the same outcome for the member at a lower cost than the covered state plan service (e.g., services in a free standing psych facility in lieu of a psychiatric unit in an acute care hospital for adults age 21-64). The Contractor cannot require that members use state plan substituted (in lieu of) services over state plan services, but the Contractor can provide these services as an option to members. The Contractor must provide to the Department a justification for utilization of substitute services and data summarizing the utilization of and expenditures for substitute services provided to members during the contract year for rate setting purposes.

6.2.21 Model of Care

The Contractor shall ensure that members have ready access (e.g., a telephone number, e-mail address) to their care manager. If the care manager is not available to the member, the care manager shall be notified by the next business day of any issues/changes/concerns of the member (this includes contacts from the member, their representative, or providers made through a member support line, 24-hour nurse/behavioral health crisis lines, etc.).

The Contractor shall be responsible for appropriately training care managers and verifying that training or any certifications remain current. The Contractor must have policies in place to address non-compliance with training by care managers.

In circumstances where individuals receive TCM services, care coordination provided by the MLTSS Contractor and the TCM provider shall be collaborative with clearly delineated responsibilities and methods of sharing important information between the Contractor and the TCM provider (e.g., conference calls, e-mails, document sharing, face-to-face meetings). TCM is separate from care coordination and they shall work in concert for individuals receiving both services. For example, to the greatest extent possible, the Contractor shall include the TCM provider in the development of, revisions to, and maintenance of Individualized Care Plans (ICPs). Furthermore, to the greatest extent possible, the Contractor also shall include the TCM provider in Interdisciplinary Care Teams (ICTs).

Training

The Contractor shall be responsible for appropriately training care coordinators and verifying that training or any certifications remain current. The Contractor must have policies in place to address non-compliance with training by care coordinators.

The Contractor's staff (as identified by DMAS) shall participate in DMAS sponsored training at DMAS's discretion. DMAS reserves the right to have representatives attend the Contractor's staff MOC trainings.

Provider Network having Specialized Expertise in the MLTSS Population and Use of Clinical Practice Guidelines and Protocols

Contractor shall monitor and ensure that network providers providing services to EDCD, and Tech Waiver participants comply with the provider requirements as established in the DMAS provider manuals available at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal> and the following regulations:

- a. EDCD Waiver: 12VAC30-120-900 through 12VAC30-120-995 and
- b. Tech Waiver: 12VAC30-120-1700 through 12VAC30-120-1770.

For EDCD and Tech Waiver participants, Contractor shall comply with regulations regarding service levels for Personal Care and Private Duty Nursing and shall incorporate into the plan for services (12VAC30-120-924 and 12VAC30-120-1720).

Assessments

Contractor shall meet the requirements for HRA compliance. Simply completing the screening tool does not meet the requirements.

The qualifications of Contractor personnel who conduct the HRAs must meet the qualifications of care coordinators.

When the Contractor conducts HRAs by phone interview for the community well population, consent must be audio recorded and made available to DMAS upon request.

DMAS will require specific elements to be included in the Contractor HRAs and the Contractor shall be expected to report specific data elements from the HRAs in a format and frequency specified by DMAS in the MLTSS contract.

- a. The Contractor must incorporate pertinent information from the Minimum Data Set (MDS) into HRAs for individuals residing in nursing facilities. Information from the MDS Section Q must be included, in addition to separate documentation of the enrollee's interest and desire for transition to the community and available resources and barriers to doing so.
- b. The Contractor must incorporate pertinent information from the Uniform Assessment Instrument (UAI)¹¹, when available, into HRAs for individuals enrolled in the EDCD and Tech Waivers.

¹¹ The UAI may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/forms/032-02-0168-01-eng.pdf and the UAI User's Manual may be found at http://www.dss.virginia.gov/files/division/dfs/as/as_intro_page/manuals/uai/manual.pdf. Pre-admission screening criteria is available in the Preadmission Screening manual at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

The annual LOC reassessment for individuals who are in the EDCD or Tech waivers must include all the elements on the DMAS 99 (LOC Review Instrument). The annual LOC reassessment for pediatric Tech waiver participants must also include all the elements on the DMAS 109 (Technology Assisted Waiver Pediatric Referral Form); and the annual LOC reassessment for adult Tech waiver participants must also include all the elements on the DMAS 108 (Technology Assisted Waiver Adult Referral Form) LOC reassessments must be performed by qualified Contractor staff or Contractor's sub-contractors as specified by DMAS.

Contractor shall submit the annual LOC and reassessment LOC data and results for Waiver participants within the timeframe and the format specified by DMAS.

ICP

Prior to or during ICP development, the Contractor must ensure the care manager gathers advance directive information in accordance with Federal advance directives requirements set forth in 42 C.F.R. § 422.128. This includes educating the enrollee about advance directives, and obtaining any advance directive documentation and filing them in the enrollee's file. The status of advance directives must be reviewed during reassessments and with a significant change in health or functional status and shall be included in the ICP.

When the Contractor conducts the ICT and develops the ICP by phone for the community well population, agreement must be audio recorded and made available to DMAS upon request.

The Contractor shall ensure that ICPs for Tech Waiver members are implemented in compliance with *Model of Care Assessment and Individualized Care Plan (ICP) Expectations* table. The Contractor must honor all existing plans of care and existing service authorizations (SAs) until the authorizations ends or 90 days from enrollment, whichever is sooner. The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA; services must be continued until the HRA has been completed and the ICP has been developed.

Care Coordination

Care Coordinators must:

1. Be locally/regionally based (e.g., care managers cannot be in other states, regions) and cannot perform care coordination only by phone.
2. Be available to meet with members face-to-face as needed
3. Act as the primary point of contact for members and the ICT.
4. Execute the following responsibilities:
 - (1) participate in the HRA process
 - (2) lead ICT meetings and facilitate communications among relevant parties
 - (3) monitor the provision of services as outlined in the ICP and achievement of desired outcomes.

- (4) assess for appropriate changes or additions to services, facilitate referrals for the members, and ensure the ICP is updated as necessary
- (5) ensure that appropriate mechanisms are in place to receive enrollee input.
- (6) ensure member complaints and grievances are submitted according to the policies and procedures
- (7) actively participate during care transitions

At a minimum, the Contractor shall provide the following to members: (i) a single, toll-free for assistance; (ii) development, maintenance, and monitoring of the ICP; (iii) facilitate referrals that result in timely appointments; (iv) communication and education regarding available services and community resources in a mode and manner that is culturally and developmentally appropriate and considers the enrollee's physical and cognitive abilities and level of literacy; and (v) assistance developing self-management skills to effectively access and use services.

The Contractor shall communicate with members about their ongoing or newly identified needs on at least a monthly basis (or a frequency as requested by the member), to include a phone call or face-to-face meeting, depending on the individual's needs and preferences. For LTSS members, contact shall be at a frequency of at least every 90 days, even if the member requests less frequent contact.

Robocalls or automated telephone calls that deliver recorded messages are not an acceptable form of contacting individuals.

Care coordinator caseload ratios shall be finalized during the readiness review process and will be included in the MLTSS Contract. Contractors shall be accountable for maintaining these caseload ratios. DMAS reserves the right to require adjustments to the caseload ratios at any time based on the needs of the MLTSS members, the program requirements, Contractor performance, and at any time the Department determines that the Contractor does not have sufficient care coordination staff to properly and timely perform the requirements outlined in the MLTSS Contract.

The Contractor shall ensure continuity of care when care coordinator changes are made whether initiated by the member or by the Contractor.

Care Transitions

The Contractor shall have at least one full-time dedicated staff person without a caseload in each region in which the Contractor serves MLTSS members to assist individuals with transitions where the goal is to serve individuals in the community versus relying on institutional care. This would include transitioning individuals from NFs, hospitals, inpatient rehabilitation, or other institutional care settings into the community, but would also include helping individuals remain in the community. The dedicated staff person must meet the qualifications of a care coordinator as described in the Model of Care. The staff person also

shall serve as DMAS' point of contact for when DMAS learns of complex, challenging cases that need assistance with transition activities. Any such staff shall not be reported in the care coordinator ratios, and shall be responsible for proactively identifying MLTSS members in NFs or other institutions who are candidates for transitioning to the community and for assisting with the completion of the transition process.

6.2.22 Integrated Health Home Systems of Care

When CCBHC becomes available in a region, the Contractor's BHH models shall include the CCBHC.

6.2.23 Consumer Directed Fiscal/Employer Agent (F/EA) Services for EDCD Waiver Participants

The Contractor shall maintain a contract with DMAS' F/EA for each MLTSS region(s) in which the Contractor participates to provide the following services to EDCD Waiver individuals who choose consumer-direction:

- Criminal records and child abuse and neglect background check fees for Consumer-Directed employees, with appropriate follow-up and communication to appropriate individuals. The Contractor shall reimburse the exact fees paid by the F/EA for background checks
- Connectivity with DMAS and F/EA systems. The Contractor shall establish and maintain the ability to exchange EDI. These transactions may include, and are not limited to the 837P, 835 and 270/271 batch processing formats. All EDI transactions must comply with current DMAS and industry standards, and where applicable are required to meet HIPAA Security Standards for electronic PHI. All connectivity with DMAS and the F/EA shall be approved by DMAS prior to implementation.
- Processing electronic files and invoices for verification of service authorizations, patient pay, eligibility, pay rates and other necessary data to ensure accurate payroll. The Contractor shall have two employee pay rates: a higher rate for employees of individuals residing in Northern Virginia localities (see Attachment A) and a base rate for employees of individuals residing elsewhere in the state. All database and automated payroll and invoice processing systems shall be approved by DMAS prior to implementation.

DMAS shall compensate the F/EA for administrative fees based on a fixed fee Per Member Per Month (PMPM). The Contractor shall not accept responsibility for Administrative Services Payments to the F/EA. This amount will not be included in the Contractors capitation rates. Further expectations regarding F/EA services will be outlined in the MLTSS Contract.

6.2.24 Eligibility

The Department shall have sole responsibility for determining the eligibility of an individual for Medicaid-funded services. DMAS shall also have sole responsibility for determining enrollment with the Contractor. Such determinations shall be final and are not subject to review or appeal by the Contractor. This does not preclude the Contractor from providing the Department with information to ensure that enrollment with the Contractor is correct.

The Contractor shall monitor member eligibility renewal dates and proactively assist members through the Medicaid renewal process.

6.2.25 Eligible Populations

DMAS reserves the right to transition additional populations and services into MLTSS Program in the future.

6.2.26 Exclusions from MLTSS Participation

DMAS shall exclude individuals who meet at least one of the exclusion criteria listed below:

1. Individuals enrolled in the AAL Waiver.
2. Individuals enrolled in the Commonwealth's Medallion 3.0 and Title XXI CHIP Programs (FAMIS, FAMIS MOMS). *Note: Individuals enrolled in HAP will transition to MLTSS (other than AAL Waiver participants).*
3. Individuals enrolled in a PACE program.
4. Individuals enrolled in MFP.
5. Newborns whose mothers are MLTSS enrollees on their date of birth, unless the newborns qualify for MLTSS as outlined in the MLTSS Contract. However, Contractors must adhere to a process that assures newborns get enrolled in Medicaid as soon as possible by completing the DMAS-213 form per http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx.
6. Dual eligible members without full Medicaid benefits, such as:
 - i. Qualified Medicare Beneficiaries (QMBs)
 - ii. Special Low-Income Medicare Beneficiaries (SLMBs)
 - iii. Qualified Disabled Working Individuals (QDWIs)
 - iv. Qualifying Individuals (QIs)

These are individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles). Dual eligible members may receive Medicaid coverage for the following:

- i. Medicare monthly premiums for Part A, Part B, or both;
- ii. Coinsurance, copayment, and deductible for Medicare-allowed services; and
- iii. Medicaid-covered services, including those that are not covered by Medicare.

1. Individuals enrolled in a Medicaid-approved hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in MLTSS, the member will remain enrolled in MLTSS.
2. Individuals who live on Tangier Island.
3. Individuals under age 21 who are approved for DMAS Psychiatric RTC Level C programs as defined in 12VAC 30-130-860.
4. Individuals with end stage renal disease (ESRD) at the time of enrollment into MLTSS. However, an individual who develops ESRD while enrolled in MLTSS will remain in MLTSS (DMAS will manually exclude these individuals going forward upon receipt of notification).
5. Individuals who are institutionalized in state and private ICF/ID and state mental health nursing facilities.
6. Individuals who reside at Piedmont, Catawba, and Hancock State facilities operated by DBHDS.
7. Individuals who reside in nursing facilities operated by the Veterans Administration.
8. Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH individuals may enroll in the MLTSS program if they choose to disenroll from IAH (DMAS will manually exclude these individuals).
9. Certain individuals in out-of-state placements as will be specified in the MLTSS contract.
10. Individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention).
11. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIP) program.
12. Individuals enrolled in the Governor's Access Plan (GAP), which provides basic medical and targeted behavioral health care to some uninsured Virginians with severe mental illness, or other limited benefit aid categories.

Individuals enrolled in MLTSS who subsequently meet one or more of the criteria outlined above shall be excluded as determined by DMAS. Individuals excluded from mandatory MLTSS enrollment shall receive Medicaid services under the current FFS system unless eligible for one of DMAS' other managed care programs. When individuals no longer meet the criteria for MLTSS exclusion, they shall be required to re-enroll in MLTSS.

The Contractor shall promptly notify the Department upon learning that a member meets one or more of the exclusion criteria.

The Department shall, upon new State or Federal regulations or Department policy, modify the list of excluded individuals as appropriate. If the Department modifies the exclusion criteria, then the Contractor shall comply with the amended list of exclusion criteria.

6.3 OPERATIONS

6.3.1 Staffing

The Contractor shall have staff who are assigned and available to provide immediate individualized assistance to providers including but not limited to community based providers, nursing facilities, and other providers who are both new to managed care delivery systems and need assistance with the managed care delivery systems.

The Contractor's MLTSS care coordinators, shall at a minimum, have a bachelor's degree in a health or human services field with at least one year of experience directly working with individuals who meet the MLTSS target population criteria or be a Registered Nurse (RN), licensed in Virginia with at least one year of experience working as a RN. The care coordinators shall have demonstrated ability to communicate with members who have complex medical needs and may have communication barriers.

The Contractor's MLTSS care coordinators for NF residents and EDCD or Technology Assisted Waiver members shall be an RN licensed in Virginia with at least one year of experience working as a RN with experience working with the elderly, individuals with physical disabilities, or individuals with complex medical needs.

The Contractor shall have dedicated staff to perform member advocacy. Member services staff must assist members in writing complaints and shall be responsible for monitoring the complaint through the Contractor's grievance process.

The Contractor shall have adequate information management personnel and resources in place to meet all standards and procedures regarding receipt, processing, and transmission of program data and information as outlined in the MLTSS Contract.

The Contractor shall immediately notify DMAS whenever a key staff member vacates the assigned position. The Contractor shall also notify DMAS when the position is filled temporarily and permanently and by whom.

If DMAS is concerned that any of the key personnel are not performing their responsibilities, DMAS shall inform the Contractor of this concern. The Contractor shall investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of the MLTSS Contract, and notify DMAS of such actions. If the Contractor's actions fail to ensure full compliance with the terms of the MLTSS Contract, as determined by DMAS, corrective action provisions may be invoked by DMAS.

6.3.2 Quality and Program Evaluation

The Contractor shall apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements.

6.3.2.1 Quality Improvement (QI) Program

The Contractor shall structure its QI program for MTLSS separately from any of its existing Medicaid, Medicare, or commercial lines of business. Specifically, required measures and reports for the MLTSS Contract must be reported for the MLTSS population only.

The Contractor shall maintain a QI organizational and program structure that is proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart D, Quality Assessment and Performance Improvement and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

The Contractor shall have in place a written description of the QI program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. The Contractor shall submit an annual QI Work Plan and evaluation.

The Contractor shall maintain sufficient and qualified staff employed to manage the QI activities required under the MLTSS Contract, and establish minimum employment standards and requirements (e.g., education, training, and experience) for employees who will be responsible for QI.

The Contractor shall participate in QI workgroups and meetings designed to support QI activities and provide forums for discussing relevant issues. These workgroups and meetings may be facilitated by DMAS (or its designee) and shall be attended by DMAS representatives, DMAS Contractors, or other entities, as appropriate. The Contractor shall also serve as a liaison to, and maintain regular communication with, DMAS or its designated QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

6.3.2.2 EQR Activities, Performance Measurement, and other Quality Assurance Activities

The Contractor shall comply with all of DMAS' or the Department's designated agents (e.g., EQRO and/or other Contractors) on EQR activities, performance measurements and reporting, quality assurances activities, quality improvement activities and any additional studies, in accordance with the MLTSS Contract. This will include, but will not be limited to, readiness

reviews; accreditation requirements; annual quality management plan and evaluation; the collecting and reporting of specified quality measures including surveys, and assurances, conducting quality improvement projects in the focus areas as directed by DMAS; operational systems reviews; performance measure validation; performance improvement project validations; DMAS audits on MLTSS Contractors; waiver specific performance activities and quality assurances; program evaluations; member advisory committee; and all other quality related activities.

6.3.2.3 MLTSS Quality Measurement Reporting Requirements

As part of the MLTSS reporting requirements, quality performance measures reporting will be required to cover the following four domains:

1. Enhanced member experience and engagement for person- and family- centered care
2. Better quality of care
3. Maintain or improve population health
4. Reduce per capita costs

Within these four domains, DMAS identified five priority areas and selected measures that align with federal, state and MLTSS quality improvement aims and priorities. The MLTSS Core Measures List is included in Attachment J. MLTSS Health Plans will be required to report on all measures listed in the MLTSS Core Measures List. A subset of the core measures are designated as MLTSS Key Performance Indicators, which can be found in Attachment K. Key Performance Indicators represent MLTSS performance measure and quality improvement priority areas. MLTSS Key Performance Indicators may require more frequent and early reporting requirements. Measure requirements will be included in the MLTSS Contract and will include: data elements, relevant definitions, reporting timeframes, frequency requirements, and additional criteria. DMAS reserves the right to modify the MLTSS Core Measures and/or the MLTSS Key Performance Indicators list, as needed based on DMAS' sole discretion.

6.3.2.4 MLTSS Waiver Assurances

DMAS must meet federal requirements for HCBS programs, which include the following six assurances: 1) Level of Care; 2) Service Plan; 3) Qualified Providers; 4) Health and Welfare; 5) Financial Accountability; and 6) Administrative Authority (see Attachment L).

Under MLTSS, the Contractor shall be delegated by DMAS to conduct waiver quality management reviews under DMAS' supervision and monitoring and in accordance with parameters required through the CMS Quality Improvement strategy. MLTSS Contractors will be required to follow all DMAS waiver quality assurances procedures and protocols, as outlined in the MLTSS Contract.

6.3.2.4 MLTSS Program Evaluation Activities

DMAS and its designated agents will conduct ongoing evaluations of the MLTSS program over time from multiple perspectives using both quantitative and qualitative methods. The evaluation will be used for program improvement purposes and to assess the program's overall impact on various outcomes including but not limited to, enrollment patterns, member access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, behavioral health, home health, prescription drugs, nursing facility and home and community based waiver services), integrated care strategies, care coordination, program staff and provider experiences.

As such, the evaluations will include surveys, site visits, claims and encounter data analysis, focus groups, key informant interviews, observations, waiver assurance results, reporting records, and document reviews. The Contractor shall participate in evaluation activities as directed by DMAS or its designee and provide information or data upon request and in the manner requested.

6.3.3 Enrollee Advisory Committee

The Contractor shall establish an Enrollee Advisory Committee that will provide regular feedback to the Contractor on issues related to MLTSS management and enrollee care. The Contractor shall ensure that the Enrollee Advisory Committee: (1) meets at least quarterly beginning the second quarter of CY 2018 and (2) is comprised of enrollees, family members, and other caregivers that reflect the diversity of the MLTSS population, including individuals with disabilities and individuals residing in NFs. DMAS reserves the right to review and approve enrollee membership. The Contractor shall include Ombudsman reports in quarterly updates to the Enrollee Advisory Committee and shall participate in all statewide stakeholder and oversight meetings as requested by DMAS.

6.3.4 Encounter Reporting

The Contractor must meet all encounter reporting requirements as defined by DMAS. The Contractor's Systems shall generate and transmit encounter data files according to additional specifications as may be provided by DMAS and updated from time to time.

DMAS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

The Contractor shall:

- Collect and maintain 100% encounter data for all covered services provided to enrollees, including encounter data from any sub-capitated sources. Such data must be able to be linked to DMAS eligibility data.

- Participate in site visits and other reviews and assessments by DMAS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of encounter data.
- Upon request by DMAS, or its designee, provide medical records of enrollees and a report from the Contractor's administrative databases of the encounters of such enrollees in order to conduct validation assessments. The Contractor shall conduct validation assessments annually at the direction of DMAS or its designee.
- Produce encounter data according to the specifications, format, and mode of transfer established by DMAS, or its designee, in consultation with the Contractor. Such encounter data shall include elements and level of detail determined necessary by DMAS and included in DMAS's EDI Companion Guides. As directed by DMAS, such encounter data shall also include the NPI of the ordering and referring physicians and professionals and any National Drug Code and Unit of Measure.
- The Contractor must develop a process and procedure to identify drugs administered under section 340B of the Public Health Service Act as codified at 42 U.S.C. § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program. Contractor shall identify encounter claims administered under section 340B in a manner, mutually agreed upon between DMAS and the Contractor, that allows for an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing.
- Submit complete, timely, reasonable and accurate encounter data to DMAS no less than weekly and in the form and manner specified by DMAS. The encounters submitted will be in the EDI X12 837I and 837P Post Adjudication standard formats, and the NCPDP D.0 or Post Adjudication standards
- Submit encounter data that meets DMAS minimum standards for completeness and accuracy. The Contractor must also correct and resubmit encounters that result in fatal or rejected errors based on DMAS's encounter processing. The corrections for the fatal or rejected errors must be returned for processing to DMAS within thirty (30) days after receipt or notification of the fatal or rejected errors from DMAS
- Report, as a voided or reversal claim in the weekly encounter data submission, any claims that the Contractor pays and then determines should not have paid

If DMAS or the Contractor determines at any time that the Contractor's encounter data is not complete and accurate, the Contractor shall:

1. Notify DMAS, prior to encounter data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution
2. Submit for DMAS approval a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level.

Timeframe for submission shall be established by DMAS, not to exceed thirty (30) calendar days from the day the Contractor identifies or is notified that it is not in compliance with the encounter data requirements

3. Implement the DMAS-approved corrective action plan within DMAS approved timeframes. Implementation completion shall not exceed thirty (30) calendar days from the date that the Contractor submits the corrective action plan for DMAS approval
4. Participate in a validation review to be performed by DMAS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the encounter data is complete and accurate. DMAS or its designee shall determine whether the Contractor is financially liable for such validation review

6.3.5 Other Required Reporting Deliverables

The Contractor shall have adequate resources to support MLTSS reporting needs as required by DMAS. Examples of reports will include, but are not limited to, behavioral health, pharmacy, claims, provider network, appeals, quality, program integrity, expenditures related to rebalancing efforts (institutional vs. community based), call center statistics (broken out by behavioral health and all other service categories), and dashboards. Refer to Attachment B for links to the MLTSS Reporting Manual for minimum MLTSS requirements. The final MLTSS reporting requirements will be included in the MLTSS Contract. The Contractor shall successfully generate and send these reports as directed by DMAS. DMAS reserves the right to modify reporting requirements with advance notice.

6.3.6 Critical Incident Reporting and Management

The Contractor shall develop policies and implement procedures for critical incident reporting and management of incidents that occur in a NF, inpatient behavioral health or home-and community-based service delivery setting (e.g., an adult day health care center, a member's home or any other community-based setting), among other settings. Critical incidents shall include but not be limited to the following incidents: medication errors, severe injury or fall, theft; suspected physical or mental abuse; financial exploitation and death of a member.

The Contractor shall identify, document details, track, review, and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Services (APS) and Child Protective Services (CPS) (if available); identify trends and patterns; identify opportunities for improvement; and develop, implement and evaluate strategies to reduce the occurrence of incidents.

The Contractor shall require its staff and contracted MLTSS providers to report, respond to, and document critical incidents to the Contractor in accordance with applicable requirements.

The Contractor shall develop and implement a critical incident reporting and notification process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the Contractor shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

The Contractor shall participate in the DMAS' mortality review activities for MLTSS populations.

Additional critical incident requirements will be outlined in the MLTSS Contract.

6.3.7 Program Integrity and Oversight Policies

The Contractor must have in place policies and procedures, specific to Virginia Medicaid, for ensuring protections against actual or potential fraud, waste and abuse. The Contractor also shall have in place written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards for the prevention, detection and reporting of incidents of potential fraud, waste and abuse by members, network providers, subcontractors, and the Contractor. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to, sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening and disclosure of ownership and control. DMAS shall approve the Contractors' program integrity policies.

Procedures

The Contractor shall have surveillance and utilization control programs and procedures (42 C.F.R. §§ 456.3, 456.4, 456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Contractor shall have in place a process for assessment of all claims for fraud, waste, and abuse activity by members and providers through utilization of computer software and through regularly-scheduled audits of medical records. The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 C.F.R. §§ 455.13, 455.14, 455.21). The Contractor shall have adequate staffing and resources to investigate complaints and unusual incidents, and develop and implement corrective action plans to address all potential fraud, waste, and abuse activities, specific to Virginia Medicaid. Pursuant to 42 C.F.R. § 455, et seq.,

the Department may conduct audits of services rendered and claims paid by the Contractor to their provider network, and as a result of those audits, may recover funds as appropriate. The Department may also choose to conduct joint audits with Contractors. The Contractor shall agree to provide any staffing or technical support required by DMAS to conduct audits. DMAS may direct Contractors to investigate particular providers identified by data analysis or referrals and report their findings to DMAS. The Contractor will be expected to prioritize these investigations and may be given a deadline for completing the investigation.

Reporting and Notification

The Contractor will be required to notify DMAS in a timely manner regarding all internal (such as identified patterns of outliers, audit concerns, critical incidences) and external (such as hotline calls) and allegations of potential improper payments and/or safety concerns of enrollees. In addition to a notification, the Contractor will be required to take steps to triage and/or substantiate allegations and provide timely updates to DMAS when any allegations are authenticated. The Contractor will be expected to promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud, waste, or abuse. The Contractor shall promptly provide the results of its preliminary investigation to DMAS. When the Contractor identifies potential or actual fraud (as defined in 42 § C.F.R. 455.2) by one of its providers or subcontractors, the allegation must be referred to the Department immediately.

All confirmed or suspected enrollee fraud and abuse shall be reported immediately to DMAS as well. Allegations of suspected and/or actual fraud, waste, or abuse must be reported to DMAS within forty- eight (48) hours of discovery and before initial investigation. Reporting on allegations, provider investigations, provider fraud, and member fraud will be required to be submitted on standard forms provided by DMAS.

The Contractor will be required to notify DMAS before initiating any recoupment or withholding of any program integrity related funds to ensure that the recoupment or withhold is permissible. The Contractor may choose to utilize a pre-payment review process as a part of their program integrity plan. The Contractor will be required to notify DMAS of all providers subject to pre-payment review and of any claims that are not paid as a result of these reviews. In accordance with the process that will be outlined in the MLTSS contract, the Contractor will be required to report any overpayments made to a provider and/or subcontractor through a standard periodic report.

Based on identified or potential program integrity issues, the Contractor may choose to terminate a provider from its network, decline to enroll a provider in their network, or decline to offer a contract to a provider previously enrolled in their network. The Contractor shall report the names, National Provider Identification numbers, and a summary of the providers'

program integrity issues to DMAS on an individual basis as they are identified and on regularly-scheduled reports.

6.3.8 Program Integrity Plan

The Contractor must have a formal comprehensive Virginia Medicaid Program Integrity Plan for MLTSS, reviewed and updated annually, to detect, correct, and prevent fraud, waste, and abuse. This plan shall be specific to the Virginia Medicaid program. The Contractor must define how it will adequately identify and report suspected fraud, waste and abuse by members, network providers, subcontractors, and the Contractor. This plan will be required to be specific and include identification of relevant staff members and the proportion of their time that will be dedicated to performing program integrity activities for this contract. The Contractor will also be expected to identify specific program integrity monitoring activities to be performed for that contract year, including projections of the number and type of investigations that are planned.

This plan will be evaluated by DMAS staff on an annual basis to determine if it provides adequate protection against program integrity abuses. Part of this evaluation will include the completion of an annual Program Integrity Compliance Audit (PICA), which is a compliance and evaluation measure to evaluate organization-level compliance and adherence to the terms of the MLTSS contract and best practice models. Completion of the PICA requires electronic submission of any and all referenced materials (Policies and Procedures manuals, etc.) and documents annually to DMAS, as will be specified in the MLTSS contract. The Department may customize the PICA to reflect areas of particular importance or focus based on trends, previous PICA findings, or other Departmental concerns. The Contractor must use the most current version of DMAS' PICA tool, which will be included in the MLTSS contract. The Contractor will be required to include a risk assessment of its various fraud and abuse/program integrity processes. The assessment shall at a minimum include a listing of the Contractor's top three vulnerable areas and shall outline action plans in mitigating such risks.

6.3.9 Grievances

An enrollee may file a grievance with the Contractor and the Contractor shall be responsible for properly responding to all grievances. The DMAS Appeals Division does not handle grievances.

In accordance with 42C.F.R. § 438.400 et seq., and as directed by DMAS, the Contractor must have a system in place for addressing enrollee grievances, including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act. The Contractor must maintain written records of all grievance activities and notify DMAS of all internal grievances through a reporting format approved by DMAS.

6.3.10 General Appeals Requirements

The Contractor must maintain written records of all appeal activities, and notify DMAS of all internal appeals in the manner and format determined by DMAS. The Contractor is required to promptly respond to any requests made by DMAS pertaining to appeals.

In accordance with 42 C.F.R. § 438.400 et seq., the Contractor must give the enrollee written notice of any adverse benefit determination. For termination, suspension, or reduction of previously authorized Medicaid-covered services, such notice shall be provided at least ten (10) days in advance of the date of its action. For denial of payment, such notice shall be provided at the time of action. The form and content of the notice must have prior approval by DMAS; however, the notice must explain:

1. The action the Contractor has taken or intends to take;
2. The reasons for the action;
3. The citation to the law or policy supporting such action;
4. The enrollee's or the provider's right to file an internal appeal with the Contractor and that exhaustion of the Contractor's internal appeal processes is a prerequisite to filing an external appeal to Medicaid;
5. The procedures for exercising the enrollee's rights to appeal;
6. The enrollee's right to request an appeal with the Department (a State fair hearing) in accordance with 12 VAC 30-110-10 through 12 VAC 30-110-370, including representation rules at a hearing;
7. The provider's right to file an appeal with DMAS in accordance with the Virginia Administrative Process Act (Virginia Code § 2.2-4000 *et seq.*) and the Department's provider appeals regulations 12 VAC 30-20-500 through 12 VAC 30-20-560;
8. Circumstances under which expedited resolution is available and how to request it; and
9. If applicable, the enrollee's rights to have benefits continue pending the resolution of the appeal, and the circumstances under which the enrollee may be required to repay the costs of these services.

The written notice must be translated for individuals who speak prevalent languages. Additionally, written notices must include language explaining that oral interpretation is available for all languages and how to access it.

Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. Enrollees must be informed that information is available in alternate formats and how to access those formats.

The Contractor is responsible for the preservation and production of documents associated with any appeal. The Contractor shall be responsible for all costs related to the preservation and production of documents as required in response to a subpoena, Freedom of Information Act (“FOIA”) request, or any litigation involving the Contractor or the Department, including but not limited to, external appeals.

6.3.11 Contractor Level Appeals

Initial appeals must be filed with the Contractor. The filing of an internal appeal and exhaustion of the Contractor’s internal appeal process is a prerequisite to filing an external appeal to DMAS. If an appeal is sent to DMAS by the enrollee or provider, and the internal Contractor appeal process has not been exhausted, the Contractor must respond to DMAS within two (2) business days of notification of the appeal by DMAS that the Contractor’s internal appeal process has not been exhausted.

The Contractor’s appeals process must include the following requirements:

1. Acknowledge receipt of each appeal;
2. Ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision making;
3. An appeal may be submitted orally or in writing. If the Appellant does not request an expedited appeal pursuant to 42 C.F.R. § 438.410, the Contractor may require the Appellant to follow an oral appeal with a written, signed appeal;
4. Provide the Appellant a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The Contractor must inform the Appellant of the limited time available for this, especially in the case of expedited resolution;
5. Provide the Appellant and his or her representative opportunity, before and during the appeals process, to examine the enrollee’s case file, including any medical records and any other documents and records considered during the appeals process; and
6. Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

The Contractor shall respond in writing to standard appeals as expeditiously as the enrollee’s health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the Contractor provides evidence satisfactory to DMAS that a delay in rendering the decision is in the enrollee’s interest. For any appeals decisions not rendered within thirty (30) calendar days where the enrollee has not requested an extension, the Contractor shall provide written notice to the enrollee of the reason for the delay.

The Contractor shall establish and maintain an expedited review process for appeals where either the Contractor or the enrollee's provider determine that the time expended in a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports an enrollee's appeal. In instances where the enrollee's request for an expedited appeal is denied, the appeal must be transferred according to the timeframe for standard resolution of appeals, and the enrollee must be given prompt oral notice of the denial (or make reasonable efforts) to treat it as an expedited appeal and a written notice within two (2) calendar days.

The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the Contractor provides evidence satisfactory to the Department that a delay in rendering the decision is in the enrollee's interest. For any extension not requested by the enrollee, the Contractor shall provide written notice to the enrollee of the reason for the delay. The Contractor shall make reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two (2) calendar days with a written notice of action.

All Contractor appeal decisions must be made in writing and shall include, but not be limited to, the following information:

1. The decision reached by the Contractor, including a specific discussion of the reason for the denial, including citations to the policies, procedures, and/or authority that support the decision;
2. The date of the decision; and
3. For appeals not resolved wholly in favor of the enrollee:
 - a. The right to request an appeal to DMAS of the Contractor's final denial. The final denial letter shall clearly identify that the reconsideration process has been exhausted, and include the timeframe for filing an appeal, the address to file an appeal, and list pertinent statutes/regulations governing the appeal process; and
 - b. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the Contractor's action.

6.3.12 State Fair Hearing Process

Members have the right to appeal adverse decisions to the Department. However, the Contractor's internal appeal process must be exhausted prior to an enrollee filing an appeal

with the DMAS Appeals Division. DMAS enrollee appeals are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370. Adverse actions include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Standard appeals must be requested in writing to DMAS by the enrollee or the enrollee's representative. Expedited appeals may be filed by telephone or in writing. The appeal may be filed at any time after the Contractor's appeal process is exhausted and extending through 30 days after receipt of the Contractor's appeal decision. For appeals not filed within this timeline, an acceptable reason for delay, as determined by DMAS, must exist.

The Contractor agrees to be fully compliant with all state and federal laws, regulations, and policies governing the Appeal and State Fair Hearing process, as applicable, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited requests. The Contractor shall be financially liable for all judgments, penalties, costs, and fees related to an appeal in which the Contractor has failed to comply fully with said requirements.

Upon receipt of notification by the Department of an appeal, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS MLTSS Contract Monitor, and the member involved in the appeal in accordance with required time frames. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS Appeals Division. Contractor travel and telephone expenses in relation to appeal activities shall be borne by the Contractor. Failure to attend and defend the Contractor's actions at all appeal hearings and/or conferences shall result in the application of liquidated remedies as set forth in the MLTSS Contract.

Appeals to DMAS that do not qualify as expedited shall be resolved or a decision will be issued by DMAS within ninety (90) days of the date of filing the appeal. The timeline for resolution or issuance of a decision in State Fair Hearing Appeals may be extended for delays not caused by DMAS, in accordance with the existing Federal court order in *Shifflett v. Kozlowski* (W.D.Va 1994), relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays (e.g., the hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant; the appellant or representative requests to reschedule/continue the hearing; the hearing officer receives additional evidence from a person other than the appellant or his representative and the appellant requests to

comment on such evidence in writing or to have the hearing reconvened to respond to such evidence).

Appeals to DMAS that qualify as expedited appeals shall be resolved within three (3) business days or as expeditiously as the enrollee's condition requires.

For appeals filed with the DMAS Appeals Division, an enrollee may request continuation of services. DMAS will make a determination on continuation of services in accordance with the Commonwealth's existing appeals policy at 12 VAC 30-110-100, in accordance with 42 C.F.R. § 438.420. If the final resolution of the appeal upholds the Contractor's action, and services to the enrollee were continued while the appeal or State Fair Hearing was pending, the Contractor may recover the cost of the continuation of services from the enrollee.

In accordance with 42 C.F.R. § 438.424, if the appeal decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the Contractor must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

The Contractor does not have the right to appeal DMAS' appeal decisions.

The Department's final administrative appeal decision may be appealed through the court system by the member. However, the court review is limited to legal issues only. No new evidence is considered. During the court appeal process, DMAS and/or its counsel at the Office of the Attorney General (OAG) may have a need to confer with the Contractor to gain further information about the appealed action. The Contractor must respond to inquiries from DMAS or the OAG within one business day or sooner, if the situation warrants a quicker response. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

6.3.13 Provider Appeals

Provider appeals are governed by the Virginia Administrative Process Act (Virginia Code § 2.2-4000 et seq.) and the Department's provider appeals regulations 12 VAC 30-20-500 through 12 VAC 30-20-560.

Medicaid providers have the right to appeal adverse decisions to the Department. However, the Contractor's internal appeal process must be exhausted prior to a DMAS provider filing an appeal with the DMAS Appeals Division. The Contractor shall assist DMAS by presenting the Department's position in the administrative appeals process in conjunction with appeals of Contractor actions filed by providers.

DMAS has two levels of administrative appeals, generally referred to as the *informal level* and the *formal level*. At the informal level, the Contractor prepares the DMAS appeal summary and represents DMAS at an informal conference with the provider before a DMAS employee Informal Appeals Agent. At the formal level, the Contractor assists DMAS staff counsel in preparing the Department's evidence and discussing issues related to the appeal, complies with any subpoena or deposition requests that may be issued pursuant to the Virginia Administrative Process Act, and acts as a witness at a hearing before a hearing officer as appointed by the Virginia Supreme Court.

Upon receipt of notification of an appeal by the Department, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS MLTSS Contract Monitor, and the provider involved in the appeal in accordance with required applicable regulatory requirements and timeframes. The appeal summary content and timelines are specified by appeal regulations. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. All documents, including appeal summaries, must be filed with the Appeals Division by 5:00 p.m. on the deadline date. Failure to submit appeals summaries within the required timeframe and/or that fail to meet the applicable regulatory requirements shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to, the amount in dispute together with costs and legal fees, as well as the application of liquidated remedies as set forth in the MLTSS contract.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. If the Contractor's decision was based, in whole or part, upon a medical determination, including but not limited to, medical necessity or appropriateness or level of care, the Contractor shall provide sufficiently qualified medical personnel to attend the appeal related conference(s) and hearing(s). All appeal activities, including but not limited to, travel, telephone expenses, copying expenses, staff time, and document retrieval and storage, shall be borne by the Contractor. Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to, the amount in dispute together with costs and legal fees, as well as any other performance penalties specified in this contract.

The Contractor does not have the right to appeal DMAS' appeal decisions.

The Department's final administrative appeal decision may be appealed through the court system. However, the court review is limited to legal issues only. No new evidence is considered. During the court appeal process, DMAS and/or its counsel at the OAG may have a

need to confer with the Contractor to gain further information about the appealed action. However, the Contractor is not a party to the lawsuit because the issue being contested is DMAS' appeal decision. The Contractor must respond to inquiries from DMAS or the OAG within one business day or sooner, if the situation warrants a quicker response. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

6.3.14 Training and Meetings

The Contractor shall attend meetings and forums with providers (e.g., NFs, community LTSS providers, community behavioral health providers, etc.), and contractors as necessary, and at DMAS' request, to resolve any identified MLTSS start-up and/or on-going issues.

1. Trainings will be especially numerous during MLTSS regional start-ups and during open enrollment. The Contractor also shall conduct on-going provider technical assistance /guidance/trainings.
2. Trainings should encompass general information regarding the MLTSS program (e.g., what is MLTSS, what is managed care, what the Contractor will do for providers, where do providers go for assistance, protected health information, etc.).
3. Trainings could also cover specific topics, such as claims submission, claims processing, service authorizations, audit procedures, edit checks, etc.
4. Trainings also shall be tailored to the specific needs of MLTSS providers (e.g., how to achieve program goals, how to promote health and wellness, how to provide coordinated care, improving member experience, how to recognize and report signs of elder abuse/neglect and financial exploitation, and how to promote the efficient use of services).
5. Contractor shall develop and provide DMAS-approved streamlined education and training plans on topics such as the claims submission process, provider contracting, benefits of the MLTSS program, etc., for LTSS and community behavioral health providers. The Contractor shall agree to coordinate these efforts in conjunction with DMAS and the other selected Contractors.

6.3.15 Member Outreach and Marketing Services

Marketing, promotional, and outreach activities (including provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute and civil monetary penalty prohibiting inducements to beneficiaries.

The Contractor shall submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Contractor shall coordinate and submit to the Department all of its schedules, plans, and informational materials for community education, member health education materials, networking, and outreach programs in a

manner and format specified by DMAS. The Contractor shall also submit an annual marketing plan.

The Contractor must have a policy/procedure in place to ensure member access to services and expedient issuance of Member ID cards, new member packets, provider directories, and member handbooks.

The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds. Additionally, the Contractor shall ensure that written membership material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited (42 C.F.R. § 438.10(d)(1)(ii)). The Contractor must have a mechanism in which to capture the alternate format needs of the individual and use it for future communications. The Contractor shall assure that all marketing and informational materials shall be at or below a 6th grade reading level using the Flesch readability formula and certify compliance.

The Contractor must make available member handbooks in languages other than English when five percent (5%) of the Contractor's enrolled population is non-English speaking and speaks a common language. The populations will be assessed by MLTSS regions and will only affect handbooks distributed in the affected regions.

Oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education (42 C.F.R. § 438.10(c)(4)). Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the member, a family member, or a friend. In addition, the Contractor must provide TTY/TDD services for the hearing impaired.

In accordance with 42 C.F.R. § 438.100, the Contractor shall have written policies and procedures regarding member rights and shall ensure compliance of its staff and affiliated providers with applicable Federal and State laws that pertain to member rights. At a minimum, such member rights include the right to: obtain information on available treatment options, seek and receive a second opinion, be treated with respect, participate in decisions, be free from restraint/seclusion and request/receive medical records.

The Contractor is allowed to offer free non-cash promotional items and "giveaways" that do not exceed a total combined nominal value of \$25.00 to any prospective member or family for marketing purposes. Such items must be offered to all prospective members for marketing purposes whether or not the prospective member chooses to enroll with the Contractor. The Contractor is encouraged to use items that promote good health behaviors (e.g., toothbrushes).

The Contractor shall adopt DMAS' brand for the MLTSS Program for all marketing and member and provider materials. The Contractor also shall adhere to marketing and promotional requirements that will be further specified in the MLTSS Contract.

6.3.16 Call Center Requirements

The Contractor shall provide the capacity for the Department to timely monitor calls remotely from DMAS offices at no cost to the Department.

General Call Center Components (Member and Provider) and Hours of Operation

1. General customer service (available 8:00 am-8:00 pm, seven (7) days a week. Alternative technologies may be used on Saturdays, Sundays, and State of Virginia holidays)
2. Provider services and coverage determinations (available 8:00 am-6:00 pm, Monday through Friday)
3. Nurse triage/nurse advice line (available 24 hours per day; 7 days per week)
4. Behavioral health crisis line (available 24 hours per day; 7 days per week)
5. Care coordination support (available 24 hours per day; 7 days per week)
6. Pharmacy Technical Support Line (hours of operation for technical support cover all hours for which any network pharmacy is open, seven (7) days a week)

General Call Center Performance Standards (Member and Provider)

The Contractor's call center must answer 85% of all member and provider calls within 30 seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the IVR system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five (5) percent. The Contractor must have a process to measure the time from which the telephone is answered to the point at which a member reaches an Enrollee Service Representative (ESR) capable of responding to the Member's question in a manner that is sensitive to the member's language and cultural needs.

The Contractor shall record 100% of incoming calls to its member and provider helplines using up-to-date call recording technology. Call recordings must be searchable by provider NPI, member ID # (if available), phone number (when identified) and date and time of the call. Recordings will be made available to the Department within one (1) business day upon request, and stored for a period of no less than fifteen months from the time of the call. The Contractor shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

The Contractor shall provide robust reports on a monthly basis that detail the types of calls handled and regarding the Contractor's call center performance. The Contractor shall report separately from other Virginia lines of business. Additionally the call center must report by service area (primary, acute, behavioral health, and LTSS). The Contractor's system must also track and report on behavioral health crisis calls.

Member Call Center

The Contractor shall operate a toll-free telephone line (member services information line) to respond to member questions, concerns, inquiries, and complaints from the member, the member's family, or the member's provider.

The Contractor shall develop member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including MLTSS referrals from all sources, monitoring of calls via recording or other means, and compliance with standards.

The member services information line shall handle calls from individuals with cognitive, physical (e.g., speech and hearing), or mental disabilities, or from individuals with limited English proficiency (including access to interpreter and translation services as necessary).

The Contractor shall ensure that the member services information line is staffed adequately to respond to members' questions during the required hours of operation. The member call center shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from members and to facilitate transfer of calls to a care coordinator from or on behalf of a MLTSS member that requires immediate attention by a care coordinator. The Contractor may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements.

The Contractor shall ensure that all calls from MLTSS members to the nurse triage/nurse advice line that require immediate attention are immediately addressed or transferred to a care coordinator through a "warm transfer." Additionally, the Contractor shall ensure that all calls from MLTSS members who are in a behavioral health crisis are connected to a behavioral health professional with the appropriate clinical expertise to assist the individual via a "warm transfer". The Contractor shall implement protocols, subject to approval by DMAS that describe how calls to the nurse triage/nurse advice line from MLTSS members will be handled and how the member's care coordinator is made aware of all calls in order to ensure appropriate follow-up, continuity of care, etc.

The member services call center shall be adequately staffed with staff trained to accurately respond to member questions regarding Virginia MLTSS Program, the Contractor's MCO, covered services, the Contractor's provider network, etc.

The Contractor shall implement protocols, subject to DMAS' approval, to ensure that calls to the member services information line that should be transferred/referred to other Contractor staff, including but not limited to a member services supervisor or a care coordinator, or to an external entity, including but not limited to the FEA, are transferred/referred appropriately.

The Contractor shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

The Contractor shall provide language assistance services, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, auxiliary aids, free of charge to members and/or the member's representative.

Provider Call Center

The Contractor shall establish and maintain a provider services function to timely and adequately respond to provider questions, comments, and inquiries.

The Contractor shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

The Contractor shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding authorization requests as described in the MLTSS Contract. The Contractor may meet this requirement by having a separate utilization management line.

The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the Virginia MLTSS program, the Contractor's MCO, covered services, utilization management and referral requirements, care coordination, the Contractor's provider network, etc. For a period of at least twelve (12) months following implementation in each MLTSS Region covered by the MLTSS Contract, the Contractor shall maintain a dedicated queue to assist long-term services and support providers with enrollment, service authorization, or reimbursement questions or issues and shall ensure that long-term services and support

providers are appropriately notified regarding how to access the dedicated queue for assistance. Such period may be extended as determined necessary by DMAS.

For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the Contractor shall have a specific process in place whereby the Emergency Department (ED) can contact the Contractor twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The Contractor may use the 24/7 nurse triage line for this purpose or may use another line the Contractor designates. The Contractor shall track and report the total number of calls received pertaining to patients in ED's needing assistance in accessing care in an alternative setting. Reporting requirements for the 24/7 ED assistance line will be finalized in the MLTSS Contract.

The Contractor shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

The Contractor shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall include, at a minimum, a secured voice mailbox for callers to leave messages. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages. The Contractor shall return messages on the next business day.

Additional information regarding the call center requirements will appear in the MLTSS Contract.

6.3.17 Access to Care Standards

In accordance with 42 C.F.R. 438.206, the Contractor shall be responsible for arranging and administering covered services to enrolled individuals and shall ensure that its delivery system shall provide available, accessible, and adequate numbers of facilities, locations and personnel for the provision of covered services.

Contractors must provide members with a choice of a minimum of two (2) providers for each type of service (including LTSS), in accordance to time and distance standards. Each provider must have the capacity to serve each member within the time and distance standards specified below (except for DME providers and personal emergency response systems). Additionally, the Contractor shall ensure that its provider network meets access to timely care for services, including where the provider travels to the member's home to provide services.

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

1. The anticipated enrollment for the MLTSS Program;
2. The expected utilization of services, taking into consideration the cultural and ethnic diversity and demographic characteristics of the anticipated population to be served;
3. The complex medical, behavioral health, and LTSS needs of the anticipated population to be served;
4. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;
5. The numbers of network providers not accepting new patients;
6. The geographic location of providers and enrollees, considering distance, travel time, and the means of transportation ordinarily used by enrollees; and
7. Whether the location provides physical access for enrollees with disabilities, including items such as exam tables that accommodate individuals who have mobility limitations.
8. Recruiting and retaining agency- and community-based LTSS providers may be challenging due to low pay, limited benefits, and transportation costs. Urban areas generally have the advantage of public transportation systems. However, the distances workers have to travel, variable gas prices, other costs associated with automobile ownership, seasonal road and weather conditions, and serving fewer individuals per day due to travel time can present challenges in rural areas. Therefore, the Contractor may consider: carpooling, scheduling based on geography, reimbursing workers for mileage expenses, arranging with rental companies to rent fuel-efficient cars for workers to use, etc., in the rural areas.

6.3.18 Travel Time and Distance

Enrollee Travel Time Standard – For urban areas, the Contractor shall ensure that each enrollee has a choice of at least two (2) providers of each service type located within no more than thirty (30) minutes travel time from any enrollee unless the Contractor has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). For rural areas, the Contractor shall ensure that each enrollee has a choice of at least two (2) providers of each service type located within no more than sixty (60) minutes travel time from any enrollee unless the Contractor has a Department-approved alternative time standard. Travel time standards only apply to the enrollee’s travel time. Travel time standards only apply to the time an enrollee must travel to receive a service. Time standards do not apply to providers who travel to provide a service (e.g., home health, personal care, respite, etc.).

Enrollee Travel Distance Standard - The Contractor shall ensure that each enrollee has a choice of at least two (2) providers per service type located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the Contractor has a Department-approved alternative distance standard. Travel distance standards only apply to

the distance an enrollee must travel to receive a service. Travel distance standards do not apply to providers who travel to provide a service (e.g., home health, personal care, respite, etc.).

6.3.19 Credentialing/Recredentialing Policies and Procedures

The Contractor shall implement written policies and procedures and have the proper provisions to determine whether physicians and other health care professionals who are licensed or certified by the Commonwealth, and other providers who are under contract with the Contractor or its subcontractor(s) are qualified to perform their medical, clinical services, and support services. The Contractor shall have written policies and procedures for the credentialing process that are consistent with the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with MCHIP standards at 12 VAC 5-408-170. The Contractor's non-traditional BH providers (public and private) shall also meet any applicable Department of Health Professions' Licensing Boards or DBHDS licensing/certification standards. The Contractor's LTSS providers shall also meet DMAS' provider participation requirements as described in the applicable DMAS Provider Manuals, including the EDCD and Technology Assisted Waiver Manuals.

The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and member satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this contract. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license. The Contractor shall report to DMAS quarterly all providers who have failed to meet accreditation/credentialing standards, been denied application (including terminated providers), and/or have had program integrity-related adverse actions. The Contractor shall require its providers and subcontractors to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 C.F.R. § 455 Subpart B.

6.3.20 Provider Credentialing and Licensure Verification

The Contractor shall have written policies and procedures for the credentialing process that are consistent with the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with MCHIP standards at 12 VAC 5-408-170 or other state regulations. The Contractor shall verify that providers are appropriately licensed by the State and received proper certification or training to perform the services agreed to under the contract. For providers where licensure is not required, the Contractor shall ensure providers

are adequately qualified. The Contractor’s standards for licensure and certification shall be included in its participating provider network contracts.

6.3.21 Enrollment Process

The Contractor shall adhere to additional enrollment and disenrollment processes and procedures that will be outlined in the MLTSS Contract.

Enrollment in MLTSS will be mandatory for eligible individuals. The Department shall have sole authority and responsibility for enrollment into the MLTSS Program. There shall be no retroactive enrollment in MLTSS. Dual eligible members will have the option of having their MLTSS and Medicare services coordinated by the same Contractor. Therefore, the Contractor shall encourage dual eligible members that are enrolled with them for MLTSS to also enroll in their companion D-SNP for the Medicare portion of their benefits. However, these members will continue to have the option of receiving their Medicare benefits from fee-for-service Medicare or through another Medicare Advantage Plan.

Enrollment in MLTSS will be phased-in by region as illustrated in table below (see Attachment A for a list of regions and localities). DMAS reserves the right to modify the order and/or timing of the regional phase-in at the Department’s discretion.

MLTSS Regions and Proposed Effective Enrollment Dates

Date	Region
July 2017	Tidewater; including CCC opt-outs
September 2017	Central; including CCC opt-outs
October 2017	Charlottesville/Western; including CCC opt-outs
November 2017	Roanoke/Alleghany; including CCC opt-outs
November 2017	Southwest; including CCC opt-outs
December 2017	Northern/Winchester; including CCC opt-outs
January 2018	Remaining populations, including ABDs and individuals enrolled in the CCC program (following the CMS/DMAS designed transition plan)

All eligible members, except those meeting one of the exclusions outlined above, shall be enrolled in MLTSS as defined in the MLTSS Contract.

An enrollment file (834) will be sent to the Contractor weekly on the 6th and 13th of each month, and monthly on the 19th (known as mid-month) and on the last day of the month. The

weekly 834 files will contain any changes of member information, adds for new MLTSS Contractor enrollments, and terminations (dropped) for members who are disenrolled from the Contractor. The monthly 834 file will contain changes (audit), add and termination records for full eligibility/enrollment information for all members in the Contractor for current and future enrollment dates. The member's Contractor coverage begin date will depend upon whether Medicaid eligibility and/or Contractor change information is entered/uploaded into VAMMIS on or before the 18th or on or after the 19th of the month. The 834 includes all related MLTSS members' Level of Care (LOC) benefit information, including retro changes, based upon the transaction date.

DMAS will send a Medical Transition Report (MTR) File to the Contractor (with the 834) on the 6th, 13th, 19th, and at the end of each month (EOM). The member's Contractor will receive one full MTR with the earliest 834 run that reflects a member's enrollment with the Contractor. The full MTR includes claims and encounter history for the past two (2) years and any active service authorization (SA) history for the previous six months. The Contractor will also receive interim MTRs (which will include SA information only) on the 6th, 13th, 19th, and EOM. An interim MTR is only sent for members who have experienced SA changes since the prior full/interim MTR. Therefore, if a member has not had any changes since the last report, the member will not appear on the Contractor's interim MTR. The MTR and 834 may not match for the same reporting period. The Contractor shall have established procedures to receive this critical service information, incorporate it into the Contractor's system(s) as needed, honor SAs, and initiate care management for these members.

When the Contractor is notified by the Department that a member has disenrolled from its plan, the Contractor shall send MTR files (SA only) to DMAS. The files shall be sent to the Department within three (3) calendar days of notification on the 834 that shows that the member is being disenrolled. The Contractor shall send MTR files on the 9th, 16th, 22nd, and the 3rd. The Contractor shall also send an interim MTR one day prior to the last day of the month, for a total of five (5) MTR reports during a month. Only changes from the prior MTR are to be reported. Contractor MTR information shall be sent using the established MTR format reflected in the MLTSS Reporting Manual (refer to Attachment B for the link to the MLTSS Reporting Manual). In circumstances where a member changes from one Contractor to another, DMAS will share the prior Contractor's MTR information with the new Contractor for care management, utilization management and other related activities.

The Contractor will be responsible for providing and paying for covered services as of the effective enrollment date for each individual.

DMAS will notify individuals of their ability to change Contractors during an annual open enrollment period at least sixty (60) calendar days before the end of their enrollment period.

6.3.22 Enrollment Process for HAP and CCC Program Members

Individuals enrolled in HAP and the CCC program will be seamlessly transitioned to MLTSS so as to prevent them from returning to FFS coverage prior to their MLTSS enrollment. Whenever possible, DMAS will maintain a member's Contractor membership (e.g., if the member's CCC Contractor is also a MLTSS Contractor, that member will be enrolled with that Contractor), unless the member elects to change Contractors. If the HAP or CCC individual's Contractor does not participate in MLTSS, the member will be notified that he/she needs to select an MLTSS Contractor. If the individual does not make a selection, an MLTSS Contractor will be selected for him/her (a default Contractor). Default assignment will be based on the intelligent assignment rules. Individuals who have opted out of the CCC program prior to the CCC program's end date will be assigned to an MLTSS Contractor.

6.3.23 Intelligent Assignment

DMAS will use the following intelligent assignment process that seeks to preserve existing provider-member relationships. For example:

1. Individuals in a NF will be assigned to a Contractor that includes the individual's NF in its network. If the NF is in more than one Contractor's network, the assignment will be equitable random between the Contractors with NFs in the network
2. Individuals in the EDCD Waiver will be assigned to a Contractor that includes the individual's current adult day health care (ADHC) provider in its network. If more than one Contractor's network includes the individual's ADHC provider in its network, the assignment will be random between the Contractors;
3. Individuals in the Tech Waiver will be assigned to a Contractor that includes the individual's private duty provider. If more than one Contractor's network includes the individual's private duty provider in its network, the assignment will be random between the Contractors; and
4. A limit of 70% of enrolled lives within an operational region may be placed on any Contractor participating within that region. Should a Contractor's monthly enrollment within an operational region exceed 70%, the Department reserves the right to suspend random assignments to that Contractor until the number of enrolled individuals is at 70% or below. However, the enrollment cap may be exceeded due to recipient-choice assignment changes, for continuity of care, or other reasons as the Department deems necessary. Even though random assignments may be suspended, assignments based upon continuity of care and individual choice by a member will be allowed to that Contractor.

The Department reserves the right to revise the intelligent assignment methodology, as needed based upon DMAS' sole discretion.

Individuals who have been previously enrolled with a MLTSS Contractor who regain eligibility within sixty (60) days will be re-enrolled with their previous Contractor.

6.3.24 Open Enrollment

Annual open enrollment for MLTSS will occur during October, November and December for a January 1st effective date. During the first year of MLTSS program operations, in addition to the annual open enrollment period, there may also be a mid-year open enrollment to assure that individuals are afforded the option to change Contractors without cause at least once every 12 months, per CMS rules (42 C.F.R. § 438.56). CMS rules further require that individuals be given 60 days advance notice of open enrollment periods. DMAS will send annual notices notifying individuals of the open enrollment period, their right to change Contractors, and comparison information for the Contractors that participate in the individual's locality. Open enrollment procedures will be more fully outlined in the MLTSS Contract.

6.3.25 Information Requirements upon Enrollment

The Contractor shall provide the following information to new individuals: a member handbook, a provider network listing, an identification card, and information regarding how to access and/or request a provider directory. Member materials must be provided in accordance with Federal managed care requirements described in 42 C.F.R. § 438.10. Requirements for member materials will be fully described in the MLTSS Contract.

6.3.26 Disenrollment and Contractor Election Changes

Consistent with § 1932(a)(4) of the Social Security Act, as amended (42 U.S.C. § 1396u-2), the Department must permit a member to disenroll at any time for cause. The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll such as poor quality care, lack of access to necessary providers for services covered under the State Plan, or other reasons satisfactory to the Department. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 C.F.R. § 438.56(d)(2) .

6.3.27 Services Received Through an Indian Health Service (IHS) or Tribal Facility

The Contractor shall provide coverage for services that Native Americans access from an IHS or Tribal provider, including out-of-network IHS or Tribal providers, in accordance with the State Health Official Letter (SHO #16-002) (available at <https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf>).

6.3.28 Patient Utilization Management & Safety (PUMS) Program

The Contractor must have a PUMS program to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and case management program designed to promote proper medical management of essential health care. Upon the member's

placement in the PUMS, the Contractor must refer members to appropriate services based upon the member's unique situation.

6.3.29 Placement into a PUMS Program

Members may be placed into a PUMS program for a period of 12 months when **either** of the following trigger events occurs:

1. The Contractor's utilization review of the member's past twelve (12) months of medical and/or billing histories indicates the member may be accessing or utilizing health care services inappropriately, or in excess of what is normally medically necessary. Please note that members with a cancer diagnosis will be excluded.
2. Medical providers or social service agencies provide direct referrals to the Department or the Contractor.

At the end of the 12 month period, the member must be re-evaluated by the Contractor to determine if the member continues to display behavior or patterns that indicate the member should remain in the PUMS Program.

6.3.30 PUMS Program Details

Once a member meets the requirements of the PUMS program, the Contractor may limit a member to a single pharmacy, primary care provider (PCP), controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider type as determined by the Contractor and the circumstances of the member.

If the member changes from another Contractor to the Contractor while the member is enrolled in a PUMS, the Contractor must re-evaluate the member within thirty (30) days to ensure the member meets the minimum criteria above for continued placement in the Contractor's PUMS.

6.3.31 PUMS Member Rights, Notifications and Requirements

The Contractor must, upon placement of a member into its PUMS program, issue a letter to the member or family member/caregiver that includes the following information:

- A brief explanation of the PUMS program;
- A statement that the member was selected for placement into the program;
- A explanation that the decision is appealable;
- A statement clearly outlining the provisions for emergency after hours prescriptions if the member's selected pharmacy does not have 24-hour access; and
- A statement indicating the opportunity and mechanisms by which the member may choose a pharmacy, primary care provider, controlled substance provider, hospital (for non-emergency hospital services only) and/or on a case-by-case basis, other qualified

provider types. The language must clearly state that if the member does not select the relevant providers within 15 days of enrollment into the PUMS Program, the Contractor may select one for the member.

6.3.32 PUMS Reporting Requirements

Refer to Attachment B for the link to the MLTSS Reporting Manual which includes reporting requirements for the PUMS program.

6.3.4 Coordination of Other Coverage

The Contractor shall be responsible for coordination of benefits for its MTSS members as described in the MLTSS Contract.

6.3.4.1 Comprehensive Health Coverage

Members enrolled in Medicaid, determined by the DMAS as having comprehensive health coverage including Medicare, will remain enrolled in MLTSS. The Contractor is responsible for coordinating all benefits with Medicare and other insurance carriers (as applicable) and following Medicaid “payer of last resort” rules. The contractor shall also cover the member’s deductibles and coinsurance up to the maximum allowable reimbursement amount that would have been paid in the absence of other primary insurance coverage. When the other payor is a commercial MCO/HMO organization, the Contractor is responsible for the full member copayment amount. The Contractor shall ensure that the member is held harmless for payments and copayments for any Medicaid covered service.

Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to the Department. The Contractor shall notify DMAS on a monthly basis of any members identified during that past month who were discovered to have comprehensive health coverage.

6.3.4.2 Workers’ Compensation

If a member is injured at his or her place of employment and files a workers’ compensation claim, the Contractor shall remain responsible for all services. The Contractor may seek recoveries from a claim covered by workers’ compensation if the Contractor reimbursed providers and the claim is approved for the workers’ compensation fund. The Contractor shall notify DMAS on a monthly basis of any members identified during that past month who are discovered to have workers’ compensation coverage.

If the member’s injury is determined not to qualify as a worker’s compensation claim, the Contractor shall be responsible for all services provided while the injury was under review, even if the services were provided by out-of-network providers, in accordance with worker’s compensation regulations.

6.3.4.3 Estate Recoveries

The Contractor is prohibited from collecting estate recoveries. The Contractor shall notify DMAS on a monthly basis of any members identified during that past month who have died and are over the age of 55.

6.3.4.4 Other Non-Health Insurance Coverage

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds.

Members with these other resources shall remain enrolled in MLTSS. The Contractor shall notify the Department or its designated agent on a monthly basis of any members identified during that past month who are discovered to have any of the above coverage types, including members identified as having trauma injuries. The Contractor shall provide DMAS with all encounter/claims data associated with care given to members who have been identified as having any of the above coverage.

6.4 TECHNOLOGY

6.4.1 Electronic Visit Verification (EVV) System

Electronic Visit Verification (EVV) provides “real time” monitoring of service provision, verifies that service visits occur, and documents the precise times service provision begins and ends. The Offeror shall attest that if Virginia develops and implements an EVV system, the Offeror agrees to establish connectivity, transfer data, and fulfill program requirements as set forth by DMAS at no additional cost to the Department.

6.4.2 Secure E-mail

The Contractor shall provide secure email services between DMAS and the Contractor and any other entity where PHI is communicated. The emails associated with PHI must be sent to DMAS using COV security standards and encrypted methods to ensure the receiver of email has the capability to view the content based on the submission encryption and is able to do so.

All expenses incurred in establishing a secure connectivity between the Contractor and DMAS, any software licenses required, and any training necessary shall be the responsibility of the Contractor.

The Contractor shall provide SSL secure email access over the Internet between DMAS and the Contractor and any other entity where PHI is communicated. No direct connection of VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. Such secure email will only require DMAS staff to use a greater than 128-bit SSL enabled web browser to access the Contractor or send email to the Contractor. DMAS will provide no special application server(s) for this purpose. Routing of emails over point-to-point telecommunications circuits between DMAS and the Contractor supports Secure SMTP over

Transport Layer Security (TLS) RFC 3207 over the internet. The solution must include a method for secured industry standard email using strong encryption keys (greater than 128 bit) between DMAS and the Contractor throughout the contract term. Bidirectional TLS email encryption must be tested and documented between DMAS and the Contractor's SMTP server. DMAS additionally has implemented functionality that allows for point-to-point TLS email encryption.

6.4.3 Contractor's Information Management and Information Systems

The Contractor shall:

- Maintain Information Systems (Systems) that will enable the Contractor to meet all of DMAS's requirements as detailed in the MLTSS Contract. The Contractor's Systems shall be able to support current DMAS requirements, and any future IT architecture or program changes. Solutions must be compliant with COV Information Technology Resource Management (ITRM) policies, standards, and guidelines, and may be updated from time to time. A complete list can be located: <http://www.vita.virginia.gov/library/default.aspx?id=537>.
- Ensure a secure, HIPAA-compliant exchange of enrollee information between the Contractor and DMAS and any other entity deemed appropriate by DMAS. Such files shall be transmitted to DMAS through secure FTP, HTS, or a similar secure data exchange as determined by DMAS.
- Develop and maintain a website that is accurate, up-to-date, and designed in a user-friendly way that enables enrollees and providers to quickly and easily locate all relevant information. If directed by DMAS, establish appropriate links on the Contractor's website that direct users back to the DMAS website portal
- Cooperate with DMAS in its efforts to verify the accuracy of all Contractor data submissions to DMAS
- Actively participate in any DMAS Systems Workgroup, as directed by DMAS. The workgroup shall meet in the location and on a schedule determined by DMAS

6.4.4 Design Requirements

The Contractor shall comply with DMAS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

The Contractor's Systems shall interface with DMAS' VaMMIS/MES system, the DMAS Virtual Gateway, and other DMAS IT architecture as required by DMAS.

6.4.5 System Access Management and Information Accessibility Requirements

The Contractor shall make all Systems and System information available to authorized DMAS and other agency staff, as determined by DMAS, to evaluate the quality and effectiveness of the Contractor's data and Systems.

The Contractor is prohibited from sharing or publishing DMAS data and information without prior written consent from DMAS.

6.4.6 System Availability and Performance Requirements

The Contractor shall ensure that its enrollee and provider web portal functions and phone-based functions are available to enrollees and providers twenty-four (24) hours a day, seven (7) days a week.

The Contractor shall draft an alternative plan that describes access to enrollee and provider information in the event of System failure and submit to DMAS for approval. Such approved plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to DMAS upon request. In the event of System failure or unavailability, the Contractor shall notify DMAS upon discovery and implement the COOP immediately.

The Contractor shall preserve the integrity of enrollee-sensitive data and be able to produce the data that resides in both a live and archived environment.

6.4.7 Data Interfaces Sent To and Received From DMAS

The Contractor shall have adequate resources to support the DMAS interfaces and the care management technology system described in the MLTSS Contract. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files, may include, but are not limited to:

Inbound Interfaces

- EDI X12 837I Post Adjudication Standard format Facility Encounters
- EDI X12 837P Post Adjudication Standard format Professional Encounters
- NCPDP D.0 or Post Adjudication Standard format Pharmacy Encounters
- MLTSS weekly provider network files
- MLTSS MTR (Service Authorization information) in a file format to be outlined in the MLTSS contract
- Clinical and care coordination related data in a file format to be outlined in the MLTSS contract

Outbound Interfaces

- EDI X12 834 weekly files
- EDI X12 820 monthly capitation payment file
- Service Authorization in a file format to be outlined in the MLTSS contract
- Medical Transition Report, including, service authorizations, and claims data, in a frequency and file format to be outlined in the MLTSS contract
- DMAS monthly provider network file

The Contractor shall conform to HIPAA compliant standards and all state and federal standards for data management and information exchange and must implement new versions as made available by HIPAA according to DMAS's needs and guidance.

The Contractor shall demonstrate controls to maintain information integrity.

The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DMAS for reconciliation processes to be determined upon contract award.

6.4.8 Data Certifications

All Contractor encounter submissions are required to be certified. The Contractor shall keep track of every encounter submission made through the State's Fiscal Agent during the month and the tracking number assigned to each. At the end of each calendar month, the Contractor shall report this data to the Department with the required certification. The required certification and reporting mechanism will be defined in the MLTSS Contract. In accordance with 42 C.F.R. § 438.606, the Encounter Certification form shall be signed by the Contractor's Chief Financial Officer, Chief Executive Officer or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor.

6.4.9 All Payers Claim Database

The Contractor shall comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 of the *Code of Virginia* for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Specifically, the Contractor shall be responsible for the submission of claims data related to services provided under this Contract. Such data submission, pursuant to §32.1-276.7:1 of the *Code of Virginia*, has been determined by the Department of Medical Assistance Services to support programs administered under Titles XIX and XXI of the *Social Security Act*.

6.4.10 Interface and Connectivity to the Virginia Medicaid Management Information System (VaMMIS) and Medicaid Enterprise System (MES)

The Contractor's interface with VaMMIS/MES must include, but will not be limited to, receiving Medicaid participant enrollment information in HIPAA standard EDI X12 834 format; the submission of encounter data in the HIPAA standard X12 Post Adjudication Standard 837I, 837P, and the NCPDP D.0 or Post Adjudication Standard formats; and receiving monthly capitation payments in the HIPAA standard X12 820 format. All Contractor's staff shall have access to equipment, software and training necessary to accomplish their stated duties in a timely, accurate, and efficient manner. The Contractor shall supply all hardware, software, communication and other equipment necessary to meet the requirements of the MLTSS Contract. The Contractor shall allow sufficient time for installation, configuration, and testing of the data line and associated equipment prior to production.

Any expenses, including equipment, services, etc., incurred in establishing and maintaining connectivity between the Contractor and the Fiscal Agent-hosted VaMMIS /MES will be the responsibility of the Contractor. It is the responsibility of the Contractor to ensure that bandwidth is sufficient to meet the performance requirements of the MLTSS Contract. The Contractor will be granted access to the DMAS EDI portal used for submission and receiving of X12 standard data files and other non-X12 data files as determined during the contract implementation timeframe. This access will be through the secured EDI portal maintained by DMAS and production access will be granted after a testing process has been completed.

Additional information may be found at

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/EDISupport>.

The Contractor will be granted access to VAMMIS through the web portal (<https://www.viriniamedicaid.dmas.virgini.gov>) with an ACF2 secure sign on. This will enable the Contractor to view eligibility and pertinent VAMMIS data as deemed necessary by DMAS. The Contractor's Help Desk employees supporting this contract must have access to the Internet. The Department will ensure the Contractor and their staff individuals receive VAMMIS training.

6.4.11 Central Data Repository

DMAS is in the process of expanding its data integration and analytics capabilities by developing a system that collects, integrates, and analyzes data from a variety of sources across the full continuum of care (primary, acute, behavioral, institutional, and community based care). DMAS will track health metrics for the Medicaid population across fee-for-service and managed care programs, including the MLTSS program. Use of the data system will help DMAS evaluate how well the MLTSS program is serving individuals, identify best practices, and opportunities for improvement. In addition, this comprehensive data mining approach will enable the

Department to project risk, enhance care coordination, mitigate service gaps, and promote efficiencies.

The Contractor shall provide raw data, including data from subcontractors, in a format and frequency determined by DMAS and that will be outlined in the MLTSS Contract. The data shall be compliant with industry standards (e.g., National Information Exchange Model) and state companion guides.

At a minimum, required data will include:

- Electronic visit verifications (if a required service);
- Service authorizations;
- Full provider network;
- Assessments;
- Appeals and grievances;
- Care coordination data;
- Formulary data;
- Clinical data compliant with HL7 standards;
- Financial management reports and transaction data for any off systems payments including, but not limited to,
 - MLR reports, BOI data
 - Lump sum payments to providers
 - Incentive payments to providers
 - Cost recovery transactions (e.g., third party liability explanation of benefits, fraud/waste investigations, and/or legal actions)
- Encounter claims for 837I, 837P, and National Council for Prescription Drug Programs (NCPDP D.0 Post Adjudication Standard)) that are HIPAA Compliant Transactions and Code Sets

DMAS will work closely with MLTSS Contractors to develop the technical requirements for providing the data outlined above as well as the mechanism for data transmission, including file formats and submission frequency.

DMAS will collect, analyze, and report data in a reliable and timely manner. MLTSS Contractors shall work collaboratively with DMAS to develop solutions that align with the Department's data integration goals, based upon evidenced-based data standards which ensure the highest degree of data quality and integrity. It will be crucial that MLTSS Contractors submit the required data in a timely manner, and in the contractually required format(s). MLTSS Contractors shall be subject to liquidated damages and sanctions when data is submitted contrary to DMAS established standards of timeliness, completeness and accuracy, and where the method of submission is non-compliant with MLTSS contractual standards. The data requirements and related sanctions will be further defined in the MLTSS Contract.

6.4.12 Capitation Payments

The PMPM Capitation Payment for a particular month will reflect payment for the beneficiaries with effective enrollment with the Contractor as of the first day of the previous month. These payments will be transmitted to the Contractor using the EDI X12 820 standard.

6.5 READINESS

The scope of the readiness review will include, but is not limited to, a review of the following elements:

- Provider network composition and access to care;
- Staffing, including key personnel and functions directly impacting members (e.g., adequacy and training of staffing);
- Capabilities of subcontractors performing functions on Contractor's behalf in compliance with 42 C.F.R. §§ 438.6(l), and 438.230(b)(1);
- Care coordination capabilities;
- Content of provider contracts, including any provider performance incentives;
- Member services capability (materials, processes and infrastructure, e.g., call center capabilities);
- Comprehensiveness of quality management/quality improvement and utilization management strategies;
- Internal grievance and appeal policies and procedures in accordance with 42 C.F.R. § 438 Subpart F;
- Fraud and abuse and program integrity policies and procedures, in accordance with 42 C.F.R. § 438 Subpart H;
- Financial solvency, in accordance with; 42 C.F.R. §438.116;
- Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of encounter data, including information technology testing and security assurances.

Any changes required to the Contractor's processes as identified through readiness review activities shall be made by the Contractor prior to implementation. Costs associated with these changes shall be borne by the Contractor.

6.6 INNOVATION AND LEVERAGING VIRGINIA'S COMMUNITY SYSTEMS OF CARE

Contractors are required to form innovative partnerships with community-based organizations (such as Area Agencies on Aging, Centers for Independent Living, and Community Services Boards) that perform care coordination functions and offer support services to MLTSS individuals, such as options counseling, information and social determinants referrals (including

No Wrong Door initiative managed by DARS), employment supports, housing supports, nutrition supports, and facilitating transitions from an institution to the community, etc.

If DMAS successfully secures a section 1115 DSRIP Waiver the Contractor shall agree to participate in collaborative planning with state and community partners, in order to successfully identify models to test and implement. The Contractor shall participate in evaluations of the DSRIP Program.

6.7 FINANCIAL REQUIREMENTS

6.7.1 Capitation Payments

Capitation rates for the MLTSS program will be consistent with payment and contracting requirements under 42 C.F.R. § 438 Subpart A. DMAS will use FFS data to calculate PMPM costs from a two year base period, adjust for any policy and program changes between the base period and the rate year and trend to the rate year. DMAS will include adjustments for managed care and administrative costs. If encounter data is available, DMAS will use encounter data.

DMAS will make monthly PMPM Capitation Payments to the Contractor retrospectively for the previous month's Enrollment (e.g., payment for June enrollment will occur in July, payment for July enrollment will occur in August, etc.). The PMPM Capitation Payment for a particular month will reflect payment for the beneficiaries with effective enrollment with the Contractor as of the first day of the previous month.

DMAS shall issue actuarially sound capitation payments on behalf of enrollees at the rates established in the MLTSS Contract and which may be modified during the annual contract renewal process. The Contractor shall accept the annually established capitation rates paid each month by the Department as payment in full for all services to be provided pursuant to the MLTSS Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. Any and all costs incurred by the Contractor in excess of the capitation payment shall be borne in full by the Contractor. The Contractor shall accept the Department's electronic transfer of funds to receive capitation payments. These payments will be transmitted to the Contractor as the EDI X12 820 standard.

DMAS will calculate separate capitation rates for nursing home and HCBS. In order to incentivize HCBS, DMAS will pay HCBS rates for two months after a member transitions to nursing home; DMAS will pay nursing home rates for four months after a member transitions from nursing home to HCBS. DMAS will also consider additional incentives for members without LTSS who are at risk of needing LTSS.

The Department is progressively seeking the implementation of VBP arrangements. The Contractors shall meet expectations and benchmarks set by DMAS, as the Department implements VBP strategies. The VBP may modify the payment arrangement between DMAS and the Contractor. Any changes would be reflected in a modification to the MLTSS Contract.

6.7.2 Health Insurer Fee

The Department recognizes that the health insurer fee imposed by the Affordable Care Act is a cost to some MLTSS Contractors that should be recognized in actuarially sound capitation rates. The Department will reimburse the Contractor for the fee associated with the Virginia Medicaid

line of business. DMAS will make an adjustment for the impact of non-deductibility of the health insurer fee on Federal and State corporate income taxes but the adjustment shall not exceed the Federal or State corporate income taxes reported on the Contractor's annual financial statement and allocated to the Virginia Medicaid line of business.

Each Contractor shall furnish a copy of its Letter 5067C Final Fee Calculation from the IRS to DMAS for 2018 by September 15, 2018. Along with a copy of the letter 5067C, each Contractor shall show the methodology for allocating the health insurer fee to the Virginia Medicaid line of business and certify the results. The Department will utilize this information to determine Contractor specific PMPM adjustments to the CY 2018 capitation rates. There will be separate components for the fee itself and the impact of non-deductibility of the health insurer fee on Federal and State corporate income taxes. A health insurance premium adjustment will be determined after the amounts due are known in the fall. DMAS will make an aggregated retroactive adjustment by December 31, 2018.

Each Contractor shall compare its final CY 2018 state and corporate income tax liability for the Medicaid line of business reported to the Bureau of Insurance and the capitation adjustment for the impact of non-deductibility of the health insurer fee and refund the difference, if any, between the capitation adjustment and the actual tax liability to the Department by April 30, 2019.

6.7.3 Minimum Medical Loss Ratio (MLR)

The Contractor shall be subject to a minimum medical loss ratio (MLR) of 85%. The MLR shall be determined as the ratio of (i) incurred claims plus expenditures for activities that improve health care quality plus expenditures on fraud reduction activities to comply with certain program integrity requirements divided by (ii) adjusted premium revenue. If the MLR for a reporting year is less than 85% then the Contractor shall make payment to the Department equal to the deficiency percentage applied to the amount of adjusted premium revenue.

The Contractor is required to report a MLR annually based on 42 C.F.R. § 438.8. The Contractor shall submit to the Department, in the form and manner prescribed by the Department, the necessary data to calculate and verify the MLR within nine (9) months of the end of the reporting year. The MLR reporting year shall be the calendar year.

The Contractor shall report to the Department the following information for each MLR reporting year:

- a. Total incurred claims;
- b. Expenditures on quality improving activities;
- c. Expenditures on fraud reduction activities related to program integrity compliance;
- d. Non-claims costs;

- e. Premium revenue;
- f. Taxes, licensing and regulatory fees;
- g. Methodology for allocation of expenditures;
- h. Any credibility adjustment applied;
- i. The calculated MLR;
- j. Any remittance owed to the State;
- k. A reconciliation of the information reported in this report with the audited financial report;
- l. A description of the aggregation method by covered population; and,
- m. The number of member months.

If the Contractor is required to make a payment to the Department, the payment shall be due to the Department no later than November 1st following the MLR reporting year.

6.7.4 Reinsurance

Reinsurance is a stop-loss program provided by Virginia DMAS to the Contractor. Reinsurance is available to cover 90% of a member's annual prescription drug costs above a \$150,000 attachment point. The cost to the Department of providing reinsurance coverage will be offset by a reduction to the capitation rate otherwise payable during the contract year. The amount of the reduction shall be determined prospectively and shall be applied to all capitation payments.

The amount to be used in the computation of reinsurance will be the Contractor paid amount. The Contractor must notify the Department quarterly of all members whose prescription drug costs have exceeded the \$150,000 attachment point during the contract year. All reinsurance claims are subject to medical review by the Department.

The Department will reimburse a Contractor for 90% of the annual costs of prescription drug coverage (including prescription drugs administered in a physician's office or outpatient hospital setting) in excess of the \$150,000 attachment point for any member whose total costs of prescription drug claims incurred during the contract year, less any Medicare/TPL payment, exceed the attachment point. Such reinsurance reimbursements shall be made quarterly for the preceding 3 month period during the contract year. Contractors are required to submit documentation for reimbursable claims along with an invoice within thirty (30) days of each quarter end for the first three quarters of the contract year. The quarterly periods end on March 31, June 30, September 30 and December 31 of the contract year. The deadline for final quarter, ending December 31st, will be due March, to ensure reasonable time for outstanding physician and outpatient hospital claims. The Department will make reinsurance reimbursements within sixty (60) days of receipt of such list/invoice or provide notice to the Contractor if additional information is required.

The Department may, at a later date, perform audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits, providing the Contractor with appropriate advance notice.

6.7.5 Recoupment/Reconciliation

The Department shall recoup a member's capitation payment for a given month in cases in which a member's exclusion or disenrollment was effective retroactively. The Contractor may retract provider payments made during a period when the enrollee was not eligible, and instruct the provider to invoice DMAS for payment. The Department shall not recoup a member's capitation payment for a given month in cases in which a member is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to, death of a member, cessation of Medicaid eligibility, or transfer to an excluded MLTSS Medicaid category. This provision does not apply in cases where the Department is responsible for the total cost of medical care in a given month, e.g., hospitalization at the time of enrollment, etc. In these cases the total capitation payment for the month will be rescinded.

The Department shall recoup capitation payments made in error by the Department.

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

The Contractor shall not be liable for the payment of any services covered under the MLTSS Contract rendered to a member after the effective date of the member's exclusion or disenrollment.

The Department shall reconcile payments on a quarterly basis. The quarterly reconciliation shall be based on adjustments known to be needed through the end of the quarter.

6.7.6 Incentives and Withholds

In the annual contract, DMAS will include a withhold and/or a performance award placing up to 2% of the capitation payment at risk based on meeting quality requirements, particularly the MLTSS key performance indicators, population-based targets and VBP requirements outlined in the MLTSS Contract. DMAS intends to phase in the withhold/award program, both the amount at risk and the criteria.

6.7.7 Value-Based Payment

On an annual basis, the Contractor shall provide examples and details of its VBP initiatives for acute care services, behavioral health services and long-term services and support. At a

minimum, the Contractor shall include the following information for each VBP initiative as specified in the Technical Manual:

- VBP Category (and applicable subcategory) (using the HCP-LAN model)
- Short Description
- Goal(s) and measureable results (when available)
- Description of targeted providers and number of providers eligible and participating
- Description of targeted members, number of eligible members whose services are covered by VBP initiative, and number of participating members
- Total payments to providers for services covered in VBP initiative
- Total potential payment adjustment (either percentage or dollars) and type of adjustment (bonus, penalty, risk sharing) related to VBP initiative
- Potential overlap with other VBP programs or initiatives

The first report shall be due to DMAS on April 1, 2018 for the 2017 baseline year.

VBP is evolving in Virginia Medicaid and the Contractor shall implement the required strategies per DMAS direction.

6.7.8 Prescription Drug Rebates

Any outpatient drugs dispensed to members covered by the Contractor (including where the Contractor paid as the primary and/or secondary payer under the MLTSS Contract) shall be subject to the same rebate requirements as the State under section 1927 of the Social Security Act.

The Contractor shall submit to DMAS on a weekly basis drug utilization encounter data. The required reporting format and data elements will be finalized and included in the MLTSS Reporting Manual during contract negotiations. Drug utilization encounter data must include all drugs dispensed at point-of-sale (POS) and those administered in a provider's office or other outpatient setting. Pursuant to section 2501(c)(1)(C)(III) of the Social Security Act, the Department will require encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS physician administered code. The quantity of each NDC submitted, including strength and package size, and the unit of measurement qualifier (F2, ML, GR or UN) is also required. Each HCPCS physician administered code must be submitted with a valid NDC on each claim line. If the drug administered is comprised of more than one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a claim line using the same HCPCS physician administered code. For the purpose of the MLTSS Contract the term "dispense" is defined to include the terms "provide" and "administer." The Contractor must develop a process and procedure to identify drugs administered under section 340b of the Public Health Service Act as

codified at 42 U.S.C. § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program. Failure to identify aforementioned 340b drugs on submissions to the Department or its rebate vendor shall be treated as a compliance violation. The Contractor shall identify encounter claims administered under section 340B in a manner, mutually agreed upon between DMAS and the Contractor, that supports an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing.

The Contractor (and/or its Pharmacy Benefits Manager) shall make available two pharmacy representatives (one primary and one secondary) to work directly with the Department and its drug rebate vendor to assist in all rebate disputes and appeals. This representative must have pharmacy knowledge and/or experience in working with pharmacists and/or prescription drugs.

6.7.9 Provider Payment

Notwithstanding the exceptions outlined below, in accordance with section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. § 447.45 and section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered individuals who are enrolled with the Contractor at the time the service was delivered.

The following exceptions shall apply:

1. The Contractor shall ensure clean claims from NFs, community LTSS providers (including providers who provide community LTSS services when covered under ESPDT) and community behavioral health and SUD providers are processed within fourteen (14) days of receipt of the clean claim.
2. The Contractor shall ensure community LTSS (including these services when covered under EPSDT) and community behavioral health and SUD providers are paid no less than the current Medicaid FFS rate or a different negotiated rate as mutually agreed upon by the provider and the Contractor.
3. The Contractor shall pay NFs no less than the Medicaid rate for Medicaid covered days, using DMAS' methodology, or a different negotiated rate as mutually agreed upon by the provider and the Contractor. DMAS will publish Medicaid rates by nursing facility prior to the beginning of each fiscal year.
4. Following the Department's policy, the Contractor must obtain evidence of the completion of the UAI prior to payment to a NF for that admission.

Interest charges shall be paid for Medicaid claims in accordance with § 38.2-4306.1 of the Code of Virginia.

To the extent the Governor and/or General Assembly implement a specified rate increase for Medicaid specific nursing facility, home health, SUD, or waiver service providers, and as identified by DMAS, and these rate adjustments are incorporated into the MLTSS capitation payment rates, where required by DMAS and/or regulation, the Contractor is required to increase its reimbursement to providers at the same percentage as Medicaid's increase as reflected in the revised fee-for-service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed upon by DMAS.

DMAS reserves the right to require uniform billing practices and claims submissions processes for NFs, LTSS and community behavioral health providers. The Contractor shall develop, train providers on, and implement uniform practices in conjunction with DMAS and the other selected MLTSS Contractors.

6.7.10 Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs)

The Contractor must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs.

6.7.11 Payment Using DRG Methodology

If the Contractor has a contract with a facility to reimburse the facility for services rendered to its members, at time of admission, based on a Diagnosis Relative Grouping (DRG) payment methodology, the Contractor shall be responsible for the full inpatient medical hospitalization from admission to discharge. This will be effective for any member who is actively enrolled in the Contractor on the date of admission regardless if the member is disenrolled from the Contractor during the course of the inpatient hospitalization.

The Contractor shall provide coverage for payment of practitioner services rendered during the hospitalization for any dates in which the member was enrolled with the Contractor on the related date of service.

6.7.12 Provider Preventable Conditions

The Contractor shall comply with 42 C.F.R. § 438.6 requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §434.6(a)(12) and § 447.26. The Contractor shall submit all identified provider preventable conditions as will be outlined in the MLTSS contract. Reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 C.F.R. § 447.26.

6.7.13 Patient Pay for Long Term Services and Supports

When an individual's income exceeds an allowable amount, the member must contribute toward the cost of their LTSS. This contribution, known as the *patient pay amount*, is required

for individuals residing in a NF and for those receiving Waiver services. Patient pay is required to be calculated for every individual receiving NF or Waiver services, although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be outlined in the MLTSS contract.

DMAS will provide information to the Contractor that identifies enrollees who are required to pay a patient pay amount and the amount of the obligation on a monthly basis. DMAS capitation payments to the Contractor for individuals who are required to pay a patient pay amount will be net of the monthly patient pay amount. The Contractor shall develop policies and procedures regarding the collection of the patient pay obligation. The Contractor may collect it directly from the enrollee or assign this responsibility to LTSS providers. If it is the responsibility of the LTSS provider(s), the Contractor shall reduce reimbursements to LTSS providers equal to the patient pay amounts each month. The Contractor must use DMAS' method for assigning patient pay collection to LTSS providers unless an alternate methodology is approved by DMAS. DMAS' method for assigning patient pay collection to LTSS providers will be outlined in the MLTSS contract.

6.7.14 Billing Members for Covered Services

The Contractor shall assure that all in-network provider agreements include requirements whereby the member shall be held harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. However, if a member agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan covered service, then the Contractor, directly or through its network provider or subcontractor, can bill the member for the service.

6.7.15 Protecting Members from Liability from Payment

The Contractor and its subcontractors are subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a member under the State Plan or covered under the MLTSS Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in section 1128B (d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if the Contractor becomes insolvent until such time as members are withdrawn from assignment to the Contractor.

Pursuant to section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), the Contractor and all of its subcontractors shall not hold a member liable for:

- Debts of the Contractor in the event of the Contractor's insolvency

- Payment for services provided by the Contractor if the Contractor has not received payment from the Department for the services or if the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor
- Payments to providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the member if the service had been received directly from the Contractor

6.8 ENFORCEMENT, REMEDIES, AND COMPLIANCE

6.8.1 Basis for Imposition of Sanctions

Pursuant to 42 CFR §.438.700, the Department shall establish intermediate sanctions, as specified in §438.702, that it may impose if it makes any of the determinations specified below. The Department shall base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source. The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth in 42 CFR § 438 Subpart I and to resort to other remedies provided by law. Remedies shall be imposed in situations where the Department determines the Contractor acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its contract with the Department, to an enrollee covered under the contract.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the Department.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §§422.208 and 422.210.
- Has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- Has violated any of the other requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

6.8.2 Remedies

In the event of any breach of the terms of the Contract resulting from the MLTSS Contract by the Contractor, including the violations described above, the Contractor shall pay damages to the Department, or shall comply with other intermediate sanctions identified in 42 C.F.R. §438 Subpart I, for such breach at the sole discretion of the Department. The types of intermediate sanctions that a State may impose under this subpart include the following:

- Civil money penalties in the amounts specified in 42 C.F.R. §438.704
- Appointment of temporary management for an MCO as provided in 42 C.F.R §438.706
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to dis-enroll
- Suspension of all new enrollments, including default enrollment, after the effective date of the sanction
- Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur

The Department retains the authority to impose additional sanctions under State law or State regulations that address areas of noncompliance specified in §438.700, as well as additional areas of noncompliance.

In addition, if, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

6.8.3 DMAS Compliance Monitoring

DMAS shall monitor Contractor compliance with all aspects of the MLTSS Contract. As part of this contract monitoring process, the Department may, at its sole discretion, conduct any or all of the following activities:

- conducting periodic audits and surveys of the Contractor
- investigation of complaints
- review of marketing materials and procedures
- review of grievance and appeals data and procedures
- review of the contractor's outreach and orientation materials and procedures
- conducting site visits as determined necessary to verify the accuracy of reported data
- analysis of encounter data and quality reviews conducted by the external quality review organization

- inspection or other means, to determine the Contractor's compliance with reporting requirements, and quality, appropriateness, and timeliness of services performed by the Contractor and its provider network
- conducting periodic audits of the Contractor, including, but not limited to an annual independent external review and annual site visit
- conducting annual member surveys
- meeting with the Contractor at least semi-annually to assess the Contractor's performance

In addition, DMAS shall institute a Compliance Monitoring Process (CMP) to detect and respond to issues of noncompliance and to remediate contractual violations when necessary. The CMP shall use a system that assigns points based upon key areas of non-compliance. Depending upon the severity of the violation and the accumulation of points, a Corrective Active Plan, Improvement Plan, fines, and/or other sanctions may be imposed upon the Contractor. The DMAS MLTSS CMP will be further detailed in the MLTSS contract.

6.8.4 Contractor Compliance Program

The Contractor shall develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. §§ 438.600-610, 42 C.F.R. 455. The compliance program must, at a minimum, include written policies, procedures and standards of conduct that:

- Articulate the Contractor's commitment to comply with all applicable federal and state standards
- Describe compliance expectations as embodied in the standards of conduct
- Implement the operation of the compliance program
- Provide guidance to employees and others on dealing with potential compliance issues
- Identify how to communicate compliance issues to appropriate compliance personnel
- Describe how potential compliance issues are investigated and resolved by the Contractor
- Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials

6.9 SPECIAL TERMS AND CONDITIONS

6.9.1 Audit

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents and/or state auditors shall have full access to and the right to examine any of said materials during said period.

6.9.2 Award

Selection shall be made of two or more Offerors per region deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals. Negotiations shall be conducted with the Offerors so selected. After negotiations have been conducted, the Department shall select the Offerors which, in its opinion, have made the best proposals, and shall award the contract to those Offerors. The Commonwealth reserves the right to make multiple awards as a result of this procurement. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (*Code of Virginia, § 2.2-4359D*). The award document shall be a contract incorporating by reference all the requirements, terms and conditions of the RFP and the Offeror's proposal as negotiated.

6.9.3 Termination

This Contract may be terminated in whole or in part:

- a. By the Department, for convenience, with not less than ninety (90) days prior written notice, which notice shall specify the effective date of the termination,
- b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
- c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
- d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

6.9.3.1 Termination for Convenience

a. The Department may terminate this contract at any time without cause, in whole or in part, upon giving the Contractor notice of such termination. Upon such termination, the Contractor shall immediately cease work and remove from the project site all of its labor forces and such of its materials as DMAS elects not to purchase or to assume in the manner

hereinafter provided. Upon such termination, the Contractor shall take such steps as owner may require to assign to the owner the Contractor's interest in all subcontracts and purchase orders designated by owner. After all such steps have been taken to DMAS' satisfaction; the Contractor shall receive as full compensation for termination and assignment the following:

- (1) All amounts then otherwise due under the terms of this contract,
- (2) Amounts due for work performed subsequent to the latest Request for Payment through the date of termination,
- (3) Reasonable compensation for the actual cost of demobilization incurred by the Contractor as a direct result of such termination. The Contractor shall not be entitled to any compensation for lost profits or for any other type of contractual compensation or damage other than those provided by the preceding sentence. Upon payment of the forgoing, owner shall have no further obligations to the Contractor of any nature.

b. In no event shall termination for the convenience of DMAS terminate the obligations of the Contractor's surety on its payment and performance bonds.

6.9.3.2 Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether federal and/or state funds. The Department may terminate this Contract at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

6.9.3.3 Termination Because of Financial Instability

If DMAS determines that there are verifiable indicators that the Contractor will become financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, DMAS shall require verification of the Contractor's financial situation. If from the information DMAS determines the Contractor will inevitably become financially unstable, DMAS may terminate the contract before this occurs. If the Contractor ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, DMAS may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

6.9.3.4 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice shall identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to member notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that DMAS determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of

Medicaid/FAMIS Plus or FAMIS individuals, DMAS may immediately terminate this contract prior to providing notice to the Contractor.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure or contract from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

6.9.4 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention.

Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

6.9.5 Renewal of Contract

This contract may be renewed or extended by the Commonwealth for up to five successive twelve month periods under the terms and conditions of the contract. During the contract renewal or contract amendment process, new Capitation Rates may be calculated and established by the Department and written notice of the Commonwealth's intention to renew shall be given at least 90 days prior to the expiration date of each contract period.

6.9.6 Business Associate Agreement (BAA)

The Contractor shall be required to enter into a DMAS-supplied Business Associate Agreement (BAA) with DMAS to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI). The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and regulations with regards to handling, processing, or using the Department's PHI and ePHI. This includes but is not limited to 45 C.F.R. Parts 160 and 164 Modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, January 25, 2013 and related regulations as they pertain to this agreement.

The Contractor shall keep abreast of any future changes to the regulations. The Contractor shall comply with all current and future HIPAA regulations at no additional cost to DMAS, and agrees to comply with all terms set out in the DMAS BAA, including any future changes to the DMAS BAA. The current DMAS BAA template is available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx.

6.9.7 eVA Orders and Contracts

The solicitation/contract will result in one (1) purchase order(s) with the applicable eVA transaction fee assessed for each order.

Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following: If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eVA.virginia.gov. Contractors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov.

6.9.8 State Corporation Commission Identification Number

Pursuant to *Code of Virginia*, § 2.2-4311.2 subsection B, an Offeror organized or authorized to transact business in the Commonwealth pursuant to Title 13.1 or Title 50 is required to include in its proposal the identification number issued to it by the State Corporation Commission (SCC). Any Offeror that is not required to be authorized to transact business in the Commonwealth as a foreign business entity under Title 13.1 or Title 50 or as otherwise required by law is required to include in its proposal a statement describing why the Offeror is not required to be so authorized. Indicate the above information on the SCC Form provided (Reference Attachment I – State Corporation Commission Form). Contractor agrees that the

process by which compliance with Titles 13.1 and 50 is checked during the solicitation stage (including without limitation the SCC Form provided) is streamlined and not definitive, and the Commonwealth's use and acceptance of such form, or its acceptance of Contractor's statement describing why the Offeror was not legally required to be authorized to transact business in the Commonwealth, Shall not be conclusive of the issue and Shall not be relied upon by the Contractor as demonstrating compliance.

6.9.9 Standards for the Electronic Health Record Technology Incentive Program

The Contractor shall comply with the current Federal laws and Regulations with regards to the Standards for the Electronic Health Record Technology Incentive Program as referenced under 42 C.F.R. Part 495 (the "Standards"). The Contractor shall comply with the current Standards at no additional cost to DMAS. The current Standards are located at the following site: <http://cfr.regstoday.com/42cfr495.aspx>. The parties will work diligently and in good faith to amend this Contract 10023, including but not limited to changes in scope of work or price, to conform to any new or revised legislation, laws, or regulations regarding the Standards to which DMAS or Contractor become subject subsequent to the start of the Period of Performance.

6.9.10 Risk Management and Security

The Contractor, at a minimum, shall comply with VITA standards, which may be found on the VITA website at <http://www.vita.virginia.gov>. DMAS requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that will document Contractors compliance with the most stringent requirements listed below:

- Section 1902 (a) (7) of the Social Security Act (SSA);
- 45 C.F.R. Parts 160, and 164 Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Genetic Information Nondiscrimination Act (GINA); Other Modifications to the HIPAA Rules; Final, January 25, 2013
- COV ITRM Policy SEC5519-00 (latest version);
- COV ITRM Standard SEC501-07 (latest version).
- At a minimum, the following specific security measures shall be included in the Risk Management and Security Plan Computer hardware controls that ensure acceptance of data from authorized networks only:
 - At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;
 - Manual procedures that provide secure access to the system with minimal risk.
 - Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel;

- All Contractor database software changes may be subject to the Department's approval prior to implementation; and
- System operation functions must be segregated from systems development duties.

If requested, the Contractor agrees that the Plan will be made available to appropriate State and Federal agencies as deemed necessary by DMAS. If any changes to the Plan occur during the contract period, the Contractor shall notify the contract administrator at the Department within 30 days to the change occurring.

6.9.11 Continuity of Operations

The Contractor shall be required to provide written assurances that they have a Continuity of Operations (COOP) Plan that relates to the services or functions provided by them under this contract. Key information to be included in the Contractor's COOP and used as an example can be found on the VITA website at

<http://www.vita.virginia.gov/library/default.aspx?id=537#securityPSGs> for templates for Virginia Department of Emergency Management (VDEM) Continuity documents:

- VDEM Continuity Plan Template
- VDEM Guide to Identifying Mission Essential Functions and
- Mission Essential Function Identification Worksheets

The COOP document shall be available to the Department at its request and at least 30 days prior to beginning operations. If any changes occur during the contract period, the Contractor shall notify the Department's contract administrator within 30 days prior to the change occurring.

6.9.12 Security Training

The Contractor shall be required to provide written assurances that they have a Security Training Plan that relates to the services or functions provided by them under this contract. The Security Training Plan document shall be available to the Department at its request and at least 30 days prior to beginning operations. If any changes occur during the contract period, the Contractor shall notify the Department's contract administrator within 30 days prior to the change occurring and provide documentation of the changes.

6.9.13 Controls

6.9.13.1 Annual Review of Controls

The Contractor shall provide the Department, at a minimum, a report from its external auditor on the effectiveness of its internal controls. If the report discloses deficiencies in internal controls, the Contractor shall include management's corrective action plans to remediate the

deficiency. If available, report shall be compliant with the AICPA Statement on Standards for Attestation Engagements (SSAE) No 16, Reporting on Controls at a Service Organization, Service Organizations Controls (SOC) 2, Type 2 Report, and include the Contractor and its third-party service providers. If a review of internal controls has not been performed, a peer review report shall be submitted. Reports shall be provided annually each June 1st for the preceding calendar year

6.9.13.2 Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. Such policies and procedures must be in accordance with federal regulations described in 42 C.F.R. Parts 455 and 456. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

6.9.13.3 Fraud and Abuse Compliance Plan

a. The Contractor shall have a written Fraud and Abuse compliance plan. The Contractor's specific internal controls and policies and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the Department with this Contract and as an annual submission as part of the Contract. The Plan must define how the Contractor shall adequately identify and report suspected fraud and abuse by Medicaid enrollees, by network providers, by subcontractors and by the Contractor. The Plan must be submitted annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent marketing practices, or other types of fraud and program abuse and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or federal laws and regulations.

The Department shall provide notice of approval, denial, or modification to the Contractor within 30 calendar days of annual submission. The Contractor shall make any requested updates or modifications available for review after modifications are completed as requested by the Department within 30 calendar days of a request. At a minimum the written plan shall:

- i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;
- ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;
- iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:
 - a. Service Authorization
 - b. Relevant subcontractor and provider agreement provisions;

- c. Utilization Management
 - iv. Contain provisions for the confidential reporting of plan violation to DMAS by providers and subcontractors.
 - v. Contain provisions for the investigation and follow-up of any compliance plan reports;
 - vi. Ensure that the identities of individuals reporting violations of the plan are protected;
 - vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
 - viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to the Department and that Medicaid enrollee fraud and abuse be reported to the Department;
 - ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is subjected to retaliation
- b. The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.
 - c. The Contractor shall report incidents of potential or actual fraud and abuse to the Department within 2 business days of initiation of any investigative action by the Contractor or within 2 business days of Contractor notification that another entity is conducting such an investigation of the Contractor. All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other state and federal offices. The Contractor shall provide an annual report to the Department of all activities and results.

6.9.13.4 Referrals for Fraud (MFCU)

All cases where fraud is suspected or detected shall be referred to the Department for referral to MFCU prior to any actions or recoupment taking place. The Contractor shall provide support to the MFCU on matters relating to specific cases involving detected or suspected fraud. Referrals shall be submitted to the Department in a format to be determined by the Department.

6.9.14 Audited Financial Statements and Income Statements

The Contractor shall provide to the Department copies of its annual audited financial (or fiscal) statements no later than 90 calendar days after the end of their fiscal year. If the Contractor does not have audited financial statements, non-audited financial statements shall be provided.

6.9.15 Public Filings

The Contractor shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this contract.

6.9.16 Subcontractors

Legal Responsibility

In accordance with requirements described in 42 C.F.R. § 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at <http://www.cms.gov/smdl/downloads/SMD061208.pdf>), the Contractor shall comply with all of the following federal requirements. Failure to comply with accuracy, timeliness, and in accordance with federal and contract standards may result in refusal to execute this Contract, termination of this Contract, and/or liquidated damages by the Department.

6.10.16.1 Contractor Owner, Director, Officer(s) and/or Managing Employees

(a) The Contractor and/or its subcontractors shall not knowingly have a relationship of the type described in paragraph (b) of this section with:

(1) An individual or entity who is debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the Federal List of Excluded Individuals and Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) The relationships described in this paragraph are as following:

(1) Director, officer, or partner of the Contractor.

(2) Person with beneficial ownership of 5percent or more of the Contractor's equity.

(3) Person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

(c) Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. and § 455.106, the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest; and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the Disclosure of Ownership and Control Interest Statement (CMS 1513).

(d) The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with

these federal regulations. The LEIE database is available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

(e) The Contractor shall report to the Department within 5 business days of discovery of any Contractor or subcontractor owners or managing employees identified on the Federal List of Excluded Individuals/Entities (LEIE) database and the action taken by the Contractor.

(f) Failure to disclose the required information accurately, timely, and in accordance with federal and contract standards may result in refusal to execute this Contract, termination of this Contract, and/or liquidated damages by the Department.

6.9.16.2 Contractor and Subcontractor Service Providers

(a) In accordance with 1902(a)(39) and (41), 1128, and 1128A of the *Social Security Act*, 42 C.F.R. § 438-610, 42 C.F.R. § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for fraud and abuse. Additional guidance may be found in the Department's 4/7/09 Medicaid Memo titled "Excluded Individuals/Entities from State/Federal Healthcare Programs."

(b) The Contractor shall inform providers and subcontractors about federal requirements regarding providers and entities excluded from participation in federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor shall inform providers and subcontractors about the U.S. Department of Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at <http://exclusions.oig.hhs.gov>. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in federal health care programs. Providers and subcontractors shall also be advised to immediately report to the Contractor any exclusion information discovered. The Contractor must also require that its subcontractor(s) have written policies and procedures outlining provider enrollment and/or credentialing process. The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its providers against the LEIE database to ensure that their contracted health care professionals have not been included on the Federal List of Excluded Individuals/ Entities (LEIE) database, available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States.

(c) The Contractor shall report to the Department within 5 business days of discovery of any network providers or its subcontractor providers that have been identified on the Federal LEIE database and the action taken by the Contractor.

(d) Failure to disclose the required information accurately, timely, and in accordance with federal and contract standards may result in sanctions by the Department in accordance with this subsection of the Contract.

6.9.16.3 Prior Approval

All subcontracts, amendments, and revisions that directly affect this contract must be approved in advance by the Department. All subcontracts shall be maintained in accordance with the applicable terms of this Contract. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to the Department within 30 business days of execution.

6.9.16.4 Notice of Approval

Approval of subcontracts shall not be considered granted unless the Department issues its prior approval in writing (to include e-mail). The Department may revoke such approval if the Department determines that the subcontractor(s) fails to meet the requirements of this Contract.

6.9.16.5 Notice of Subcontractor Termination

When a subcontract that relates to the provision of the scope of services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least 30 days prior written notice of the termination to the Department. Such notice shall include, at a minimum, the Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how continuity of the project shall be maintained. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted provider of the change. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

6.9.17 Mandatory Preproposal Conference

A mandatory preproposal conference will be held on May 10, 2016, 2:00 P.M. EST at the Department of Medical Assistance Service, 600 E. Broad Street, Conference Room 7B,

Richmond, VA 23219. The purpose of this conference is to allow DMAS an opportunity to clarify various facets of the RFP. DMAS will not respond to questions during the preproposal conference. Due to the importance of all Offerors having a clear understanding of the specifications/scope of work and requirements of this RFP, attendance at this conference will be a prerequisite for submitting a proposal. Proposals will only be accepted from those Offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. No one will be permitted to sign the register after 2:15 P.M on day of conference. Due to space limitations, Offerors are limited to two (2) representatives each at the preproposal conference. To ensure adequate accommodations, Offerors need to pre-register with Tammy Driscoll by sending an email to RFP2016-01@dmas.virginia.gov stating the name of Offeror and Offeror's participating representatives. For planning purposes, Offerors should pre-register with Tammy Driscoll by 1:00PM EST the day before the conference. Offerors should bring a copy of the RFP to the conference. Any changes resulting from this conference will be issued in a written addendum to the RFP.

6.9.18 E-Verify

EFFECTIVE 12/1/13. Pursuant to *Code of Virginia*, §2.2-4308.2., any employer with more than an average of 50 employees for the previous 12 months entering into a contract in excess of \$50,000 with any agency of the Commonwealth to perform work or provide services pursuant to such contract shall register and participate in the E-Verify program to verify information and work authorization of its newly hired employees performing work pursuant to such public contract. Any such employer who fails to comply with these provisions shall be debarred from contracting with any agency of the Commonwealth for a period up to one year. Such debarment shall cease upon the employer's registration and participation in the E-Verify program. If requested, the employer shall present a copy of their Maintain Company page from E-Verify to prove that they are enrolled in E-Verify.

6.9.19 Severability

Invalidity of any term of this Contract, in whole or in part, shall not affect the validity of any other term. DMAS and Contractor further agree that in the event any provision is deemed an invalid part of this Contract, they shall immediately begin negotiations for a suitable replacement provision to this RFP.

6.9.20 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole

negligence of the Department or to failure of DMAS to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

7.0 GENERAL TERMS AND CONDITIONS

7.1 VENDORS MANUAL

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in Section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.eva.virginia.gov under “Vendors Manual” on the vendors tab.

7.2 APPLICABLE LAWS AND COURTS

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Department and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, § 2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual*. The Contractor shall comply with all applicable federal, state and local laws, rules and regulations.

7.3 ANTI-DISCRIMINATION

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the *Virginia Public Procurement Act* (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any individual of goods, services, or disbursements made pursuant to the contract on the basis of the individual’s religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1 E).

In every contract over \$10,000, the provisions in Sections 7.3.1 and 7.3.2 below apply.

7.3.1 During the performance of this contract, the Contractor agrees as follows:

The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited

by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.

Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

7.3.2 The Contractor shall include the provisions of 7.3.1 per above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

7.3.3 Ethics in Public Contracting

By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

7.3.4 Immigration Reform and Control Act of 1986

By entering into a written contract with the Commonwealth of Virginia (COV), the Contractor certifies that the Contractor does not, and shall not during the performance of the contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the Federal Immigration Reform and Control Act of 1986.

7.3.5 Debarment Status

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, state or local government from submitting bids or proposals on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

7.3.6 Antitrust

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth

of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

7.3.7 Mandatory Use of State Form and Terms and Conditions

Failure to submit a proposal on the official State form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

7.3.8 Clarification of Terms

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Tammy Driscoll at RFP2016-01@dmas.virginia.gov no later than 5:00 P.M. EST, May 13, 2016. Any revisions to the solicitation will be made only by addendum issued by the buyer.

7.3.9 Payment

1. To Prime Contractor:

- a) Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
- b) Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
- c) All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
- d) The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
- e) Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations

with respect to those charges that are not in dispute (*Code of Virginia, § 2.2-4363*).

2. To Subcontractors:
 - a. A Contractor awarded a contract under this solicitation is hereby obligated:
 - (1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
 - (2) To notify the agency and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.
 - b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.
3. Each prime Contractor who wins an award in which provision of a Small Business Subcontracting (SWAM) Plan is a condition to the award, shall deliver to the Department, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the Small Business Subcontracting (SWAM) Plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the Department or other appropriate penalties may be assessed in lieu of withholding such payment.
4. The Commonwealth of Virginia encourages Contractors and subcontractors to accept electronic and credit card payments.

7.4 PRECEDENCE OF TERMS

The following General Terms and Conditions: *VENDORS MANUAL*, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEPARTMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

7.5 QUALIFICATIONS OF OFFERORS

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

7.6 TESTING AND INSPECTION

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure goods and services conform to the specifications.

7.7 ASSIGNMENT OF CONTRACT

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

7.8 CHANGES TO THE CONTRACT

Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the terms, conditions, or scope of the contract. Any additional goods or services to be provided shall be of a sort that is ancillary to the contract goods or services, or within the same broad product or service categories as were included in the contract award. Any increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract. **In any such change to the resulting contract, no increase to the contract price shall be permitted without adequate consideration, and no waiver of any contract requirement that results in savings to the Contractor shall be permitted without adequate consideration. Pursuant to Code of Virginia § 2.2-4309, the value of any fixed-price contract shall not be increased via modification by more than 25% without the prior approval of the Division of Purchases and Supply of the Virginia Department of General Services.**
2. The Purchasing Agency may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed, the method of packing or shipment, and the place of delivery or installation. The Contractor shall comply with the

notice upon receipt, unless the Contractor intends to claim an adjustment to compensation, schedule, or other contractual impact that would be caused by complying with such notice, in which case the Contractor shall, in writing, promptly notify the Purchasing Agency of the adjustment to be sought, and before proceeding to comply with the notice, shall await the Purchasing Agency's written decision affirming, modifying, or revoking the prior written notice. If the Purchasing Agency decides to issue a notice that requires an adjustment to compensation, the Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Purchasing Agency a credit for any savings. Said compensation shall be determined by one of the following methods:

- a. By mutual agreement between the parties in writing; or
- b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or
- c. By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

7.9 DEFAULT

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

7.10 INSURANCE

By signing and submitting a proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Offeror further certifies that the Contractor and any subcontractor will maintain this insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability: \$100,000.
3. Commercial General Liability: \$1,000,000 per occurrence and \$2,000,000 in the aggregate. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: \$1,000,000 combined single limit. (Required only if a motor vehicle not owned by the Commonwealth is to be used in the contract. Contractor must assure that the required coverage is maintained by the Contractor (or third party owner of such motor vehicle.)

7.11 ANNOUNCEMENT OF AWARD

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the DGS/DPS eVA VBO (www.eva.virginia.gov) for a minimum of 10 days.

7.12 DRUG-FREE WORKPLACE

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in

the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "*drug-free workplace*" means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

7.13 NONDISCRIMINATION OF CONTRACTORS

A bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

7.14 eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION, CONTRACTS, AND ORDERS:

Internet electronic procurement solution, web site portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution by completing the free eVA Vendor Registration. All bidders or Offerors must register in eVA and pay the Vendor Transaction Fees specified below; failure to register will result in the bid/proposal being rejected.

Vendor transaction fees are determined by the date the original purchase order is issued and the current fees are as follows:

- a. For orders issued July 1, 2014, and after, the Vendor Transaction Fee is:
 - (i) DSBSD-certified Small Businesses: 1%, capped at \$500 per order.
 - (ii) Businesses that are not DSBSD-certified Small Businesses: 1%, capped at \$1,500 per order.
- b. Refer to Special Term and Condition “eVA Orders and Contracts” to identify the number of purchase orders that will be issued as a result of this solicitation/contract with the eVA transaction fee specified above assessed for each order.

For orders issued prior to July 1, 2014, the vendor transaction fees can be found at www.eVA.virginia.gov.

The specified vendor transaction fee will be invoiced, by the Commonwealth of Virginia Department of General Services, typically within 60 days of the order issue date. Any adjustments (increases/decreases) will be handled through purchase order changes.

7.15 AVAILABILITY OF FUNDS

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

7.16 SET-ASIDES IN ACCORDANCE WITH THE SMALL BUSINESS ENHANCEMENT AWARD PRIORITY

This solicitation is set-aside for award priority to DSBSD-certified micro businesses or small businesses when designated as “Micro Business Set-Aside Award Priority” or “Small Business Set-Aside Award Priority” accordingly in the solicitation. DSBSD-certified micro businesses or small businesses also includes DSBSD-certified women-owned and minority-owned businesses when they have received the DSBSD small business certification. For purposes of award, bidders/Offerors shall be deemed micro businesses or small businesses if and only if they are certified as such by DSBSD on the due date for receipt of bids/proposals.

7.17 PRICE CURRENCY

Unless stated otherwise in the solicitation, Offerors shall state offer prices in US dollars.

7.18 AUTHORIZATION TO CONDUCT BUSINESS IN THE COMMONWEALTH

The Contractor organized as a stock or non-stock corporation, limited liability company, business trust, or limited partnership or registered as a registered limited liability partnership

shall be authorized to transact business in the Commonwealth as a domestic or foreign business entity if so required by Title 13.1 or Title 50 of the *Code of Virginia* or as otherwise required by law. Any business entity described above that enters into a contract with a public body pursuant to the *Virginia Public Procurement Act* shall not allow its existence to lapse or its certificate of authority or registration to transact business in the Commonwealth, if so required under Title 13.1 or Title 50, to be revoked or cancelled at any time during the term of the contract. A public body may void any contract with a business entity if the business entity fails to remain in compliance with the provisions of this section.

8.0 GLOSSARY

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

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

Activities of Daily Living (ADLs) – Personal care tasks such as bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining the appropriate level of care and service needs.

Acute Care – Preventive care, primary care, and other inpatient and outpatient medical and behavioral health care provided under the direction of a physician for a condition having a relatively short duration.

Adoption Assistance – A social services program, under Title XX of the Social Security Act, that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the Commonwealth of Virginia.

Adult Day Health Care (ADHC) – Long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those EDCD waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility (NF). The program shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC). The services offered by the center shall be required by the waiver individual in order to permit the individual to remain in his home rather than entering a NF. ADHC can also refer to the center where this service is provided.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, a prepaid inpatient health plan (PIHP), or a prepaid ambulatory health plan (PAHP), any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension, or

termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) the failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (vi) for a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Agency-Directed Services – A model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

All Payers Claim Database – Established by the Virginia General Assembly to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system.

Alternate Formats – Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternate Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, and information read aloud to an Enrollee.

Alzheimer's Assisted Living (AAL) Waiver – CMS-approved home and community-based care waiver that covers a range of community support services offered to individuals who have a diagnosis of Alzheimer's or dementia, (they may not have a diagnosis of intellectual disability or serious mental illness), are over age 55, who meet nursing facility level of care and who are receiving an Auxiliary Grant. The AAL waiver serves individuals who reside in an assisted living facility (ALF) licensed by the Virginia Department of Social Services that offers a safe and secure environment. AAL Waiver participants and services will be excluded from MLTSS.

Ameliorate – Necessary to improve or to prevent the condition from getting worse, with regard to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services

Appeal (Enrollee) – An enrollee's request or a provider on behalf of an enrollee's request for review of the Contractor's coverage or payment determination, in accordance with 42 C.F.R. § 438.400 et seq. (<http://www.gpo.gov/fdsys/pkg/C.F.R.-2012-title42-vol4/pdf/C.F.R.-2012-title42-vol4-part438.pdf>).

Appeal (Provider) – Requests made by the Contractor's MLTSS providers (in-network and out-of-network) to review the Contractor's adverse benefit determination in accordance with the

statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the Contractor's appeal process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act (*Code of Virginia* section 2.2-4000 et seq.) and Virginia Medicaid's provider appeal regulations (12 VAC 30-20-500 et seq.).

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

Assessment – Processes used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status, and other factors to determine which services, if any, should be authorized and provided. Assessment information supports the development of the Individualized Care Plan (ICP) and the determination of whether an individual requires waiver services.

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

Attendant – An individual who provides consumer-directed personal assistance, respite or companion services through the consumer-directed model of care

Audit – A formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures

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

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

Behavioral Health Services – An array of therapeutic services provided in inpatient and outpatient psychiatric and community behavioral health settings. Services are designed to provide necessary support and address mental health and behavioral needs in order to

diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance use disorder.

Behavioral Health Services Administrator (BHSA) – An entity that manages or directs a behavioral health benefits program on behalf of the program’s sponsor. The BHSA is responsible for administering the Department’s behavioral health benefits that are currently carved out of managed care on a statewide basis for Title XIX Medicaid individuals and Title XXI FAMIS members to include care coordination, provider management, and reimbursement of such behavioral health services.

Business Associate – Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department’s capability for effective administration of the program. A Business Associate includes, but is not limited to, those applicable parties referenced in 45 C.F.R. §160.103.

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

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

Capitation Rate – The monthly amount, payable to the Contractor, per individual, for the provision of contract services as defined herein. The Contractor shall accept the annually established capitation rates paid each month by the Department as payment in full for all Medicaid services to be provided pursuant to the contract resulting from this RFP and all administrative costs associated therewith, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

Caregiver – A person who assists to provide services and supports for an individual who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers may include relatives, friends, or others who volunteer to help. Paid caregivers provide services in exchange for payment for the services rendered.

Care Coordination – The Contractor’s responsibility of assessing and planning of services; linking the individual to services and supports identified in the integrated care plan (ICP); assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family members involved with the individual; making collateral contacts to

promote the implementation of the ICP and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and training, education, and counseling that guides the individual and develops a supportive relationship that promotes the ICP (also see Targeted Case Management).

Carved-Out Services – The subset of Medicaid covered services for which the Contractor shall not be responsible under the program

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

Certified Community Behavioral Health Clinics (CCBHCs) – An opportunity for states to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improving access to high quality care. See http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf for additional information.

C.F.R. – Code of Federal Regulations

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

Clean Claim – A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act.

Community-Based Organizations (CBOs) – Organizations such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) that have historically formed the backbone of the home and community based service (HCBS) delivery system for seniors and adults with physical disabilities. CBOs provide long-term services and supports (LTSS), care planning, and care coordination using a variety of funding sources including federal funds and state appropriations.

Commonwealth Coordinated Care (CCC) Program – The program name for the Department’s capitated, managed care, financial alignment demonstration model, administered under the Center for Medicare & Medicaid Innovation authority. Virginia operates CCC with CMS under a Memorandum of Understanding (MOU) and a three-way contract between DMAS, CMS and

contracted Medicare-Medicaid Plans (MMPs). Commonwealth Coordinated Care provides coordinated care for full-benefit dual eligible individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. The program is designed to coordinate delivery of primary, preventive, acute, behavioral, and long term services and supports. In this way, the individual receives high quality, person centered care that is focused on their needs and preferences. The CCC Program will end on December 31, 2017. Additional information is available at: http://www.dmas.virginia.gov/Content_pgs/valtc.aspx.

Community Well – Individuals who have limited or no current medical, behavioral health, or long term services and supports (LTSS) needs but may have needs in the future

Community Service Board (CSB) – A citizens' board established pursuant to Virginia Code §37.2-500 (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-500>) and §37.2-600 (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-600>) that provides mental health, intellectual disability and substance use disorder programs and services within the political subdivision or political subdivisions participating on the board. In all cases the term CSB also includes Behavioral Health Authority (BHA).

Complaint – See definition for “grievance.”

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Health Care Policy and Research, the Research Triangle Institute and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of managed care plans.

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

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

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

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

Contractor – A managed care health plan selected and contracted with DMAS to participate in the MLTSS program in accordance with this RFP.

Coordination of Benefits” or “COB”/ (Coordination of Other Coverage) – A method of integrating benefits payable under more than one form of health insurance coverage so that the covered member’s benefits from all sources do not exceed 100 percent of the allowable medical expenses. COB rules also establish which plan is primary (pays first) and which plan is secondary; recognizing that Medicaid is the payer of last resort.

Cost Sharing – Co-payments paid by the member in order to receive medical services

COV Security Standards – COV Information Technology Resource Management (ITRM) policies, standards, and guidelines that may be updated from time to time. A complete list can be located at <http://www.vita.virginia.gov/library/default.aspx?id=537>.

Covered Services – The subset of services for which the Contractor shall be responsible for covering under the program

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

Crisis Intervention Services – Immediate mental health care, available 24 hours a day, seven days a week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention

Crisis Stabilization Services – Direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Day Support Services – Training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services focus on enabling the individual to attain or maintain his maximum functional level.

Day Support (DS) Waiver – The CMS-approved HCBS § 1915 (c) waiver whose purpose is to provide support in the community for individuals who are on the Intellectual Disability (ID) Waiver waiting list. Services include day support, prevocational services, and supported employment (group and individual). The DS Waiver is administered collaboratively by DMAS and DBHDS.

Day Treatment/Partial Hospitalization – Time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when an individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. Services consist of diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for individuals with serious mental health disorders.

Delivery System Reform Incentive Payment (DSRIP) – DSRIP provides financial incentives to states, based on the achievement of agreed upon metrics and measures. DSRIP is intended to dramatically improve health care quality, contain costs, and maximize the value of health care investments for Medicaid populations. DSRIP financing is to help Medicaid programs achieve delivery system transformation through infrastructure development and support, serving as provider-based building blocks for other broader health care transformation efforts.

Department of Behavioral Health and Developmental Services (DBHDS) – DBHDS is the State Agency in the Commonwealth of Virginia that is responsible for coordination of behavioral health, developmental disabilities, and substance use disorder services through the local community services boards (CSBs). This agency has responsibility for the day-to-day operations of the Intellectual Disability (ID) Waiver, the Individual and Family Developmental Disabilities Support (DD) Waiver, and the Day Support (DS) Waiver.

Department of Health Professions – Agency that issues licenses, registrations, certifications, and permits to healthcare practitioner applicants that meet qualifications established by law and regulation. In addition to the Board of Health Professions, the following applicable boards are included within the Department: Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Long-Term Care Administrators, Board of Medicine, Board of Nursing, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology and Board of Social Work.

Department of Medical Assistance Services (DMAS or Department) – The single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act.

Disease Management – System of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant

Disenrollment – The process of changing enrollment from one Contractor to another. This term does not refer to termination of eligibility in a Medicaid program.

Dual Eligible Individuals – A Medicare beneficiary who receives Medicare Part A, B, and/or D benefits and who also receives full Medicaid benefits. This term will be used throughout the RFP to reference individuals eligible for the MLTSS program. Individuals who receive both Medicare and Medicaid coverage but who are NOT eligible for full Medicaid benefits (e.g., individuals who qualify as Specified Low-Income Medicare Beneficiaries (SLMBs), Qualified Medicare Beneficiaries (QMBs), Qualified Disabled and Working Individuals (QDWIs), or Qualifying Individuals (QIs)) are not included in the MLTSS program.

Dual Eligible Special Needs Plan (D-SNP) – A type of Medicare Advantage (MA) plan that enrolls only individuals dually eligible for Medicare and Medicaid

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

Early Intervention (EI) – Early Intervention (EI) services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three (3) who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program benefit for individuals under the age of 21 and provides coverage for children with a comprehensive set of screenings, interventions, and other support services. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT member to correct, ameliorate or prevent the condition from worsening or prevent the development of additional

health problems, even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. See also, 42 C.F.R. § 441 Subpart B (Sections 50-62).

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

Electronic Visit Verification (EVV) – Home visit tracking systems that verify service visits occur in the home or in the community and document the precise time the provision of service begins and ends.

Emergency Custody Order – Judicial intervention to order law enforcement personnel to take into custody and transport for needed mental health evaluation and care or medical evaluation and care a person who is unwilling or unable to volunteer for such care pursuant to 42 C.F.R. § 441.150 and Code of Virginia, § 16.1- 335 et seq. and § 37.1-67.1 et seq. A magistrate is authorized to order such custody on an emergency basis for short periods. Different emergency custody statutes apply to adults than to juveniles.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance use disorder) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services – Those health and/or behavioral health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms or behavior of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

Employer of Record (EOR) – An individual, or their representative, who directs their own care and receives consumer-directed services from an attendant who is hired, trained, and supervised by the individual or the individual's representative

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

Encryption – A security measure process involving the conversion of data into a format which cannot be interpreted by outside parties

Enhanced Benefits – Benefits Contractors may choose to offer outside of the required covered services. Enhanced benefits are not considered in the development of the Contractor’s capitation rate

Enrollment (MLTSS) – Assignment of an individual to a Contractor by the Department. This does not include attaining eligibility for the Medicare or Medicaid programs.

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

Enrollment Period – The time that a member is enrolled with a Contractor

Environmental Modifications – Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.

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

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

Federally Qualified Health Centers (FQHCs) – Those facilities as defined in 42 C.F.R. §405.2401(b), as amended

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

Firewall – Software or hardware-based security system that controls the incoming and outgoing network traffic based on an applied rule set. A firewall establishes a barrier between a trusted, secure internal network and another network (e.g., the internet) that is not assumed to be secure and trusted. Firewall also includes physical security measures that establish barriers between staff, the public, work areas, and data to ensure information is not shared inappropriately or in violation of any applicable State or Federal laws and regulations.

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

Flesch Readability Formula – The formula by which readability of documents is tested as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974)

Formal Support – Services provided by professional, trained employees, typically paid for their work, such as the personal care attendant who helps with bathing

Formulary – A list of drugs that the Contractor has approved. Dispensing some of the drugs may require service authorization for reimbursement.

Foster Care – Pursuant to 45 C.F.R. § 1355.20, a “24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility.” Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is predicated upon the child being placed outside of the home and with an individual who has “placement and care” responsibility for the child. The term “placement and care” means that Local Department of Social Services (LDSS) is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care.

Fraud – Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit. Fraud also includes any act that constitutes fraud under applicable Federal or State law.

Grievance – In accordance with 42 C.F.R. § 438.400 et seq., grievance means an expression of dissatisfaction about any matter other than an “action.” A “grievance” is any complaint or dispute expressing dissatisfaction with any aspect of the Contractor’s or Provider’s operations, activities, or behavior. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the enrollee’s rights, as provided for in 42 C.F.R. § 438.400 et seq.

Health and Acute Care Program (HAP) – Managed care program that provides acute and primary medical services to individuals enrolled in one of five HCBS waivers. Waiver services are paid as carved out services. This includes individuals enrolled in the Elderly or Disabled with Consumer-Direction (EDCD) Waiver, the Intellectual Disability (ID) Waiver, the Individuals and Family Developmental Disabilities Support (IFDDS) Waiver, the Day Support (DS) Waiver, and the Alzheimer’s Assisted Living (AAL) Waiver. HAP individuals (other than AAL Waiver participants) will be included in MLTSS.

Healthcare Effectiveness Data and Information Set (HEDIS) – Tool developed and maintained by the National Committee for Quality Assurance that is used to measure performance on dimensions of care and service in order to maintain and/or improve quality.

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

Health Risk Assessment (HRA) – A comprehensive assessment of a member’s medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, long-term services and support (LTSS), and social needs.

High Touch Model of Care – A model of care providing highly focused health care services for individuals, including of health risk assessments, person-centered care planning, interdisciplinary care teams, care coordination and smooth transitions to and from hospitals, nursing facilities, and the community.

Home and Community-Based Services (HCBS) Waiver – A variety of home and community-based services paid for by DMAS as authorized under an §1115 or §1915(c) waiver designed to

offer individuals an alternative to institutionalization. Individuals may be authorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutional placement. Three of Virginia's six HCBS waivers are undergoing a complete system redesign to address access to care and federal community-based settings requirements. These are the Day Support (DS) waiver, the Intellectual Disability (ID) waiver, and the Individual and Family Supports Developmental Disabilities (DD) waiver. This redesign effort will be completed in 2016.

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

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

Hospital – A facility that meets the requirements of 42 C.F.R. § 482 et seq., as amended

Individualized Care Plan (ICP) – The Contractor's comprehensive written document developed with an individual that specifies the individual's services and supports (both formal and informal). The ICP is developed through a person-centered planning process that incorporates the individual's strengths, skills, needs, preferences, and goals. The ICP is updated as indicated by the MLTSS Contract. The ICP includes all aspects of an individual's care needs including, but not limited to, medical, behavioral, social, and long term services and supports, as appropriate.

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

Individual and Family Developmental Disabilities Support (DD) Waiver – The CMS-approved HCBS §1915(c) waiver whose purpose is to provide care in the community rather than in an Intermediate Care Facility for Persons with Intellectual Disability (ICF/IID). Participants include individuals who are 6 years of age and older, have a developmental disability (DD) diagnosis or a related condition, do not have a diagnosis of intellectual disability (ID), and meet the ICF/IID level of care criteria. DD Waiver participants are also determined to be at imminent risk of ICF/IID placement where receipt of services under the DD waiver are critical and will enable the individual to remain at home rather than being placed in an ICF/IID.

Informal Support – The support provided by a member's social network and community, such as family, friends, faith-based organizations, etc., and is typically unpaid.

Intellectual Disability (ID) Waiver – The CMS-approved HCBS §1915(c) waiver whose purpose is to provide care in the community rather than in an Intermediate Care Facility for Persons with Intellectual Disability (ICF/IID). Participants include individuals up to 6 years of age who are at developmental risk and individuals age 6 and older who have Intellectual Disability (ID) and meet the ICF/IID level of care criteria. ID Waiver participants are also determined to be at imminent risk of ICF/IID placement and that community-based care services under the waiver are the critical services that will enable the individual to remain at home rather than being placed in an ICF/IID.

Intensive Community Treatment Services – An array of mental health services for individuals with significant mental illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Services are designed to be provided through a designated multi-disciplinary team of mental health professionals. Services are available either directly or on call 24 hours per day, seven days per week and 365 days per year.

Intensive In-Home Services (IIH) for Children/Adolescents Under Age 21 – Time-limited interventions provided in the individual's residence and when clinically necessary in community settings. IIH services are designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual.

Intensive Outpatient (IOP) Substance Use Disorder Services – Services shall include the major psychiatric, psychological and psycho-educational modalities: individual and group counseling; family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Intensive outpatient services for individuals are provided in a non-residential setting.

Interdisciplinary Care Team (ICT) – A team of professionals that collaborates, either in person or through other means, to develop and implement a person-centered ICP built on an individual's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and with dignity to meet the medical, behavioral, LTSS, and social needs of members. ICTs may include physicians, physician assistants, LTSS providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the individual's medical diagnoses and health condition, co-

morbidities, and community support needs. ICTs employ both medical and social models of care.

Intermediate Care Facility for Individuals with Intellectual Disabilities – Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) is a facility, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to intellectually disabled individuals who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming, boarding home, or group home. Such facilities must comply with Title XIX standards, provide health or rehabilitative services, and provide active treatment to clients toward the achievement of a more independent level of functioning.

Investigation – As used in this RFP related to program integrity activities, an investigation is a review of the documentation of a billed claim or other attestation by a provider to assess appropriateness or compliance with contractual requirements. Most investigations involve the review of medical records to determine if the service was correctly documented and appropriately billed. DMAS reserves the right to expand upon any investigation.

Laboratory – A place performing tests for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 C.F.R. § 493.3, as amended.

Level of Care (LOC) – The specification of the minimum amount of assistance that an individual requires in order to receive services in a community or institutional setting under the State Plan for Medical Assistance Services or to receive waiver services.

Level of Care Re-evaluation – The periodic, but at least annual, review of an individual's condition and service needs to determine whether the individual continues to need a level of care specified in the waiver.

List of Excluded Individuals and Entities (LEIE) – When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs, information about the provider is entered into the LEIE, a database that houses information about all excluded providers. This information includes the provider's name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

Local Education Agency – Means a local school division governed by a local school board, a state-operated program that is funded and administered by the Commonwealth of Virginia or

the Virginia School for the Deaf and the Blind at Staunton. Neither state operated programs nor the Virginia School for the Deaf nor the Blind at Staunton are considered a school division as that term is used in these regulations. (§ 22.1-346 C of the *Code of Virginia*; 34 C.F.R. 300.28).

Long Stay Hospital (LSH) – Hospitals that provide a slightly higher level of care than Nursing Facilities. The Department recognizes two facilities that qualify as Long Stay Hospitals: Lake Taylor Hospital (Norfolk) and Hospital for Sick Children (Washington, DC).

Long-Term Acute Care Hospitals (LTAC) – A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in treating patients with serious and often complex medical conditions. DMAS recognizes these facilities as Acute Care Facilities.

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

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

Managed Long Term Services and Supports (MLTSS) Program – The program name for the Department’s mandatory integrated care initiative pursuant to this RFP for certain qualifying individuals, including dual eligible individuals (except duals participating in other managed care delivery models), and individuals receiving long term services or supports (LTSS). LTSS includes services received through NF care or one of the Department’s six HCBS waiver programs.

Managing Employee – In accordance with 42 C.F.R. § 455 Subpart B, means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Marketing Materials – Any materials that are produced in any medium, by or on behalf of an MCO, are used by the MCO to communicate with individuals, members, or prospective members, and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.

Medallion 3.0 – A statewide mandatory Medicaid program which operates under a CMS §1915(b) waiver and utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. Medallion 3.0 serves over 700,000 members: children, individuals who are aged, blind, and/or disabled, care taker parents, pregnant women, and acute care for waiver individuals.

Medicaid – The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof.

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

Medicaid Enterprise System (MES) – DMAS is modernizing its technology system to replace the current Medicaid Management Information System.

Medicaid Fraud Control Unit (MFCU) – Unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for in the *Code of Virginia* § 32.1-320, as amended.

Medicaid Management Information System (MMIS) – The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.

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

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

Medical Necessity or Medically Necessary – Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an enrollee’s condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21), and federal regulations as defined in 42 C.F.R. § 438.210 and 42 C.F.R. § 440.230.

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

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

Medicare Part A – Insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care

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

Medicare Part D – Medicare prescription drug coverage

Member Handbook – Document required by the Contract to be provided by the Managed Care Organization (MCO)/Contractor to the member prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, member eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, member services, emergency care, member identification cards, member responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

Member, Individual, Recipient, Enrollee, Participant, or Client – Any person having current Medicaid eligibility and authorized by the Department to participate in the MLTSS program

Mental Health Case Management – Service to assist individuals who reside in a community setting in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct clinical or treatment services.

Mental Health Skill-Building Services – Goal directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services shall include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the individual’s health and safety; activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

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

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

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

Monitoring – The ongoing oversight of the provision of waiver and/or other services to determine that services are administered according to the individual’s ICP and effectively meet his or her needs, thereby assuring health, safety and welfare. Monitoring activities may include,

but are not limited to, telephone contact, observation, interviewing the individual and/or the individual's family, as appropriate, and in person or by telephone, and/or interviewing service providers.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

National Provider Identifier (NPI) – NPI is a national health identifier for all typical health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire. All providers who provide services to individuals enrolled in MLTSS will be required to use an NPI.

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

Nursing Facility (NF)/"Certified Nursing Facility" – Any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and the *Code of Virginia*, [§32.1-137](#).

Offeror – Unless otherwise stated, the entity that is offering a proposal in response to this RFP.

Ombudsman – The independent State entity that will provide advocacy and problem-resolution support for MLTSS participants, and serve as an early and consistent means of identifying systemic problems.

Open Enrollment – The time frame in which members are allowed to change from one Contractor to another, without cause, at least once every 12 months per 42 C.F.R. § 438.56 (c)(2) and (f)(1). To coincide with Medicare open enrollment, for MLTSS members, open enrollment will occur during October, November and December for a January 1st effective date. Within sixty (60) days prior to the open enrollment effective date, the Department will inform members of the opportunity to remain with the current Contractor or change to another Contractor without cause. Those members who do not choose a new Contractor during the open enrollment period shall remain with his or her current Contractor selection until their next open enrollment effective date.

Opioid Treatment – An intervention strategy that combines psychological and psycho-educational treatment with administering or dispensing of opioid agonist treatment medication

Out-of-Network – Coverage provided outside of the established Contractor network or medical care rendered to a member by a provider not affiliated or sub-contracted with the Contractor.

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

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

Personal Care Provider – A provider that renders services to prevent or reduce institutional care by providing eligible individuals with personal care services

Personal Care Services – A range of support services necessary to enable the waiver individual to remain at or return home rather than enter a nursing facility and that includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care services shall be provided by aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model or by personal care attendants under the CD model of service delivery.

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

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

Plan of Care (POC) – A plan, primarily directed by the member, and family members of the member as appropriate, with the assistance of the member's Interdisciplinary Care Team to meet the medical, behavioral, long term care and supports, and social needs of the member.

Post-Payment – Subjecting claims for services to evaluation after the claim has been adjudicated. This activity may result in claim reversal or partial reversal, and claim payment recovery.

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

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

Pre-Payment Review – A type of program integrity activity that requires a provider to submit additional documentation to support a billed claim before that claim is processed for payment. Pre-payment review is often focused on a claim type, a provider type, or a specific provider based on an indication that additional scrutiny is needed. It may be used after identifying an area/provider that presents a program integrity risk, or prior to evidence of risk in order to mitigate potential issues.

Prevalent Languages – When five (5) percent of the Contractor’s enrolled population is non-English speaking and speaks a common language other than English.

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

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

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

Privacy – Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing Medicaid regulations, including 42 C.F.R. §§ 431.300 through 431.307, as well as relevant Virginia privacy laws.

Private Duty Nursing – Nursing care services available for children under age 21 under EPSDT that consist of medically necessary skilled interventions, assessment, medically necessary monitoring and teaching of those who are or will be involved in nursing care for the individual. Private duty nursing differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services.

Protected Health Information (PHI) – Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

Provider Contract – An agreement between a Contractor and a provider which describes the conditions under which the provider agrees to furnish covered services to members under this Contract. All provider contract templates for Medicaid-funded services between the Contractor and a provider must be approved by DMAS.

Provider Network – A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance use disorder providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor.

Psychosocial Rehabilitation Services – A program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, SUD, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

Quality Improvement Program (QIP) – A quality improvement program with structure, processes, and related activities designed to achieve measurable improvement in processes and

outcomes of care. Improvements are achieved through interventions that target health care providers, practitioners, Contractors, and/or members.

Reassessment – The periodic, but at least annual, review of an individual’s condition and service needs.

Residential Services (Community-Based) for Children and Adolescents Under 21 (Level A) – A combination of therapeutic services rendered in a residential setting. This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and behavioral health treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan. The individual must also receive at least weekly individual psychotherapy services in addition to the therapeutic residential services.

Residential Treatment Facilities (Level C) (RTC) – A facility as defined in 12 VAC 30-130-860, as amended.

Respite Services – Services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of unpaid caregivers who normally provide the care. Respite services may refer to skilled nursing respite or unskilled respite. Respite services may be available through agency- and/or consumer-directed models of care.

Rural Area – A census designated area outside of a metropolitan statistical area.

Rural Health Clinic – A facility as defined in 42 C.F.R. § 491.2, as amended.

Safety Net Providers – Providers that organize and deliver a significant level of healthcare and other related services to Medicaid, uninsured, and other vulnerable populations.

Serious Emotional Disturbance – Used to refer to children, age birth through seventeen (17), who have had a serious mental health problem diagnosed under the DSM or who exhibit all of the following: problems in personality development and social functioning that have been exhibited over at least one year’s time, problems that are significantly disabling based upon the social functioning of most children of the child’s age, problems that have become more disabling over time, and service needs that require significant intervention by one or more agency (see <http://www.dbhds.virginia.gov/> for additional information).

Serious and Persistent Mental Illness – Used to refer to individuals ages 18 and older, who have serious mental illness diagnosed under the DSM in the following major diagnostic categories: schizophrasias and other psychotic disorders, bipolar disorders, and major depressive disorders.

Service Authorization (SA)/Prior Authorization (PA) – A type of program integrity activity that requires a provider to submit documentation to support the medical necessity of services before that claim is billed and processed for payment. Pre-payment review is often focused on controlling utilization of specific services by a pre-determination that the service is medically necessary for an individual.

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

Significant Change – A change (decline or improvement) in an individual’s status that: (1) will not normally resolve itself without intervention or by implementing standard disease-related clinical or social interventions, is not “self-limiting;” or (2) impacts more than one area of the individual’s health or psychosocial status; and (3) requires interdisciplinary review and/or revision of the ICP.

Skilled Private Duty Nursing Services (Skilled PDN) – Skilled in-home nursing services listed in the Plan Of Care that are (i) not otherwise covered under the State Plan for Medical Assistance Services home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the *Code of Virginia*, respectively); and (iv) provided by a licensed RN, or by an LPN under the supervision of an RN, to Tech Waiver members who have serious medical conditions or complex health care needs. Skilled nursing services are to be used as hands-on member care, training, consultation, as appropriate, and oversight of direct care staff, as appropriate.

Specialty Plan – Specialty Plans are Managed Care Plans who provide specialized care coordination and service delivery for a designated population (e.g., SMI/SED/SUD, dementia care, etc.) Specialty Plans are regionally based and may include more of certain types of specialty providers or primary care physicians in their provider network, based on the needs of the specialty population.

Social Determinants – Economic and social conditions that affect health risk and outcomes.

Stabilized – As defined in 42 C.F.R. § 489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta.

State Fair Hearing – The Department’s evidentiary hearing process for enrollees. Any “action” or appeal decision rendered by the Contractor may be appealed by the enrollee to the Department’s Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-380.

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

State Plan Substituted Services (In Lieu of Services) – Alternative services or services in a setting that are not included in the state plan or otherwise covered by the resulting MLTSS contract but are medically appropriate, cost effective substitutes for state plan services included within the resulting MLTSS contract (for example, a service provided in an ambulatory surgical center or sub-acute care facilities, rather than an inpatient hospital). However, the Contractor shall not require a member to use a state plan substituted service/“in lieu of” arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner.

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

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

Substance Abuse Case Management – Assists children, adults, and their families with accessing needed medical, psychiatric, SUD, social, educational, vocational services and other supports essential to meeting basic needs.

Substance Abuse Crisis Intervention – Immediate mental health care, available 24 hours a day, seven days a week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service’s objective is to prevent exacerbation of a condition, to prevent injury to the member or others, and to provide treatment in the context of the least restrictive setting.

Substance Abuse Day Treatment – Services of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week.

Substance Abuse Day Treatment for Pregnant Women – Comprehensive and intensive intervention services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance use disorder problems for the purposes of improving the pregnancy outcome, treating the substance use disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

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

Substance Abuse Residential Treatment for Pregnant Women – Comprehensive and intensive services in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance use disorder problems for the purposes of improving the pregnancy outcome, treating the substance use disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

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

Successor Law or Regulation – That section of Federal or State law or regulation which replaces any specific law or regulation cited in this Contract. The successor law or regulation shall be that same law or regulation if changes in numbering occur and no other changes occur to the appropriate cite. In the event that any law or regulation cited in this Contract is amended, changed or repealed, the applicable successor law or regulation shall be determined and applied by the Department in its sole discretion. The Department may apply any source of law

to succeed any other source of law. The Department shall provide the Contractor written notification of determination of successor law or regulation.

Targeted Case Management (TCM) – Services that will assist individuals with specific conditions in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment, development of a specific care plan, referral and related activities, monitoring and follow-up activities. Services are designed to assist consumers in their recovery by helping them gain access to needed mental health, medical, social, educational, vocational, housing and other services. Medicaid funded TCM services include: substance use disorder, mental health, intellectual or developmental disabilities, early intervention, therapeutic foster care, and high risk prenatal and infant case management services. TCM encompasses both referral/transition management and clinical services such as monitoring, self-management support, medication review and adjustment. In circumstances where individuals receive TCM services through the Medicaid State Plan, care coordination provided by the Contractor and TCM provider shall be collaborative with clearly delineated responsibilities and methods of sharing important information between the Contractor and the TCM provider. TCM is separate from “care coordination” as defined in this RFP; however, the two programs shall work in concert for individuals receiving both services. Regulations for TCM can be found in the *Virginia Administrative Code* at: 12 VAC 30-50-420 - case management services for seriously mentally ill adults and emotionally disturbed children; 12 VAC 30-50-440 - case management services for individuals with intellectual disabilities; 12 VAC 30-50-450 - case management services for individuals with intellectual disabilities and related conditions who are participants in the HCBS waivers for such individuals; 12 VAC 30-50-490 -case management for individuals with developmental disabilities, including autism; 12 VAC 30-50-491 - case management services for individuals who have an Axis I substance related disorder; 12 VAC 30-50-410 and 12 VAC 30-50-510 - case management for high risk maternity and infants up to age 2; 12 VAC 30-50-415 – early intervention case management and 12 VAC 30-50-480 - case management for foster care children.

Technology Assisted (Tech) Waiver – The CMS-approved home and community-based §1915(c) waiver that provides medically necessary covered services to individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require mechanical support, and substantial and ongoing skilled nursing care to avert further disability or death and whose illness or disability would, in the absence of services approved under this waiver, require their admission for a prolonged stay in a hospital or specialized care nursing facility.

Telehealth – The use of electronic information and telecommunications to support remote or long-distance health care services. Telehealth is different from telemedicine because it refers

to the *broader scope of remote health care services*. Telehealth refers to all remote health care services which may include non-clinical services, such as provider training, administrative public health sessions, and continuing medical education. In contrast, telemedicine only refers to clinical remote technologies for the purpose of medical diagnosis and treatment.

Telemedicine – The real time or near real time two-way transfer of data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

Temporary Detention Order (TDO) – An involuntary detention order by sworn petition to any magistrate to take into custody and transport for needed mental health evaluation and care or medical evaluation and care of a person who is unwilling or unable to volunteer for such care. A magistrate is authorized to order such involuntary detention on an emergency basis for short periods, pursuant to 42 C.F.R. § 441.150 and Code of Virginia § 16.1-340 and 340.1 and § 37.2-808 through 810. Different temporary detention statutes apply to adults than to juveniles.

Therapeutic Behavioral Services (Level B) – A combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision and treatment, and mental health care to ensure the attainment of therapeutic mental health goals. The individual must also receive individual and group psychotherapy services, at least weekly, in addition to the therapeutic residential services.

Therapeutic Day Treatment (TDT) for Children and Adolescents – A combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.) and individual, group, and family counseling offered in programs of two or more hours per day.

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

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

to 12 months after discharge date. Individuals enrolled in and receiving Transition Coordination that is provided for an individual in the Money Follows the Person Program shall be excluded from MLTSS.

Transition Services – Services that are “set-up” expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. For the purposes of transition services, an institution means a NF, or a specialized care facility/hospital as defined at 42 C.F.R. § 435.1009. Transition services do not apply to an acute care admission to a hospital.

Trauma Informed Care – An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives

Treatment Foster Care (TFC) Case Management (CM) – Serves children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. TFC case management focuses on a continuity of services, is goal directed and results oriented.

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

Urgent Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent care is appropriately provided in a clinic, physician’s office, or in a hospital emergency department if a clinic or physician’s office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition.

Utilization Management - The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria

Value-Based Payment (VBP) – A broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures. Public and private payers use VBP strategies in an effort to drive improvements in quality and to slow the growth in health care spending.

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

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

Vulnerable Sub-Populations – Populations identified in *Items a-m in Element #1 of the Model of Care*

Waste – The rendering of unnecessary, redundant, or inappropriate services and medical errors and/or incorrect claim submissions. This is generally not considered criminally negligent action but rather misuse of resources. However, patterns of repetitive waste, particularly when the activity persists after the provider has been notified that the practice is inappropriate, may be considered fraud or abuse.

ATTACHMENT A: MLTSS REGIONS AND LOCALITIES

CENTRAL REGION							
001	ACCOMACK	620	FRANKLIN CITY	111	LUNENBURG	149	PRINCE GEORGE
007	AMELIA	630	FREDERICKSBURG	115	MATHEWS	760	RICHMOND CITY
025	BRUNSWICK	075	GOOCHLAND	117	MECKLENBURG	159	RICHMOND CO.
033	CAROLINE	081	GREENSVILLE	119	MIDDLESEX	175	SOUTHAMPTON
036	CHARLES CITY	085	HANOVER	127	NEW KENT	177	SPOTSYLVANIA
041	CHESTERFIELD	087	HENRICO	131	NORTHAMPTON	179	STAFFORD
570	COLONIAL HEIGHTS	670	HOPEWELL	133	NORTHUMBERLAND	181	SURRY
049	CUMBERLAND	097	KING AND QUEEN	135	NOTTOWAY	183	SUSSEX
053	DINWIDDIE	099	KING GEORGE	730	PETERSBURG	193	WESTMORELAND
595	EMPORIA	101	KING WILLIAM	145	POWHATAN		
057	ESSEX	103	LANCASTER	147	PRINCE EDWARD		
TIDEWATER REGION							
550	CHESAPEAKE	095	JAMES CITY CO	740	PORTSMOUTH	199	YORK
073	GLOUCESTER	700	NEWPORT NEWS	800	SUFFOLK		
650	HAMPTON	710	NORFOLK	810	VIRGINIA BEACH		
093	ISLE OF WIGHT	735	POQUOSON	830	WILLIAMSBURG		
NORTHERN & WINCHESTER REGION							
510	ALEXANDRIA	059	FAIRFAX CO.	683	MANASSAS CITY	171	SHENANDOAH
013	ARLINGTON	610	FALLS CHURCH	685	MANASSAS PARK	187	WARREN
043	CLARKE	061	FAUQUIER	139	PAGE	840	WINCHESTER
047	CULPEPER	069	FREDERICK	153	PRINCE WILLIAM		
600	FAIRFAX CITY	107	LOUDOUN	157	RAPPAHANNOCK		
CHARLOTTESVILLE WESTERN REGION							
003	ALBEMARLE	037	CHARLOTTE	660	HARRISONBURG	143	PITTSYLVANIA
009	AMHERST	540	CHARLOTTESVILLE	109	LOUISA	165	ROCKINGHAM
011	APPOMATTOX	590	DANVILLE	680	LYNCHBURG	790	STAUNTON
015	AUGUSTA	065	FLUVANNA	113	MADISON	820	WAYNESBORO
029	BUCKINGHAM	079	GREENE	125	NELSON		
031	CAMPBELL	083	HALIFAX	137	ORANGE		
ROANOKE/ALLEGHANY REGION							
005	ALLEGHANY	045	CRAIG	678	LEXINGTON	770	ROANOKE CITY
017	BATH	063	FLOYD	690	MARTINSVILLE	161	ROANOKE CO.
019	BEDFORD CO.	067	FRANKLIN CO.	121	MONTGOMERY	163	ROCKBRIDGE
023	BOTETOURT	071	GILES	141	PATRICK	775	SALEM
530	BUENA VISTA	089	HENRY	155	PULASKI	197	WYTHE
580	COVINGTON	091	HIGHLAND	750	RADFORD		
SOUTHWEST REGION							
021	BLAND	051	DICKENSON	720	NORTON	185	TAZEWELL
520	BRISTOL	640	GALAX	167	RUSSELL	191	WASHINGTON
027	BUCHANAN	077	GRAYSON	169	SCOTT	195	WISE
035	CARROLL	105	LEE	173	SMYTH		

ATTACHMENT B: RESOURCES FOR OFFERORS

DMAS WEBSITE REFERENCES

Behavioral Health Services:

http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx

Commonwealth Coordinated Care Program:

http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx

Delivery System Reform Incentive Payment (DSRIP):

http://www.dmas.virginia.gov/Content_pgs/dsrp.aspx

Dental Services:

http://www.dmas.virginia.gov/Content_pgs/dnt-home.aspx

Department of Medical Assistance Services Website:

<http://www.dmas.virginia.gov/>

DMAS Program Manuals:

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

DMAS Provider Portal:

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

Early Intervention (EI):

http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx

Early Periodic Screening Diagnosis and Treatment (EPSDT) Program:

http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx

Long Term Care and Waiver Services:

http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx

Managed Long Term Services and Supports Information and Data:

http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

MLTSS Provider Network Submission Manual:

http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx

MLTSS Reporting Manual (DRAFT):

http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx

Rate Setting Information:

http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx

Waiver Services and Rates:

http://www.dmas.virginia.gov/Content_pgs/ltc-wvr.aspx

ADDITIONAL WEBSITE REFERENCES:

Certified Community Behavioral Health Clinics (CCBHCs):

<http://www.dbhds.virginia.gov/professionals-and-service-providers/excellence-in-behavioral-health>

Code of Federal Regulations:

<http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=%2Findex.tpl>

DBHDS system redesign of ID, DD, and DS Waiver services:

<http://www.dbhds.virginia.gov/professionals-and-service-providers/developmental-disability-services-for-providers/my-life-my-community-waiver-redesign> and

[http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3852015/\\$file/RD385.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3852015/$file/RD385.pdf)

EPSDT – A Guide for States:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

EPSDT – (Medicaid.gov):

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

EPSDT State Medicaid Manual:

<https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

Infant and Toddler Connection of Virginia (Part C):

<http://www.infantva.org/>

Integrated Care Resource Center:

<http://www.integratedcareresourcecenter.com/>

State Corporation Commission Bureau of Insurance:

<http://www.scc.virginia.gov/boi/index.aspx>

Virginia Association of Health Plans:

<http://www.vahp.org/>

Virginia Department for Aging and Rehabilitative Services; No Wrong Door:

<http://www.vda.virginia.gov/nowrongdoor.asp>

Virginia Legislative Information System:

<http://leg1.state.va.us/>

Virginia State Long Term Care Ombudsman:

<http://www.elderrightsva.org/>

Virginia Department of Health - Forensic Epidemiology:

<http://www.vdh.virginia.gov/medExam/ForensicEpidemiology.htm>

Virginia Department of Health – Oct 2015 – Fatal Drug Overdose Quarterly Report:

<http://www.vdh.virginia.gov/medExam/documents/pdf/Quarterly%20Drug%20Death%20Report.pdf>

ATTACHMENT C: PROVIDER NETWORK SUBMISSION FORMAT

The Offeror must submit a provider network file to the Department in an electronic MS-Excel spreadsheet format. Instructions and exhibits referenced in the table below are further detailed in the [Provider Network Adequacy Data System \(PNADS\)](#) guide, available on the DMAS MLTSS webpage.¹²

Field Name	Data Specification – Variations and Examples
PROVIDER NPI*	All providers listed must include an NPI
PROVIDER LAST NAME*	Provider Last Name
PROVIDER FIRST NAME	Provider First Name
GROUP AFFILIATION	Medical or Provider Group Affiliation
HOSPITAL AFFILIATION	Yes or No if provider is affiliated with a hospital. Valid value is ‘Y’ or ‘N’.
PRIMARY TAXONOMY*	Unique ten character alphanumeric code that enables providers to identify their specialty at the claim level. See Exhibit 1 .
PROVIDER DESIGNATION*	<p>Must contain a valid value</p> <ul style="list-style-type: none"> 01 = PCP (Primary Care Provider) – All Ages 02 = Pediatrician 03 = Specialist (See Exhibit 2) 04 = Health Department 05 = Hospice 06 = Long Term Services & Supports Waiver Provider (See Exhibit 3) 07 = Outpatient Mental Health – Traditional Services 08 = Substance Use Disorder (SUD) (See Exhibit 4) 09 = Mental Health (MH) – Community Based (See Exhibit 5) 10 = Hospital – Psychiatric 11 = Hospital – General 12 = Hospital – Physical Rehabilitation 13 = Urgent Care 14 = Nursing Facility – Skilled 15 = Nursing Facility – Intermediate Care 16 = Outpatient Rehabilitation (PT/OT/ST) 17 = Durable Medical Equipment (DME) and Supplies 18 = Radiology

¹² Submissions not meeting the network file requirements will be rejected and returned. To be evaluated, a corrected file must be returned within ten (10) calendar days; otherwise, the network requirements will be rated unsatisfactory. DMAS will use this data to evaluate the Contractor’s provider network in accordance with requirements described in this RFP.

Field Name	Data Specification – Variations and Examples
	<p>19 = Home Health</p> <p>20 = Laboratory</p> <p>21 = Pharmacy</p> <p>22 = Vision</p> <p>23 = Transportation</p> <p>24 = Other</p>
<p>PROCEDURE CODES PERFORMED*</p> <p>NOTE: Only fill this field with the Procedure codes listed in the Exhibits if the provider is for Long Term Services & Supports, SUD, or Community Based Mental Health Services. All other providers, fill the field as NA.</p>	<p>*If the provider is a Long Term Services & Supports (LTSS) provider, refer to valid value list in Exhibit 3. If the provider is a SUD provider, please refer to valid value list in Exhibit 4. If the provider is a Community Based Mental Health provider, please refer to valid value list in Exhibit 5.</p>
ROOM OR SUITE NUMBER	Provider Suite or Room Number
ADDRESS LINE*	<p>Physical location Address required.</p> <p>P.O. Box cannot be used as a service location. If there are multiple service locations for this provider, please list each new service location address on a separate row.</p>
CITY*	<p>Physical location City.</p> <p>Same practice as the 'Address Line1' field; if there are 5 different service locations, please repeat the information for each on a separate row for the city.</p>
FIPS CODE*	<p>Physical location FIPS Code.</p> <p>Submit FIPS Code appropriate for each unique service location(s). See Exhibit 6 for the valid value FIPS code.</p>
STATE*	<p>Physical location State Code.</p> <p>2 character state abbreviation for each unique service location(s).</p>
ZIPCODE*	5-digit zip code for each unique service location(s).
24 HR ACCESS	Valid value 'Y'-Yes or 'N'-No
OTHER LANGUAGE SPOKEN1	See Exhibit 7 for valid value list of other language spoken.
OTHER LANGUAGE SPOKEN2	See Exhibit 7 for valid value list.
CONTRACTED PROVIDER*	Yes or LOI (letter of intent)

*** This is a required field and must be included for every record in the file.**

ATTACHMENT D: MAPPED VERSION OF PROVIDERS

Offerors shall submit a separate mapped version of their preliminary networks by region (using network mapping software) for each of the provider types listed below. Offerors shall submit maps separated by region and by provider type. For example, hospitals must not be included on the same map as adult day health care providers.

- Primary Care
- Pediatricians
- Urgent Care
- Hospitals
- Adult Day Health Care
- Private Duty Nursing
- Nursing Facility
- Traditional Mental Health
- Community Mental Health
- Substance Use Disorder

ATTACHMENT E: MLTSS COVERED SERVICES

This attachment is not intended to be a comprehensive list of covered benefits. The Offeror shall provide benefits as defined in this RFP within at least equal amount, duration, and scope as available under the State Plan for Medical Assistance Services, and as further defined in the Virginia Administrative Code, Title 12 VAC 30-50, and the appropriate DMAS Provider Program Manuals. Services listed as non-covered by Medicaid shall be covered by the Contractor when medically necessary for children under age 21 in accordance with Federal EPSDT requirements.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Abortions, induced	12 VAC 30-50-100 and 12 VAC 30-50-40	Yes, limited to those cases where there would be substantial danger to life of mother	Yes, limited to those cases where there would be substantial danger to life of mother	The Contractor shall provide coverage for abortion in limited cases where there would be a substantial danger to life of the mother as referenced in Public Law 111-8, as written at the time of the execution of this contract, shall be reviewed to ensure compliance with State and federal law. The Contractor shall be responsible for payment of abortion services meeting state and federal requirements under the fee-for-service program.
Behavioral Health	See Part 2 of this Attachment			
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service except as medically necessary in accordance with EPSDT criteria.
Christian Science Sanatoria	12 VAC 30-50-300	Yes	No	The Contractor is not required to cover this service. Individuals will be excluded from MLTSS participation when admitted to a Christian Science Sanatoria and services shall be covered under the fee-for-service program with DMAS established criteria and guidelines.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor shall cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor 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.
Court Ordered Services	Code of Virginia Section 37.1-67.4	Yes	Yes	The Contractor shall cover all medically necessary court ordered services included as a part of this Contract.
Dental	12 VAC 30-50-190	Yes	Only in limited circumstances	Under MLTSS, DMAS' contracted dental benefits administrator (DBA) will cover routine dental services for children under 21 and for adult pregnant women, so these services will be carved out of MLTSS. However, the Contractor shall be responsible for transportation and medication related to covered dental services. Specifically, the Contractor shall cover CPT codes billed by an MD as a result of an accident, and CPT and "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor shall also cover medically necessary anesthesia and hospitalization services for its members when determined to be medically necessary by the DMAS Dental Benefits Administrator.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	See Part 3 of this Attachment			

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Early Intervention Services	20U.S.C. § 1471 34 C.F.R. § 303.12 Code of Virginia § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415	Yes	Yes	<p>The Contractor is required to provide coverage for Early Intervention services as defined by 12 VAC 30-50-131 and 12 VAC 30-50-415 within the Department’s coverage criteria and guidelines. Early Intervention billing codes and coverage criteria are described in the Department’s Early Intervention Program Manual, on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.</p> <p>The Contractor shall also cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.</p>
Emergency Services	42 CFR §438.114 12 VAC 30-50-110 12 VAC 30-50-300	Yes	Yes	The Contractor shall cover all emergency services without service authorization. The Contractor shall also cover services needed to ascertain whether an emergency exists. The Contractor shall not restrict a member’s choice of provider for emergency services.
Post Stabilization Care following Emergency Services	42 C.F.R. § 422.100(b)(1)(iv)	Yes	Yes	The Contractor shall cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency condition has been stabilized.
Experimental and Investigational Procedures	12 VAC 30-50-140	No	No	Experimental and investigational procedures as defined in 12 VAC 30-50-140 are not covered. <i>Clinical trials are not always considered to be experimental or investigational, and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.</i>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover all family planning services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor shall not restrict a member's choice of provider or method for family planning services or supplies, and the Contractor shall cover all family planning services and supplies provided to its members by network providers and by out-of-network providers.
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01	Yes	Yes	The Contractor shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women.
Home Health Services	12 VAC 30-50-160; and 12 VAC 30-10-220; Additional information can be found in the Home Health provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits per year shall be allowed. Skilled home health visits are limited based upon medical necessity. The Contractor shall manage conditions, where medically necessary and regardless of whether the need is long or short-term, including in instances where the member cannot perform the services; where there is no responsible party willing and able to perform the services, and where the service cannot be performed in the PCP office/outpatient clinic, etc. The Contractor may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option.
Hospice Services	See Part 4 (LTSS) of this Attachment.			

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover immunizations. The Contractor shall educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 12 VAC 30-50-225 12 VAC 30-60-20 12 VAC 30-60-120 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor shall cover inpatient stays in general acute care and rehabilitation hospitals for all members; shall comply with maternity length of stay requirements; shall comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements; and shall cover an early discharge follow-up visit in maternity cases where the member is discharged earlier than 48 hours after the day of delivery.
Laboratory and X-ray Services	12 VAC 30-50-120	Yes	Yes	The Contractor shall cover all laboratory and x-ray services directed and performed within the scope of the license of the practitioner.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Lead Investigations	12 VAC 30-50-227 EPSDT Supplement	Yes	Yes	The Contractor shall provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Environmental investigations are coordinated by local health departments. Coverage includes costs that are eligible for federal funding participation in accordance with current federal regulations and does not include the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis. Contact the member's local health department to see if a member qualifies for a risk assessment. More information is available at http://www.vdh.virginia.gov/environmental-epidemiology/fact-sheets-for-public-health/elevated-blood-lead-levels-in-children/ . Payments for environmental investigations under this section shall be limited to no more than two visits per residence.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor shall cover low-dose screening mammograms for determining presence of occult breast cancer.
Medical Supplies and Equipment	12 VAC 30-50-165; 12 VAC 30-60-75; and 12 VAC 30-80-30 Additional information can be found in the DME and Supplies provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall cover medical supplies and equipment at least to the extent covered by DMAS. The Contractor's DME benefits shall be limited based upon medical necessity. (There are no maximum benefit limits on DME). The Contractor shall cover nutritional supplements and supplies. The Contractor shall cover specially manufactured DME equipment that was prior authorized by the Contractor per requirements specified in the DME supplies manual.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Mental Health Services	See Part 2 of this Attachment			
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor shall cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.
Organ Transplantation	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	The Contractor shall cover organ transplants for children and adults in accordance with 12 VAC 30-50-540 through 12 VAC 30-50-580. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. Contractor shall cover necessary procurement/donor related services. Transplant services for medically necessary transplantation procedures that are determined to not be experimental or investigational, as experimental is defined in the MLTSS contract, shall be covered for children (under 21 years of age) per EPSDT guidelines.
Outpatient Hospital Services	12 VAC 30-50-110 -	Yes	Yes	The Contractor shall cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The Contractor shall cover limited oral surgery as defined under Medicare.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor shall cover annual pap smears.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 and 12 VAC 30-50-225 12 VAC 30-60-150	Yes	Yes	The Contractor shall cover physical therapy, occupational therapy, and speech pathology and audiology services that are provided as an inpatient, outpatient hospital service, outpatient rehabilitation agencies, or home health service. The Contractor's benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity. There are no maximum benefit limits on PT, OT, SLP, and audiology services.
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130	Yes	Yes	The Contractor shall cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT.
Podiatry	12 VAC 30-50-150	Yes	Yes	The Contractor shall cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot.
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410 12 VAC 30-50-280 12 VAC 30-50-290	Yes	Yes	The Contractor shall cover case management services for its high risk pregnant women and children (up to age two). The Contractor shall provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The Contractor shall cover pregnancy-related and post-partum services for sixty (60) days after pregnancy ends for the Contractor's enrolled members.
Prescription Drugs	12 VAC 30-50-210	Yes	Yes	The Contractor shall cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Private Duty Nursing (PDN)	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 C.F.R. § 441.50 1905(a) of Social Security Act	Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. Coverage is also available for PDN under the Technology Assisted Waiver.	Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. Coverage is also available for PDN under the Technology Assisted Waiver.	The Contractor shall cover medically necessary private duty nursing services for children under age 21 consistent with the Department’s criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal (Also see Technology Assisted Waiver in Part 4 of this Attachment)
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male members for prostate cancer.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120	Yes	Yes	The Contractor shall cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	The Contractor shall cover reconstructive breast surgery.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
School-Health Services	12 VAC 30-50-130	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department’s criteria will continue to be covered as a carve-out service through the DMAS fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Local Education Agency school provider manual. The Contractor shall cover EPSDT screenings for the general Medicaid student population. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school. Private duty nursing services provided through EPSDT or a waiver are not considered school health services, including when provided in the school setting.
Skilled Nursing Facility Care	See Part 4 (LTSS) of this Attachment			
Substance Use Disorder Treatment	See Part 2B of this Attachment			

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The plan shall provide coverage for telemedicine services as detailed in 2.4.3. 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.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Transportation	12 VAC 30-50-530 12 VAC 30-50-300	Yes	Yes	The Contractor shall provide urgent and emergency transportation as well as non-emergency transportation to all Medicaid covered services, including those Medicaid services covered by Medicare or another third party payer and to services provided by subcontractors. These modes shall 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 Contractor shall cover air travel for critical needs. The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § CFR 440.170(a). The Contractor 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 Contractor shall cover transportation to and from Medicaid covered community mental health and rehabilitation services. ID, DD, and DS Wavier members shall receive acute and primary medical services via the Contractor and shall receive waiver services and related medical transportation to waiver services via the fee-for-service program. The Contractor must provide door-to-door transportation when indicated for waiver services transportation.
Vision Services	12 VAC 30-50-210	Yes	Yes	The Contractor shall cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. The Contractor shall also cover eyeglasses for children under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.
Waiver Services (Home and Community Based)	See Part 4 (LTSS) of this Attachment			

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
INPATIENT MENTAL HEALTH TREATMENT SERVICES				
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital (state or private)	12 VAC 30-50-230 12 VAC 30-50-250	Yes	Yes	The Contractor shall cover medically necessary inpatient psychiatric hospital stays in free standing psychiatric hospitals for covered members over age sixty-four (64) or under age twenty-one (21). The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members between the ages of 21 and 64. Coverage must comply with Federal Mental Health Parity law.
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes	Yes	The Contractor shall provide coverage for medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital for all members, regardless of age. Coverage must comply with Federal Mental Health Parity law.
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO)	42 C.F.R. § 441.150 and Code of Virginia § 16.1-340 and 340.1 and §§ 37.2-808 through 810.	Yes	Yes	The Contractor shall provide coverage for TDO and ECO services in accordance with the regulatory guidelines at: Code of Virginia § 16.1-340 and 340.1 and §§ 37.2-808 through 810.
PSYCHIATRIC RESIDENTIAL TREATMENT SERVICES FOR CHILDREN – LEVEL C				

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Residential Treatment Facility Services (RTF) for children under age 21 years – Level C <i>(Levels A and B are described in the community based mental health services section below).</i>	12 VAC 30-130-850 to 890 12 VAC 30-60-61 and 12 VAC 30-50-130 And emergency regulations for IMD cases (Level C and freestanding psych) are defined at http://townhall.virginia.gov/L/ViewStage.cfm?stageid=6572	Yes	No	DMAS authorization into a RTF level C program will result in disenrollment of the member from MLTSS. The RTF provider must contact the DMAS BHSA for authorization through the fee-for-service program. The Contractor must work closely with the Department’s BHSA to ensure against unnecessary institutional placement; i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative. Level A & B placements are group homes and members remain enrolled with the Contractor. These are described in the Community Based Mental Health Services section below.
OUTPATIENT MENTAL HEALTH SERVICES				
Electroconvulsive Therapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary electroconvulsive therapy services. Coverage must comply with Federal Mental Health Parity law.
Pharmacological Management	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary pharmacological management services.
Psychiatric Diagnostic Exam	12 VAC 30-50-180 12 VAC 30-50-140	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law.
Psychological/ Neuropsychological Testing	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law.
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law.

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
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COMMUNITY BASED MENTAL HEALTH SERVICES

The Contractor shall contract with the Department’s BHSA for the provision of non-traditional or community mental health treatment services within the Department’s established coverage criteria and guidelines until such time that the DMAS BHSA contract expires (anticipated to be no later than November 30, 2018). Once the DMAS contract with the BHSA expires, the Contractor shall continue to be responsible for the full scope of community mental health and substance use disorder treatment services, whereby the Contractor may manage these services in-house or through the Contractor’s contracted behavioral health services administrator. Additional information on behavioral health services is available on the Department’s [BHSA website](#).

Behavioral Therapy Services under EPSDT	12 VAC 30-50-130; 12 VAC 30-50-150; 12 VAC 30-60-61; 12 VAC 30-80-97; 12 VAC 30-130-2000	Yes	Yes	The Contractor is required to provide coverage for Behavioral Therapy (BT) Services as defined by 12 VAC 30-50-130, 12 VAC 30-130-2000, and the DMAS EPSDT Behavioral Therapy Provider Manual available at https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal . The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Community Intellectual Disability Case Management	12 VAC 30-50-440	Yes	No	The Contractor shall provide information and referrals as appropriate to assist members in accessing these services through the individual’s local community services boards.
Crisis Intervention Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Crisis Stabilization Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143			
Day Treatment/Partial Hospitalization	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Day Treatment/Partial Hospitalization Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Intensive Community Treatment Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Intensive Community Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	12 VAC 30-60-61 12 VAC 30-60-143			
Intensive In-Home Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSa for the provision of this service within DMAS established coverage criteria and guidelines.
Intensive In-Home Services (IIH) for Children/Adolescents	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSa for the provision of this service within DMAS established coverage criteria and guidelines.
Mental Health Case Management	12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSa for the provision of this service within DMAS established coverage criteria and guidelines.
Mental Health Skill-building Assessment	12 VAC 30-50-226 ER 12 VAC 30-60-143ER	Yes	Yes	The Contractor shall contract with the Department’s BHSa for the provision of this service within DMAS established coverage criteria and guidelines.
Mental Health Skill-building Services	12 VAC 30-50-226 ER 12 VAC 30-60-143ER	Yes	Yes	The Contractor shall contract with the Department’s BHSa for the provision of this service within DMAS established coverage criteria and guidelines.
Psychosocial Rehabilitation Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through	Yes	Yes	The Contractor shall contract with the Department’s BHSa for the provision of this service within DMAS established coverage criteria and guidelines.

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143			
Psychosocial Rehabilitation Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Residential Services (Community-Based) for Children and Adolescents under 21 (Level A)	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 130-850-890 12 VAC 30-50-130	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Therapeutic Behavioral Services (Level B)	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 130-850-890 12 VAC 30-50-130	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Therapeutic Day Treatment	12 VAC 30-50-130	Yes	Yes	The Contractor shall contract with the Department’s BHSA for

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Assessment	12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143			the provision of this service within DMAS established coverage criteria and guidelines.
Therapeutic Day Treatment (TDT) for Children and Adolescents	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years.	12 VAC 30-60-170 12 VAC 30-50-480 12 VAC 30-130-900 to 950 12 VAC 30-80-111	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Peer Support Services	To Be Determined; New Service	Yes	Yes	The Contractor shall contract with the Department’s BHSA for the provision of this service within DMAS established coverage criteria and guidelines

SUMMARY OF COVERED SERVICES - PART 2B – SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

(Service criteria defined by the American Society of Addiction Medicine - ASAM).

DMAS is in the process of transforming the SUD benefit. Details are available at: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
INPATIENT AND RESIDENTIAL SUD TREATMENT SERVICES				
Medically Managed Intensive Inpatient	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Medically Managed Intensive Inpatient Withdrawal Management	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Medically Monitored Intensive Inpatient Services	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Medically Monitored Inpatient Withdrawal Management	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Clinically Managed High Intensity Residential Services	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Clinically Managed Residential Withdrawal Management	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Clinically Managed Population-Specific High Intensity Residential Services	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Clinically Managed Low Intensity Residential Services	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
OUTPATIENT WITHDRAWAL MANAGEMENT				
SUD Partial Hospitalization	ASAM	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria.
SUD Intensive Outpatient	ASAM	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria.

SUMMARY OF COVERED SERVICES - PART 2B – SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

(Service criteria defined by the American Society of Addiction Medicine - ASAM).

DMAS is in the process of transforming the SUD benefit. Details are available at: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Ambulatory Withdrawal Management With Extended On- Site Monitoring	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Ambulatory Withdrawal Management Without Extended On- Site Monitoring	ASAM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria.
Medication Assisted Treatment (MAT)				
Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM	Yes	Yes	Counseling H0020 Opioid Treatment - individual, group counseling and family therapy and medication administration Medication S0109 Methadone 5 mg oral billed by provider Case Management/ Care Coordination H0006 SUD Case Management Physician Visit CPT E/M Code: New or Established Patient Urine Drug Screen Labs Pending for CLIA waived Hepatitis B Test (90632), Hepatitis C test (86803), HIV Test (86703)
Suboxone in Opioid Treatment Program (DBHDS-Licensed CSB and Private Methadone Clinics)	ASAM	Yes	Yes	Counseling H0020 Opioid Treatment - individual, group counseling and family therapy and medication administration Medication J0572, J0573, J0574, J0575 Suboxone Oral billed by provider J0571 Buprenorphine Oral billed by provider

SUMMARY OF COVERED SERVICES - PART 2B – SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

(Service criteria defined by the American Society of Addiction Medicine - ASAM).

DMAS is in the process of transforming the SUD benefit. Details are available at: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				Case Management/ Care Coordination Physician Visit Urine Drug Screen Labs H0006 Substance Use Disorder Case Management CPT E/M Code: New or Established Patient Pending for CLIA waived Hepatitis B Test (90632), Hepatitis C test (86803), HIV Test (86703)
Suboxone in Office-Based Opioid Treatment (Primary Care and other Physician Offices, FQHCs, etc.)	ASAM	Yes	Yes	Counseling Medication Case Management/ Care Coordination Physician Visit Urine Drug Screen Labs CPT Codes: Individual or Group Psychotherapy Patient given Rx; billed by Pharmacy G9012 Other specified case management services not elsewhere classified → DMAS recommended code for Substance Use Disorder Care Coordination CPT E/M Code: New or Established Patient Pending for CLIA waived Hepatitis B Test (90632), Hepatitis C test (86803), HIV Test (86703)

The following are required components of Opioid Treatment Services - OTS (H0020 Code):

Components of Psychosocial Treatment for Opioid Use Disorder include at a minimum: (1) Assessment of psychosocial needs, (2) Supportive individual and/or group counseling, (3) Linkages to existing family support systems, and (4) Referrals to community-based services

Must be provided by LCSWs, LPCs, or licensed psychologists (who receive supervision appropriate to their level of training and experience) knowledgeable in the assessment,

SUMMARY OF COVERED SERVICES - PART 2B – SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

(Service criteria defined by the American Society of Addiction Medicine - ASAM).

DMAS is in the process of transforming the SUD benefit. Details are available at: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
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interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders. .

Substance Use Disorder Case Management (H0006 Code):

Includes medical monitoring and coordination of on-site and off-site treatment services, provided as needed. Case managers will also assure the provision of, or referral to, educational and vocational counseling, treatment of psychiatric illness, child care, parenting skills development, primary health care, and other adjunct services, as needed. Provided by LCSWs, LPCs, or CSACs. Can be only billed by DBHDS licensed providers.

Substance Use Disorder Care Coordination (G9012 Code):

Definition: Other specified case management services not elsewhere classified.

Description: Integrates behavioral health into primary care and specialty care medical settings through co-location. Links patients with opioid addiction with community resources (including Alcoholics Anonymous, Narcotics Anonymous, peer recovery supports, etc.) to facilitate referrals and respond to social service needs. Tracks and supports patients when they obtain medical, behavioral health, or social services outside the practice. Follow up with patients within a few days of an emergency room visit or hospital discharge for opioid overdose or any other reason. Communicates test results and care plans to patients and families.

Diagnosis Code: This code must be billed with Opioid Use Disorder as the primary diagnosis.

Provider Type: Can only be provided by LCSW, LPC, Psychiatric NP, Mental Health RN, or CSAC who is providing integrated care coordination in the office of the treating physician who is prescribing suboxone or buprenorphine.

Reimbursement: Must be billed by buprenorphine-waivered physician who is prescribing suboxone or buprenorphine and providing the integrated care coordination on-site at his or her practice.

SUD CASE MANAGEMENT, OUTPATIENT, AND PEER RECOVERY SUPPORT SERVICES

SUMMARY OF COVERED SERVICES - PART 2B – SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES

Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

(Service criteria defined by the American Society of Addiction Medicine - ASAM).

DMAS is in the process of transforming the SUD benefit. Details are available at: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
SUD Case Management	12 VAC 30-60-185 12 VAC 30-50-431	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria.
Outpatient SUD Individual, Family, and Group Counseling Services	ASAM	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria
Peer Recovery Supports	To Be Determined; New Service	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria
SUD Crisis Intervention	12 VAC 30-60-180 12 VAC 30-50-228	Yes	Yes	This service is being evaluated as part of the SUD system transformation and may be discontinued.

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
EPSDT Program	12 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-	Yes	Yes	The Contractor shall cover EPSDT screenings according to the American Academy of Pediatrics periodicity schedule, diagnostic services as well as any and all services identified as necessary to correct, maintain or ameliorate any identified defects or conditions. Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. Coverage is available under EPSDT for services even if the service is not available under the State’s Medicaid Plan to the rest of the Medicaid population.

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf			The Contractor shall screen and assess all children; cover immunizations; educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates
Behavioral Therapy Services	2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf	Yes	Yes	The Contractor is required to provide coverage for Behavioral Therapy. Behavioral Therapy under EPSDT may be provided to persons with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services. Behavioral Therapy under EPSDT services are available to individuals under 21 years of age, who meet the medical necessity criteria described in the EPSDT Supplement on Behavioral Therapy Program. The need for behavioral therapy must be identified by the child’s physician, nurse practitioner, or physician assistant through an inter-periodic/problem-focused visit or an EPSDT screening/well-child visit. Therapy services are provided within the everyday routines and activities in which families participate, and in places where the family would typically spend time to ensure that the family’s daily life is supported, such as a home environment.
Clinical Trials	2 VAC 30-50-130 42 CFR § 441 Subpart B	Yes	Yes	Clinical trials are not always considered to be experimental or investigational, and must be evaluated on a case-by-case basis

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	(Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf			using EPSDT criteria as appropriate.
Dental Screenings	2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html	Yes	Yes	An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist. Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	dicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf			her one-year screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, referral must be made for needed dental services. The Contractor is not required to cover testing of fluoridation levels in well water.
Dental Varnish	2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-	Yes	Yes	Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a HCFA 1500 form shall be covered.

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf.			
Hearing Services	<p>2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62)</p> <p>Omnibus Budget Reconciliation Act of 1989 (OBRA89)</p> <p>Section 1905(r)(5) of the Social Security Act</p> <p>https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html</p> <p>https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf</p>	Yes	Yes	<p>Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.</p> <p>Periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in the Department’s EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant’s response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.</p>
Immunizations	<p>2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62)</p> <p>Omnibus Budget Reconciliation</p>	Yes	Yes	According to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines, immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination.

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf			
Laboratory Tests	2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html	Yes	Yes	The following recommended sequence of screening laboratory examinations shall be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary: <ul style="list-style-type: none"> ○ hemoglobin/hematocrit ○ tuberculin test (for high-risk groups) ○ blood lead testing including venous and/or capillary specimen (fingerstick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen (fingerstick) must be

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf			confirmed using a venous blood sample. All testing shall be done through a blood lead level determination. Results of lead testing, both positive and negative results, shall be reported to the Virginia Department of Health, Office of Epidemiology.
Private Duty Nursing	See above. 42 CFR §§ 441.50, 440.80, Social Security Act §§1905(a) and 1905(r) I.	Yes	Yes	<p>The Contractor shall cover medically necessary PDN services for children under age 21, in accordance with the Department's criteria described in the DMAS EPSDT Nursing Supplement.</p> <p>The Contractor shall use the Department's criteria, as described in the DMAS EPSDT Nursing Supplement when determining the medical necessity for PDN services. The Contractor may use an alternate assessment instrument, if desired, which must be approved by the Department. However, the Department's established coverage guidelines must be used as the basis for the amount, duration, and scope of the PDN benefit.</p> <p>Skilled PDN is also covered for Members who are enrolled in Technology Assisted Waiver who require continuous nursing that cannot be met through home health. Under EPSDT or Skilled PDN, the Member's condition warrants continuous nursing care including but not limited to, nursing level assessment, monitoring, and skilled interventions. EPSDT and Skilled PDN differ from home health nursing which provides for short-term intermittent care where the emphasis is on Member or caregiver teaching. Examples of Members that may qualify</p>

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				<p>for PDN coverage include but are not limited to those with health conditions requiring: tube feedings or total parenteral nutrition (TPN); suctioning; oxygen monitoring for unstable saturations; catheterizations; blood pressure monitoring (i.e., for autonomic dysreflexia); monitoring/intervention for uncontrolled seizures; or nursing for other conditions requiring continuous nursing care, assessment, monitoring, and intervention.</p> <p>Payment by the Contractor for services provided by any network or out-of-network provider for EPSDT or Skilled Private Duty Nursing shall be reimbursed no less than the Department’s fee-for-service rate.</p>
Screenings	<p>2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62)</p> <p>Omnibus Budget Reconciliation Act of 1989 (OBRA89)</p> <p>Section 1905(r)(5) of the Social Security Act</p> <p>https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-</p>	Yes	Yes	<p>Comprehensive, periodic health assessments (or screenings) from birth through age 20 at intervals specified by the American Academy of Pediatrics (AAP). AAP recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings should be documented in the medical record using a standardized screening tool. The Contractor shall not require any SA associated with the appropriate billing of these developmental screening services (e.g., CPT96110) in accordance with AAP recommendations.</p> <p>The medical screening shall include: (1) a comprehensive health and developmental history, including assessments of both physical and mental health development, including</p>

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf			reimbursement for developmental screens rendered by providers other than the primary care provider; and, (2) a comprehensive unclothed physical examination including vision and hearing screening, dental inspection, nutritional assessment, height/weight, and BMI assessment.
Tobacco Cessation	See above. State Medicaid Director Letter, June 24, 2011 – page 4	Yes	Yes	Medically-necessary tobacco cessation services, including both counseling and pharmacotherapy, for children and adolescents shall be covered by the Contractor. The EPSDT benefit includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. In addition to routine visits, additional counseling and tobacco cessation drug therapy must be provided when medically necessary for individuals under age 21.
Vision Services	2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-	Yes	Yes	Periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided according to the Department’s EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

SUMMARY OF COVERED SERVICES - PART 3 – EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	Periodic-Screening-Diagnostic-and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf			
Other Medically Necessary Services	2 VAC 30-50-130 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf	Yes	Yes	EPSDT includes medically necessary health care, diagnostic services, treatment, and measures as needed to correct or treat defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child’s current level of functioning or to prevent the child’s medical condition from getting worse.

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Alzheimer’s Assisted Living Waiver (AAL)	12 VAC 30-120-1600 through 12 VAC 30-120-1680 Additional information can be found in the AAL Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	AAL Waiver services will be excluded from the MLTSS Contract and will be covered under the DMAS fee-for-service program in accordance with DMAS established coverage criteria and guidelines. (See the AAL Provider Manual for additional information). AAL Waiver services require service authorization through the appropriate DMAS contractor. Through person-centered care planning, the Contractor shall ensure that members are aware of other community based treatment options available through the Contractor designed to serve members in the settings of their choice.
Day Support (DS) Waiver	12 VAC 30-120-1500 through 12 VAC 30-12-01550 Additional information can be found in the DS Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	DS Waiver services include: day support, supported employment and pre-vocational services for individuals with intellectual disabilities. Individuals on the DS Waiver will continue to receive their waiver services, including transportation to the DS Waiver services, through Medicaid fee-for-service.
Developmental Disabilities (DD) Waiver	12 VAC 30-120-700 through 12 VAC 30-120-790 Additional information can be found in the DD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	DD Waiver services include: therapeutic consultation, day support, environmental modifications, crisis stabilization in-home residential, family caregiver training, personal emergency response systems (with or without medication monitoring), supported employment, pre-vocational services, companion services, skilled nursing, respite care, personal care, assistive technology and transition services. Both agency-directed and consumer-directed services are a service delivery method for personal care, companion, and respite care services. Transition services and transition coordination are covered for those

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				individuals seeking services in the community after transition from a qualified institution. Transition may be associated with the Money Follows the Person program. Support coordination services are also covered as a state plan option in association with the provision of DD waiver services. Individuals on the DD Waiver will continue to receive their waiver services, including transportation to the DD Waiver services, through Medicaid fee-for-service.
Elderly or Disabled with Consumer Directed Services (EDCD) Waiver	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the EDCD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing these services. The Contractor shall cover personal care, respite care, adult day health care, personal emergency response systems, transition services and transition coordination. The Contractor shall cover both agency directed and consumer directed services as a service delivery model for personal care and respite care services. Personal emergency response systems may include medication monitoring as well. Transition services and transition coordination are covered for those individuals seeking services in the community after transition from a qualified institution. The Contractor shall make provisions for the collection and distribution of the member’s monthly patient pay for waiver services (if appropriate). The Contactor shall cover transportation services for the EDCD Waiver.
EDCD Waiver - Personal Care	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the EDCD Waiver provider manual available on	Yes	Yes	Agency-or consumer-directed personal care services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			described in 12VAC30-120-924. Service Definition – Personal Care A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital and which includes assistance with ADLs and IADLs, access to the community, self-administration of medication, or other medical needs, supervision, and the 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 an individual to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The individual must require assistance with ADLs in order for personal care services to be authorized.
EDCD Waiver - Respite Care	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the EDCD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Agency- or consumer-directed respite care services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. Service Definition - Respite Care Respite services are unskilled services (agency-directed or

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				<p>consumer-directed) or skilled services of a nurse (AD-skilled respite) that provide temporary relief for the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the individual.</p> <p>Skilled Respite Care (Agency-Directed Only)</p> <p>Providers may be reimbursed for respite services provided by a Licensed Practical Nurse (LPN) with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual’s skilled needs.</p> <p>Respite care can be authorized as a sole waiver service, or it can be offered in conjunction with other services.</p>
EDCD Waiver - Adult Day Health Care	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the EDCD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>Adult Day Health Care (ADHC) services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Adult Day Health Care</p> <p>Long-term maintenance or supportive services offered by a</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				<p>community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those EDCD Waiver individuals who are elderly or who have a disability and who are at risk of placement in a NF. The program shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC).</p> <p>ADHC may be offered either as the sole home- and community-based care service or in conjunction with other EDCD Waiver services.</p>
<p>EDCD Waiver - Personal Emergency Response System (PERS)</p>	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the EDCD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	<p>Yes</p>	<p>Yes</p>	<p>Personal Emergency Response Systems (PERS) services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Personal Emergency Response System (PERS)</p> <p>Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				<p>of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation via the individual’s home telephone line or other two way voice communication system. When appropriate, PERS may also include medication monitoring devices.</p> <p>PERS is not a stand-alone service. It must be authorized in conjunction with at least one other EDCD Waiver service.</p>
EDCD Waiver - Services Facilitation	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the EDCD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>Services Facilitation shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Services Facilitation</p> <p>During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual’s current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual’s satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual’s needs, and document the review of the plan.</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				<p>The SF is responsible for completion of the following tasks related to service facilitation:</p> <ul style="list-style-type: none"> • Service Facilitation Comprehensive Visit: • Consumer (Individual) Training: • Routine On-site Visits • Reassessment Visit • Management Training
EDCD Waiver - Transition Services	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the EDCD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>Transition Services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Transition Services</p> <p>Services that are “set-up” expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. Transition services do not apply to an acute care admission to a hospital.</p>
EDCD Waiver - Transition Coordination	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be</p>	Yes	Yes	<p>Transition Coordination shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within at least equal amount, duration, and scope as available under</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	<p>found in the EDCD Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>			<p>Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Transition Coordination Contractor staff member or other contracted provider responsible for supporting the individual and family/caregiver, as appropriate, with the activities associated with transitioning from an institution to the community pursuant to the Elderly or Disabled with Consumer Direction waiver.</p> <p>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 by 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.</p>
Hospice Services	<p>12 VAC 30-50-270 and 12 VAC 30-60-130</p> <p>Additional information can be found in the Hospice provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of hospice services.</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Intellectual Disabilities (ID) Waiver	<p>12 VAC 30-120-1000 through 12 VAC 30-120-1090</p> <p>Additional information can be found in the ID Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	No	<p>ID Waiver services include: therapeutic consultation, congregate residential, day support, environmental modifications, crisis stabilization in-home residential, personal emergency response systems (with or without medication monitoring), supported employment, pre-vocational services, companion services, skilled nursing, respite care, personal care, assistive technology and transition services. Both agency directed and consumer directed services are a service delivery method for personal care, companion, and respite care services. Transition services and transition coordination are covered for those individuals seeking services in the community after transition from a qualified institution. Transition may be associated with the Money Follows the Person program. Case management services are also covered as a state plan option in association with the provision of ID waiver services. Individuals on the ID Waiver will continue to receive their waiver services, including transportation to the ID Waiver services, through Medicaid fee-for-service.</p>
Long Stay Hospital – State Plan Only Service	<p>12 VAC 30-60-30; 12 VAC 30-130-100 through 12 VAC 30-130-130</p> <p>Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of long stay hospital services for adults. Long Stay Hospital services are a state plan only service which covers individuals requiring mechanical ventilation, individuals with communicable diseases requiring universal or respiratory precautions, individuals requiring ongoing intravenous medication or nutrition administration, and individuals requiring comprehensive rehabilitative therapy services. The Contractor shall make provisions for the collection and distribution of the</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				individual member’s monthly patient pay for long stay hospital services. The Contractor shall cover transportation services for long stay hospital services.
Nursing Facility	<p>12 VAC 30-90-305 through 12 VAC 30-90-320 for RUGS reimbursement</p> <p>Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of nursing facility level of care. The Contractor shall use the existing reimbursement system for payment of nursing facility level of care which is based on the RUGs payment methodology. The Contractor shall make provisions for the collection and distribution of the individual member’s monthly patient pay for nursing facility services. Transition services and transition coordination are covered for those individuals seeking services in the community under the Money Follows the Person program. The Contractor shall cover transportation services for nursing facility residents.
Money Follows the Person	<p>12 VAC 30-120-2000; 12 VAC 30-120-935; 12 VAC 30-120-935; and 12 VAC 30-120-2010</p> <p>Additional information can be found in the Waiver provider manuals (as Appendix E) available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	No	MFP demonstration services include: transition coordination up to two months prior to and 12 months following discharge from an institution (only for individuals who are enrolled in MFP and transition to the EDCD Waiver); assistive technology for individuals who are enrolled in the MFP and the EDCD Waiver, for up to 12 months after discharge from an institution; environmental modifications for individuals who are enrolled in MFP and the EDCD Waiver, for up to 12 months after discharge from an institution; and transition services up to nine months, two of which can be prior to discharge from an institution.

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				Individuals enrolled in MFP will be excluded from MLTSS.
Program of All-Inclusive Care for the Elderly (PACE)	12VAC30-50-320 http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx http://www.dmas.virginia.gov/Content_attachments/ltc/(11)%20Fact%20Sheet%20PACE%2011%2015.pdf	Yes	No	<p>Individuals in PACE will be excluded from MLTSS participation. Individuals in MLTSS have the right to transition from MLTSS to PACE, including outside of their annual open enrollment. The Contractor shall ensure that members are aware PACE. PACE provides qualifying members a fully integrated community alternative to nursing home care, and provides care/services covered by Medicare/Medicaid, and may include enhanced services not covered by Medicare/Medicaid. PACE coverage includes prescription medications, doctor care, transportation, home care, hospital visits, adult day services, respite care, restorative therapies, and nursing home stays, when necessary.</p> <p>In order to qualify for PACE, a member must be 55+ years of age, live within a PACE service area, and be able to reside safely within the community at the time of enrollment. When a member requests additional information about PACE, the contractor shall assist the member with obtaining information and related referrals. This includes checking to see if there is a PACE site in the member’s service area. This information is available via the DMAS website: http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				(based upon the member’s zip code). The Contractor shall refer members interested in enrolling in PACE to their Local Department of Social Services (LDSS) to request a UAI screening. Meeting the functional criteria for nursing home level of care is a requirement for PACE enrollment and screening must be coordinated through the member’s LDSS.
Specialized Care – State Plan Only Service	12 VAC 30-60-40; 12 VAC 30-60-320 (ADULTS) 12 VAC 30-60-340 (CHILDREN) Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of specialized care services for adults. Specialized care services are a state plan only service which covers complex trach and ventilator dependent nursing facility residents at a higher reimbursement rate. The Contractor shall make provisions for the collection and distribution of the individual member’s monthly patient pay for specialized care services. Transition services and transition coordination are covered for those individuals seeking services in the community under the Money Follows the Person program. The Contractor shall cover transportation services for specialized care residents.
Technology Assisted (Tech) Waiver	12 VAC 30-120-1700 through 12 VAC 30-120-1770 Additional information can be found in the Tech Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing these services. The Contractor shall cover skilled private duty nursing, skilled respite, personal care services (for adults only), environmental modifications, assistive technology, and transition services. Private duty nursing services and respite care services can be provided as either individual or congregate services. The Contractor shall make provisions for the collection and

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	ginia.gov			distribution of the individual member’s monthly patient pay for waiver services (if appropriate). The Contractor shall cover transportation services for the Tech Waiver.
Tech Waiver - Skilled Private Duty Nursing	12 VAC 30-120-1700 through 12 VAC 30-120-1770 Additional information can be found in the Tech Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	<p>Private Duty Nursing (PDN) services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720.</p> <p>DEFINITION OF Skilled Private Duty Nursing (Skilled PDN)</p> <p>In-home nursing services provided for individuals enrolled in the Tech Waiver with a serious medical condition and/ or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse.</p> <p>Congregate Skilled PDN</p> <p>Skilled nursing provided to three or fewer waiver individuals who reside in the same primary residence. Congregate skilled PDN may be authorized in conjunction with skilled PDN in instances where individuals attend school or must be out of the home for part of the authorized PDN hours. Congregate skilled</p>

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				PDN hours will be determined and approved according to skilled nursing needs documented on the appropriate referral form.
Tech Waiver- Skilled Private Duty Nursing Respite Care	12 VAC 30-120-1700 through 12 VAC 30-120-1770 Additional information can be found in the Tech Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Skilled Private Duty Nursing Respite Care shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720. Skilled Private Duty Nursing Respite Care The provision of skilled private duty nursing care for short period(s) of time (a maximum of 15 days or 360 hours per calendar year, per household) to provide the unpaid primary care giver a break from caregiver responsibilities.
Tech Waiver - Personal Care	12 VAC 30-120-1700 through 12 VAC 30-120-1770 Additional information can be found in the Tech Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Personal Care services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720. Personal Care Services Provided that the cost effectiveness standard will not be exceeded, personal care services as defined in 12VAC30-120-1700, shall be covered for individuals 21 years of age or older

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				<p>who have demonstrated a need for assistance with ADLs and IADLs and who have a trained primary caregiver and an authorization for skilled PDN. Due to the complex medical needs of this waiver population and the need for 24-hour supervision, the trained primary caregiver shall be present in the home and rendering the required skilled care during the entire time that the Personal Care Attendant is providing non-skilled care.</p> <p>Personal care services may be offered to assist the individual/primary care giver when full coverage of skilled PDN hours is not available from a provider. When skilled PDN hours can be covered, the personal care hours will be decreased or discontinued.</p> <p>In order to receive personal care, the individual must require assistance with monitoring of health status and physical condition. Services may be provided in home or community settings to enable an individual to maintain the health status and functional skills necessary to live in the community, or participate in community activities.</p>
Tech Waiver - Environmental Modifications (EMs)	12 VAC 30-120-1700 through 12 VAC 30-120-1770 Additional information can be	Yes	Yes	Environmental Modifications (EMs) shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	found in the Tech Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720. Service Definition – Environmental Modifications (EMs) Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.
Tech Waiver- Assistive Technology (AT)	12 VAC 30-120-1700 through 12 VAC 30-120-1770 Additional information can be found in the Tech Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Assistive Technology services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720. Service Definition – Assistive Technology (AT) Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT shall not be authorized

SUMMARY OF COVERED SERVICES - PART 4 – LONG TERM SERVICES AND SUPPORTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				<p>as a standalone service.</p> <p>Assistive technology devices, as defined in 12VAC30-120-1700, shall be portable and shall be authorized per calendar year.</p>
Tech Waiver- Transition Services	<p>12 VAC 30-120-1700 through 12 VAC 30-120-1770</p> <p>Additional information can be found in the Tech Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>Transition Services shall be offered to persons who meet the preadmission screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720.</p> <p>Service Definition – Transition Services</p> <p>Services that are “set-up” expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. Transition services do not apply to an acute care admission to a hospital.</p>

SUMMARY OF COVERED SERVICES - PART 5 – EXCLUDED AND CARVED-OUT SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Excluded Services – Individuals that receive services in the settings/programs listed below are excluded from MLTSS participation. Coverage for these services follow the DMAS established coverage rules and guidelines.				
Alzheimer’s Assisted Living Waiver	12 VAC 30-120-1600 through 12 VAC 30-120-1680 Additional information can be found in the AAL Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	Individuals in the Alzheimer’s Assisted Living Waiver will be excluded from MLTSS participation
Christian Science Sanatoria Facilities	12 VAC 30-50-300	Yes	No	The Contractor is not required to cover this service. Individuals will be excluded from MLTSS participation when admitted to a Christian Science Sanatoria and services shall be covered under the fee-for-service program with DMAS established criteria and guidelines.
Hospice and ESRD at time of Enrollment	12 VAC 30-50-270 and 12 VAC 30-60-130 Additional information can be found in the Hospice provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	Individuals receiving Hospice or who are in ESRD at time of Enrollment will be excluded from MLTSS participation. MLTSS enrolled individuals who elect hospice or have ESRD will remain MLTSS enrolled.
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID); state or private	See Section 4 of this coverage chart	Yes	No	Individuals receiving services in an ICF-ID will be excluded from MLTSS participation.

SUMMARY OF COVERED SERVICES - PART 5 – EXCLUDED AND CARVED-OUT SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Money Follows the Person	12 VAC 30-120-2000; 12 VAC 30-120-935; 12 VAC 30-120-935; and 12 VAC 30-120-2010 Additional information can be found in the Waiver provider manuals (as Appendix E) at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	MFP demonstration services include: transition coordination up to two months prior to and 12 months following discharge from an institution (only for individuals who are enrolled in MFP and transition to the EDCD Waiver); assistive technology for individuals who are enrolled in the MFP and the EDCD Waiver, for up to 12 months after discharge from an institution; environmental modifications for individuals who are enrolled in MFP and the EDCD Waiver, for up to 12 months after discharge from an institution; and transition services up to nine months, two of which can be prior to discharge from an institution. Individuals enrolled in MFP will be excluded from MLTSS.
Program of All-Inclusive Care for the Elderly (PACE)	12VAC30-50-320 http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx http://www.dmas.virginia.gov/Content_atchs/ltc/(11)%20Fact%20Sheet%20PACE%2011%2015.pdf	Yes	No	See PACE in Part 4 of this coverage chart.

SUMMARY OF COVERED SERVICES - PART 5 – EXCLUDED AND CARVED-OUT SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Psychiatric Residential Treatment Facility Services (PRTF) for children under age 21 years – Level C	12 VAC 30-130-850 to 890 12 VAC 30-60-61 and 12 VAC 30-50-130 And emergency regulations for IMD cases (Level C and freestanding psych) are defined at http://townhall.virginia.gov/L/ViewStage.cfm?stageid=6572	Yes	No	DMAS authorization into a RTF level C program will result in disenrollment of the member from MLTSS. The RTF provider must contact the DMAS BHSA for authorization through the fee-for-service program. The Contractor must work closely with the Department’s BHSA to ensure against unnecessary institutional placement; i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative. Level A & B placements are group homes and members remain enrolled with the Contractor.
State Geriatric Hospital Placements, (Piedmont and Catawba)		Yes	No	Individuals in Piedmont and Catawba state geriatric facilities will be excluded from MLTSS participation
Veterans Nursing Facility		Yes	No	Individuals residing in a Veteran’s nursing facility will be excluded from MLTSS participation
Certain DMAS Approved Out of State Placements		Yes	No	Individuals placed in certain out of state facilities by DMAS will be excluded from MLTSS participation.
Carved out Services are paid through fee-for-service for MLTSS enrolled individuals. Coverage for these services follow the DMAS established coverage rules and guidelines.				
Dental Services	12 VAC 30-50-190	Yes	Only in limited circumstances	Under MLTSS, DMAS’ contracted dental benefits administrator (DBA) will continue to cover routine dental services for children under 21 and for adult pregnant women, so these services will be carved out of MLTSS. However, the Contractor shall be responsible for transportation and medication related to covered dental services. Specifically, the Contractor shall cover CPT codes billed by an MD as a result of an accident, and CPT and “non-CDT” procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor shall also cover medically necessary anesthesia and hospitalization services for its members when determined to be medically necessary by the DMAS Dental Benefits Administrator.

SUMMARY OF COVERED SERVICES - PART 5 – EXCLUDED AND CARVED-OUT SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Community Intellectual Disability Case Management	12 VAC 30-50-440	Yes	No	The Contractor shall provide information and referrals as appropriate to assist members in accessing these services through the individual’s local community services boards.
Developmental Disability Support Coordination	12VAC30-50-490	Yes	No	Developmental Disability Support Coordination services will continue to be covered through Medicaid fee-for-service until completion of the ID/DD system redesign.
ID/DD/DS Waiver services including transportation to these waiver services	See Section 4 of this coverage chart	Yes	No	Individuals enrolled in the ID/DD/DS Waivers will continue to receive their waiver services, including transportation to these Waiver services, through Medicaid fee-for-service.
Preadmission Screening Services	http://www.dmas.virginia.gov/Content_pgs/ltc-pas.aspx	Yes	No	Preadmission screening services will continue to be covered through Medicaid fee-for-service within DMAS established criteria and guidelines.
School-Health Services	12 VAC 30-50-130	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department’s criteria will continue to be covered as a carve-out service through the DMAS fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Local Education Agency school provider manual. The Contractor shall cover EPSDT screenings for the general Medicaid student population. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school. Private duty nursing services provided through EPSDT or a waiver are not considered school health services, including when provided in the school setting.

ATTACHMENT F: VIGNETTES

Offerors must respond to each of the vignettes included in this Attachment. The RFP evaluation process will also include an in-person presentation by each Offeror on a minimum of two (2) of the vignettes selected by the Department, including a demonstration of the Offeror's electronic care management system. Emphasis should be placed on how the Offeror would coordinate and integrate Medicaid and Medicare services for those individuals depicted as dual eligible members in the vignettes. Further details regarding the presentation will be provided to respondents, but the presentation should demonstrate the Offeror's structural capability and ability to excel at meeting the needs of the enrolled population. The standards outlined in the following sections will be used to evaluate the Offeror's MOC structure and capabilities.

VIGNETTE 1: AMY, 51 YEAR OLD FEMALE

Amy is a single, unemployed, non-dual eligible who has a serious mental illness and has been diagnosed with a Mood Disorder, NOS. She also has an intellectual disability with unspecified severity. Symptoms of her mental illness have included depressed mood, suicidal and homicidal ideations, poor comprehension, poor socialization skills, anxiety, mood swings, irritability, and paranoia.

Amy has a history of psychiatric hospitalizations and requires an intensive level of community based treatment in order to maintain psychiatric stability. The range of community based services that has been provided to Amy includes emergency services, psychiatric services, intensive case management, and mental health skill building services.

Amy has also experienced very serious and chronic health/medical problems for a number of years; including diabetes, high blood pressure, heart disease, asthma, and severe joint pain. She has had one knee replaced and still requires ongoing orthopedic treatment as she experiences severe pain and swelling on a regular basis. Additionally, she has had a number of heart attacks in the past, and has required multiple stents due to poor treatment adherence and poor dietary choices. She has also suffered from uncontrolled diabetes over the past several years, due in part to her lifestyle choices.

Historically, Amy's intellectual disability has been a barrier to her fully understanding her medical conditions. She has repeatedly complained about the fact that she does not understand what doctors say to her. As a result, she has not received the ongoing medical care that she needs despite her very serious medical/health problems. Instead, Amy has repeatedly used local hospital emergency rooms for treatment of non-urgent medical problems. Consequently, Amy's medical condition has continued to deteriorate.

Another concern is the fact that Amy does not understand the basic concepts related to healthy lifestyle choices and disease management, as these concepts have never been explained to her in a way that she can understand. For example, she does not know how to check her blood pressure or her glucose levels, and does not understand the impact that nutrition and dietary choices has on her medical conditions. She also lacks awareness about what constitutes different food groups, or the nutritional value of foods, like carbohydrates, protein, sugars, etc. Consequently, Amy has made very poor dietary choices for a number of years now, including regularly consuming large amounts of food with high fat and sodium content.

Amy currently resides in an apartment with a friend and the friend's children, and has complained about her stressful living environment. The apartment, which is subsidized by the Department of Redevelopment and Housing, is located in a very unsafe area of the city. Unfortunately, she has little to no interaction with her family, and has a very limited social support system.

VIGNETTE 2: VIRGINIA, 84 YEAR OLD FEMALE

Virginia is a medically complex dual eligible individual who lives with her adult son as her primary caregiver. Virginia is enrolled with an MLTSS Contractor for Medicaid services, but a different MLTSS Contractor's D-SNP. She has diagnoses of: COPD, Chronic Respiratory Failure, Lung Cancer, Dementia and Rheumatoid Arthritis among others. She is awake at times but usually disoriented and confused. She is non-ambulatory, however she does have a chair her son is able to transfer her to when he is home as an alternative to remaining in bed continuously. When any other caregivers are present, they are unable to transfer Virginia out of bed because of her size and her bedroom is too small to use a hoist lift.

Virginia is dependent on a ventilator 24 hours/day as well as continuous oxygen support at 40%. She has a tracheostomy tube, a feeding tube in her stomach, and a foley catheter. She is on multiple medications and is at great risk for skin breakdown. Virginia has been admitted to the hospital several times in the last 6 months for respiratory distress and/or urinary tract infections. Keeping medical appointments is difficult because Virginia's son has no way to transport her. Because of her medical equipment, Virginia must be transported on a stretcher by non-emergency ambulance. Frequently appropriate medical transportation cannot be found through her insurance transportation system.

Virginia receives skilled private duty nursing services through the Technology Assisted Waiver program. She is authorized for up to 16 hours/day of skilled nursing, however not all of her nursing hours are covered due to limited availability of ventilator experienced nurses. Virginia's son is trained in providing all aspects of her home care but is frequently at odds with her home nursing agency because he wants the nurses to provide care that is either not ordered by Virginia's physician or is contrary to her physician's orders. Although Virginia's son wants to

provide care at home for his mother as long as possible, there is often frustration on the part of both the son and the nursing agency in trying to safely meet Virginia's needs in the community.

VIGNETTE 3: HELEN, 58 YEAR OLD FEMALE

Helen is a dual eligible who lives in a rural area of Virginia. She is enrolled with an MLTSS Contractor for Medicaid and the Contractor's companion D-SNP. Helen is married to Joe, a construction worker who was injured on the job and is totally disabled. Helen has been a full time homemaker who helped occasionally at the church preschool. She has battled anxiety and depression for most of her life, is diabetic and is a cancer survivor. In recent years, her depression worsened and she became confused and refused to get out of bed or tend to her personal hygiene. Her husband assumed her increased depression was due to his inability to contribute to the family income. Helen was in a car accident in 2013 that has left her disabled, unable to drive. While in the hospital recuperating from the accident, Helen was diagnosed with early onset Alzheimer's Disease. The couple has no family nearby. Due to her location and lack of transportation, Helen has had a difficult time finding assistance to come to the house to help with her physical needs, caring for the household, and providing meals.

VIGNETTE 4: CHARLES, 27 YEAR OLD MALE

Charles, who has a severe intellectual disability, is currently a resident of a group home in the northern part of the state. He also attends a local Day Program. Until the age of 22 Charles was a resident of a home in Tidewater.

Charles was born after a normal pregnancy with a birth weight of 5.2 lbs, which is lower than the average newborn birth weight of 7.5 lbs. During the last few hours of labor, it was noted on the fetal monitor that he was in distress and the obstetrician was called in to perform an emergency caesarean section. However, the obstetrician did not make it to the hospital in time and Charles was born vaginally. At birth, Charles was deep suctioned and intubated due to meconium aspiration.

Within a few hours of birth, Charles' condition declined and he became tachycardic and was transferred from the local hospital to the Neonatal Intensive Care Unit at VCU in Richmond, where he was diagnosed with aortic stenosis and failure to thrive, as he would not suck and had to be fed with a nasogastric tube. Charles was screened for all of the more common syndromes such as Phenylketonuria (PKU), Down Syndrome and Cystic Fibrosis—all were negative.

Charles' condition stabilized and he was released at one month of age from VCU on Digoxin therapy, with a heart monitor and a nasogastric tube. Charles' parents were educated and he was cared for at home. By six months of age Charles' cardiac condition had stabilized and he was able to be weaned off of Digoxin.

Charles' failure to thrive and developmental delay continued and at five months of age he was diagnosed at Children's Hospital with an inability to absorb long chain fatty acids which is often associated with genetic disorders. Charles was placed on a special high calorie formula to gain weight. At six months of age Charles began physical therapy through the local Parent Education and Infant Development program. At two years of age, Charles began school in the county's special education program. Charles continued to improve and was able to sit up by himself at age 5 and to feed himself at age 8.

Charles was able to stay at home until the age of 15. At 15, he was placed in a children's residential home, as he had become too big for his mother to care for him at home. He did well, but the distance his family had to travel to visit him was a great hardship for his parents, his four younger siblings, and his large extended family who all reside in a different part of the state.

As a teenager, Charles was screened for the ID Waiver and placed on the waiting list. At 19 years of age, Charles was diagnosed with Phelan McDermid Syndrome (also known as 22-Q-13). Although Charles still has aortic stenosis, an inability to digest fat normally, and has trouble regulating his body temperature, he has not had any hospitalizations or major set-backs in recent years. Charles' immediate family visits him frequently at both the group home and his day program. His family is able to take him for walks, take him to dinner, or take him shopping. He is also able to be a part of holiday festivities with not only his immediate family, but also his extended family. Charles is also able to go to church on Sundays, where he enjoys listening to the choir.

At the day program, Charles likes to watch movies on his iPad, listen to music or watch clips of Nascar races on his YouTube app. He goes on outings to the park, the YMCA, out to eat, and to other local events in the area. Although Charles has never been able to walk independently, he currently spends time in his prone stander and also walks with the aid of a Rifton gait trainer and protective helmet. It is also important to note that Charles has no contractures of his hands or feet and is able to scoot around on his bottom (wherever he wants to go), and likes to stand on "tall knees" and watch the birds visit the bird feeders that were placed outside his bedroom window and outside of the den window in the group home.

Charles' family is happy with his care (and believe that Charles is too), and are delighted that he is back in his own hometown.

VIGNETTE 5: SAM, 15 YEAR OLD MALE

Sam lives with his mother and two younger siblings who are living in temporary housing due to domestic violence in their home. He has cerebral palsy and epilepsy. Sam attends school during the day. He has limited social activities and exhibiting signs of anxiety. He receives support services through the EDCD Waiver and Medicaid funded occupational and physical therapy sporadically when school is not in session. Sam is on the DD Waiver waiting list.

Personal care services are provided 35 hours a week. Sam's mother initially used agency-directed supports but found them to be unavailable for the brief shifts afforded to them (Sunday-Saturday 7am-8:30am and 6pm-9pm, plus Saturday 8:30am-12pm). Respite is used sporadically. Consumer-direction has allowed her to hire attendants from Sam's high school who are 18 or older and from the local community college.

Sam has severe limb and hand contractures that are progressively getting worse. He does not want to wear splints, AFOs or other structuring appliances because of the discomfort they cause, problems with appropriate clothing fitting, and the stigma he feels when wearing them.

Sam uses a communication device that is often in need of repair and does not adequately provide communication that he is cognitively capable of expressing.

The family's home needs to be made more accessible to allow Sam greater independence.

Last year, his mother became employed resulting in the children losing their Medicaid benefits. DSS inadvertently withdrew Sam from Medicaid, causing the Medicaid payment for his consumer-directed personal care aides to be disrupted. This resulted in one of the aides quitting without adequate notice due to not receiving her wages. By the time the error was corrected, his mother was on the verge of losing her employment due to missing work hours in the morning while providing Sam's personal care until another consumer-directed attendant was recruited, trained and hired. She momentarily considered using agency-directed services during this crisis, but remembered that it was these morning shifts that the agency had previously not been able to staff.

To avoid urine stained clothes when circumstances do not allow him to have adequate personal care, he wears adult incontinence briefs during the day and overnight at home. Due to changes in DME rules, the quality of briefs that he had received through Medicaid declined and the briefs provided through Medicaid often bunched under him due to his nearly constant movement. This caused decubiti on two occasions. After much advocacy, he is now receiving more appropriate, better quality briefs that should prevent future skin breakdown.

Sam will miss medical and therapy appointments due to the lack of transportation. His family's vehicle is not wheelchair accessible so his mother must lift him and his wheelchair when transporting them. They cannot rely on paratransit or Medicaid transportation because of the family's need for the mother to bring the two younger siblings with them to medical appointments. She cannot afford child care in order to leave the younger siblings at home.

Sam would like to become more independent. He and his mother are concerned that the increased supports that he will need as he expands his activities will not be available.

VIGNETTE 6: ELLA, 79 YEAR OLD FEMALE

Ella has lived as a long term care patient at her nursing facility for 2 years. She is a dual eligible enrolled in Medicare fee-for-service. When Ella moved in, she was no longer able to live alone in the community and required assistance with her ADLs and medication. While living in the nursing facility, she has continued to maintain a healthy lifestyle. She often looks forward to her consults with the dietician in an effort to adopt better nutrition. Ella finds this helpful in managing her co-morbidities as she has a history of CHF, A-Fib, and TIAs.

Ella also stays active with the activities program at the facility and has worked with the physical therapist during the summer when she had a fall in the courtyard. Ella was identified as a fall risk following the incident in the courtyard, but participated in the rehab program with great outcomes. Ella was told this would be covered under her Medicare Part B and found these sessions to be helpful and preventive. Ella's therapist spoke to her frequently during their exercise sessions about safety awareness and Ella has been free of falls for several months.

Unfortunately, Ella's nursing assistant noticed her having slurred speech and complaints of blurred vision one night when getting ready for bed. The nurse working that evening immediately assessed further and Ella's vital signs showed a significant elevation in b/p and heart rate prompting her to contact the physician. Ella was sent to the hospital for a CT Scan and a full work-up as the nurses and physicians collaborating at the facility suspected she had a CVA. Because Ella now has a managed Medicare plan and Medicaid, she may need an authorization for this ER visit, but the change in condition has been observed outside of normal business hours.

Ella is transported by an ambulance to the ER and at first placed in an observation bed. Eventually she is admitted to the neuro floor and a CVA is indeed confirmed. While in the hospital, Ella received a new peg tube and will now require nutrition through the tube. This is a big adjustment for Ella and she has a goal of weaning off of the tube feedings and eating a regular diet once again. Because of this goal, Speech Therapy was started in the hospital. The Speech Therapist noticed some cognition issues during the evaluation and has also set some goals for her to accomplish with her speech therapist back at the nursing home to address this new development. It is suspected the CVA may have impaired her cognition, but she still has the potential to improve. It may be a slow journey, but hospitalizations can be a significant game changer for anyone. Physical Therapy and Occupational Therapy have also been working with Ella on transfers, balance, and grooming tasks in an effort to get her back to baseline. Upon discharge, the hospital physician also added Coumadin to her med list which will require weekly lab testing and consistent analysis of her lab results to ensure she is being anticoagulated appropriately.

Now that Ella is ready to come back to her nursing facility, she will need a safe, seamless transition as coordination of care involving the IDT and outside services will be a part of the

next steps in her recovery. Upon readmission, the first step is to ensure Ella receives skilled care. Another authorization will be obtained for her readmission and will need to include coverage for skilled care and rehab.

Other items to consider are her new equipment needs as well. The facility has a contract with a company who will supply peg tube supplies and formula. This company will need to check the status of their contract with Ella's insurance company or bill the facility directly for the extra equipment. The facility also works with a pharmacy that will need Ella's insurance information for any other meds that have been added during her hospitalization. There is a possibility of separate authorizations which may be needed to cover any meds that are not covered under her plan.

Today is the big day and Ella is nervous, but excited to start her journey back home. In order to monitor her progress and ensure the best outcomes, outside follow up physician appointments and services have been made for her. Once again, she is in need of transport as she is heading back to the facility. She now has oxygen ordered at 2 liters and requires two people to assist her with transfers. The case manager at the hospital has reached out to the therapist about whether or not Ella can go by wheelchair or will need a stretcher. The game plan regarding transportation will be something that her rehab team at the nursing home will also help her master as now her follow up appointments with the GI doc and swallowing studies have been scheduled and are on the calendar. Let's hope she doesn't miss any of these appointments. They will be pivotal in ensuring she does not readmit back into acute care.

ATTACHMENT G: PROPRIETARY/CONFIDENTIAL INFORMATION IDENTIFICATION FORM

To Be Completed By Offeror and Returned With Your Proposal

Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of § 2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected including the section of the proposal in which it is contained and the page numbers, and states the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must include only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. In addition, a summary of such information shall be submitted on this form. The classification of an entire proposal document, line item prices, and/or total proposal prices as proprietary or trade secrets is not acceptable. If, after being given reasonable time, the Offeror refuses to withdraw such a classification designation, the proposal may be scored lower or eliminated from further consideration.

Name of Firm/Offeror: _____, invokes the protections of § 2.2-4342F of the *Code of Virginia* for the following portions of my proposal submitted on _____.

Date

Signature: _____ Title: _____

DATA/MATERIAL TO BE PROTECTED	SECTION NO., & PAGE NO.	REASON WHY PROTECTION IS NECESSARY

ATTACHMENT H: CERTIFICATION OF COMPLIANCE WITH PROHIBITION OF POLITICAL CONTRIBUTIONS AND GIFTS DURING THE PROCUREMENT PROCESS

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

I, _____, a representative of _____,
Please Print Name *Name of Offeror*

am submitting a proposal to _____ in response to
Name of Agency/Institution

_____, a solicitation where stated or expected contract value is
Solicitation/Contract #

\$5 million or more which is being solicited by a method of procurement other than competitive sealed bidding as defined in § 2.2-4301 of the *Code of Virginia*.

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

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

Signature

Title

Date

To Be Completed By Offeror and Returned With Your Proposal

ATTACHMENT I: STATE CORPORATION COMMISSION FORM

VIRGINIA STATE CORPORATION COMMISSION (SCC) REGISTRATION INFORMATION.

The Offeror:

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

_____ **-OR-**

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

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

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

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

To Be Completed by Offeror and Returned with Your Proposal

Signature

Title

Date

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Priority One: Access, Disease Management and Service Utilization			
Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	NCQA	Health Plans
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. Initiation of AOD, engagement of AOD.	NCQA	Health Plans
SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge (NQF #1664)	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.	The Joint Commission	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605)	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.	NCQA	Health Plans
Asthma Medication Ratio (NQF #1800)	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	NCQA	Health Plans
Medication Management for People With Asthma (Medication Compliance 75% Rate only) (NQF #1799)	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	NCQA	Health Plans
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (NQF #0058)	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic	NCQA	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
	prescription.		
Comprehensive Diabetes Care (Rate—BP Control <140/90, Rate—HbA1c Control (<8.0%), HbA1c Poorly Controlled (>9.0%), Eye Examination, Medical Attention for Nephropathy) (NQF #0731)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:	NCQA	Health Plans
Controlling High Blood Pressure (NQF #0018)	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.	NCQA	Health Plans
Pharmacotherapy Management of COPD Exacerbation (Both Rates) (NQF #0549)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:	NCQA	Health Plans
Use of Imaging Studies for Low Back Pain (NQF #0052)	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	NCQA	Health Plans
Medication Reconciliation After Discharge from Inpatient Facility (All Age Groups) (Modified from NQF #0097)	The percentage of discharges for patients for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.	NCQA/DMAS	Health Plans
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (NQF #1933)	The percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic	NCQA	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
	medication and had a diabetes screening test during the measurement year.		
Care for older adults: Medication Review and Advance Care Plan (NQF #0553 and #0326)	The percentage of adults 66 years and older who had each of the following during the measurement year: Advance care planning. Medication review.	NCQA	Health Plans
Inpatient Utilization—General Hospital/ Acute Care	This measure summarizes utilization of acute inpatient care and services in the following categories: Total, Maternity, Surgery, Medicine	NCQA	Health Plans
Ambulatory Care - Emergency Department (ED) Visits	This measure summarizes utilization of ambulatory care in the following categories: Outpatient visits, ED visits	NCQA	Health Plans
Mental Health Utilization	The number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED, and other Medicaid Behavioral Health Services.	NCQA	Health Plans
Plan All-Cause Readmissions (NQF #1768)	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	NCQA	Health Plans
Antidepressant Medication Management (Both Rates) (NQF #0105) ¹	The percentage of members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment	NCQA	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Follow-Up After Hospitalization for Mental Illness (7-Day Rate only) (NQF #0576)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA	Health Plans
Use of High-Risk Medications in the Elderly	The percentage of patients 65 years of age and older who received at least one high-risk medication. The percentage of patients 65 years of age and older who received at least two different high-risk medications.	NCQA	Health Plans
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (NQF #1879)	The percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA	Health Plans
Children and Adolescents' Access to Primary Care Practitioners	The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.	NCQA	Health Plans
Adolescent's well-care visits	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA	Health Plans
Well-Child Visits in the First 15 Months of Life (NQF #1392)	The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.	NCQA	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (NQF #1516)	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	NCQA	Health Plans
Use of First-Line Psychosocial Care for Children and Adolescents	Use of First-Line Psychosocial Care for Children and Adolescents	NCQA	Health Plans
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Health Plans
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NCQA	Health Plans
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (NQF #1365)	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	AMA	Health Plans
PQI 01: Diabetes Short-Term Complication Admission Rate (NQF #0272)	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ	Health Plans
PQI 08: Heart Failure Admission Rate (NQF #0277) ¹	Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions.	AHRQ	Health Plans
PQI 05: COPD and Asthma in Older Adults Admission Rate (NQF #0275)	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Annual Monitoring for Patients on Persistent Medications (NQF #2371)	This measure assesses the percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	NCQA	Health Plans
PQA: Use of Opioids at High Dosage in Persons Without Cancer	The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	PQA	Health Plans
PQA: Use of Opioids from Multiple Providers in Persons Without Cancer	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	PQA	Health Plans
PQA: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	PQA	Health Plans
Outpatient behavioral health encounter in the last 12 months for Medicaid population with behavioral health condition	Outpatient behavioral health encounters, including both Mental Health and Substance Abuse services in the last 12 months for Medicaid population with behavioral health condition	DMAS	Health Plans
LTSS Services Utilization	Unduplicated number of members received LTSS services by major LTSS service type.	DMAS	DMAS

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Recovery Oriented Measure for Severe Mental Illness	Employment, housing and intensity of care management for person with SMI and Severe Substance Abuse Dependence	DMAS	Health Plans
Percentage of LTSS Enrollees using Consumer-Directed Services	LTSS members who used consumer-directed services by LTSS benefit types.	DMAS	DMAS
Personal Care and Respite Care Services with Increase and Decrease Authorization Hours	EDCD LTSS members who experienced an increase or decrease in authorized personal care hours or respite care hours.	DMAS	DMAS
Increase or decrease in other tech LTSS services	Tech LTSS members who experienced an increase or decrease in authorized key LTSS service hours.	DMAS	DMAS
Nursing Facility Residents Hospitalization and Readmission Rate	Example: Percent of long-stay nursing facility residents with a hospital admission within 6 months of baseline assessment	DMAS	Health Plans
Nursing Facility Diversion	Number and percent of new members meeting nursing facility level of care criteria who opt for HCBS over institutional placement	DMAS	DMAS
Priority Two: Care Management and Transition Coordination			
Care Manager to Member Ratio	Members to care management ration reported by member classifications	DMAS	Health Plans
Care Manager Encounters	Intensity of member Care Manger encounters	DMAS	Health Plans
Assessments and Reassessments	Completion of assessment and reassessments based on the requirements in MLTSS model of care	DMAS	Health Plans
Plan of Care and POC Revisions	Completion of plan of care (POC) and POC revisions based on the requirements in MLTSS model of care	DMAS	Health Plans
Documentation of Care Goals	Plan of care documentation of member care goals based on the requirements in MLTSS model of	DMAS	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
	care		
Transition of members between Community Well, LTSS and NF Services and successful retention in lower care settings	Number of members moving from different capitation rate cells including institutional care, LTSS services, and community well. Percentage of community-living MLTSS beneficiaries admitted to an institutional facility, for varying lengths of time. Percentage of MLTSS beneficiaries admitted to an institutional facility and discharged to the community after a short-term stay. Percent of MLTSS members transitioned from NF to community who returned to NF within 90 days. Percent of MLTSS members who transitioned from the LTSS to the NF for greater than 180 days Number and Proportion of Benes transitioned to LTSS from an institution and did not return within a year. Percentage of long-term facility residents discharged back to the community successfully.	DMAS	DMAS
Advance Planning Directives Counseling	Percentage of members who have received Advance Planning Directives counseling	DMAS	Health Plans
Nursing Facility Option Counseling	Members newly admitted to nursing facilities w/out a discharge plan in place were first afforded supports and services in the community	DMAS	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Transition of Members between SUD Levels of Care (including Inpatient Hospital, Residential Treatment, Partial Hospitalization, Intensive Outpatient, and Outpatient SUD Treatment) and hospitals and NF and the community (Modified from NQF #0648)	Total number of transitions where the member's PCP was notified of the transition within 1 business day of the transition. Total number of discharges with documented participation in the discharge plan by the care coordinator and the member, or the member's representative. Members, regardless of age, discharged from an inpatient facility or residential treatment facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care.	AMA/DMAS	Health Plans
Discharge Follow-up	Members with first follow-up visit within 30 days of discharge.	DMAS	Health Plans
Priority Three: Prevention, Healthy Living and Aging Well			
Adult BMI Assessment ¹	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	NCQA	Health Plans
Breast Cancer Screening (NQF #2372)	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	NCQA	Health Plans
Cervical Cancer Screening (NQF #0032)	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. 	NCQA	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (NQF #1932)	The percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	Health Plans
Colorectal Cancer Screening (NQF #0034)	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	NCQA	Health Plans
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates) (NQF #0024)	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.	NCQA	Health Plans
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Rate only) (NQF #0027)	<i>Advising Smokers and Tobacco Users to Quit.</i> A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.	NCQA	Health Plans
Flu Vaccinations for Adults Ages 18 and Older (NQF #0039)	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	NCQA	Health Plans
Pneumococcal Vaccination Status for Older Adults (NQF #0043)	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination	NCQA	Health Plans
Diabetes: Foot Exam (NQF #0056)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory	NCQA	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
	exam with mono filament and a pulse exam) during the measurement year.		
Childhood Immunization Status (NQF #0038)	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NCQA	Health Plans
Immunizations for Adolescents (NQF #1407)	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday.	NCQA	Health Plans
Human Papillomavirus Vaccine for Female Adolescents (NQF #1959)	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	NCQA	Health Plans
Screening for Clinical Depression and Follow-up Plan (NQF #0418)	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	CMS	Health Plans
Priority Four: Member Safety, Satisfaction and Quality of Life			

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Fall Prevention ¹	Percentage of MLTSS beneficiaries 18 years and older at risk of future falls who had each of the following: (1) Risk Assessment for Falls – Beneficiaries with a history of falls or one or more activity of daily living limitation who had a risk assessment for falls completed within 12 months, and (2) Plan of Care for Falls – Beneficiaries with a history of falls or one or more activity of daily living limitation who had a plan of care for falls documented within 12 months. Percentage of members who did not have any falls requiring medical intervention during the measurement period	DMAS	Health Plans
Injury Prevention	Percentage of members who did not experience any injuries, including hip fracture, other fracture, 2nd and 3rd degree burns, or unexplained injuries during the measurement period	DMAS	Health Plans
Critical Incident and Abuse	Number of critical incident and abuse reports for all members	DMAS	Health Plans
Prevalence of pressure ulcers among LTSS members	High risk long stay nursing facility residents with pressure ulcers Short stay nursing home residents with pressure ulcers that are new or worsened LTSS members with pressure ulcers	CMS and DMAS	Health Plans
HCBS experience survey	HCBS experience survey	DMAS	Health Plans
Quality of life and member satisfaction survey CMS Specific	Quality of life and member satisfaction survey CMS Specific	DMAS	Health Plans
CAHPS for Children including Medicaid and Children with Chronic Conditions Supplemental Items	Medicaid CAHPS	NCQA	Health Plans

ATTACHMENT J: MLTSS CORE QUALITY MEASURES

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Medicaid CAHPS for Adults (NQF #0006)	Medicaid CAHPS	AHRQ	Health Plans
Priority Five: Value-Based Payment			
Key performance indicators selected from this list are potential measures for value-based payment program(s).			
<p>Foot Notes:</p> <ol style="list-style-type: none"> 1. Measures in blue will only apply to ABD members, non-dual MLTSS members and dual members in a MLTSS health plan that also manages their Medicare services as their Medicare Managed Care Health Plan. All measures in black will apply to all members. 2. Measures in black will apply to all members. 3. Measures designated as key performance indicators are listed in Attachment K. 4. HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). 5. NCQA Health Plan (HP) Accreditation refers to National Committee for Quality Assurances NCQA Medicaid Health Plan Accreditation 			

ATTACHMENT K: MLTSS KEY PERFORMANCE INDICATORS

Measure	SUD Waiver Required Measure	CMS Medicaid Adult and Child Core Measure	Aligns with VA Plan for Well-being
Adults' Access to Preventive/ Ambulatory Health Services			X
Fall Prevention			
Quality of life and member satisfaction survey CMS Specific			
Nursing Facility Residents Hospitalization and Readmission Rate			
Assessments and Reassessments			
Plan of Care and POC Revisions			
Documentation of Care Goals			
Transition of members between Community Well, LTSS and NF Services and successful retention in lower care settings			
Transition of Members between SUD Levels of Care (including Inpatient Hospital, Residential Treatment, Partial Hospitalization, Intensive Outpatient, and Outpatient SUD Treatment) and hospitals and NF and the community (Modified from NQF #0648)	X	X	
Use of High-Risk Medications in the Elderly			
Ambulatory Care - Emergency Department (ED) Visits			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)	X	X	
SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664)	X		
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605)	X		

ATTACHMENT K: MLTSS KEY PERFORMANCE INDICATORS

Measure	SUD Waiver Required Measure	CMS Medicaid Adult and Child Core Measure	Aligns with VA Plan for Well-being
PQA: Use of Opioids at High Dosage in Persons Without Cancer	X	X	
PQA: Use of Opioids from Multiple Providers in Persons Without Cancer	X		
PQA: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	X		
Controlling High Blood Pressure (NQF #0018)		X	
Comprehensive Diabetes Care (Rate—BP Control <140/90, Rate—HbA1c Control (<8.0%), HbA1c Poorly Controlled (>9.0%), Eye Examination, Medical Attention for Nephropathy) (NQF #0731)		X	
Plan All-Cause Readmissions (NQF #1768)		X	
Antidepressant Medication Management (Both Rates) (NQF #0105)		X	
PQI 01: Diabetes Short-Term Complication Admission Rate (NQF #0272)		X	X
PQI 08: Heart Failure Admission Rate (NQF #0277)		X	X
PQI 05: COPD and Asthma in Older Adults Admission Rate (NQF #0275)		X	X
Follow-Up After Hospitalization for Mental Illness (7-Day Rate only) (NQF #0576)		X	X
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		X	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates) (NQF #0024)		X	
Adult BMI Assessment		X	X
Breast Cancer Screening (NQF #2372)		X	
Cervical Cancer Screening (NQF #0032)		X	
Colorectal Cancer Screening (NQF #0034)			X

ATTACHMENT K: MLTSS KEY PERFORMANCE INDICATORS

Measure	SUD Waiver Required Measure	CMS Medicaid Adult and Child Core Measure	Aligns with VA Plan for Well-being
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Rate only) (NQF #0027)		X	X
Medicaid CAHPS (Includes separate reporting for Flu Vaccination for Adults Ages 18 and older and Pneumococcal Vaccination Status for Older Adults older than 65 years) (NQF #0006)		X	X

ATTACHMENT L: MLTSS WAIVER ASSURANCES

Waiver Assurance Domain	Measure Description	Numerator and Denominator
I. LOC Determination	Number and percent of all new enrollees who have a level of care indicating a need for institutional/waiver services.	N: # of new enrollees who have level of care indicating institutional/waiver eligibility D: # of new enrollees
I. LOC Determination	Number and percent of waiver participants who received an annual LOC evaluation of eligibility within 365 days of their initial LOC evaluation or within 365 days of their last annual LOC evaluation using the states approved form(s).	N: # of participants who received a LOC review within required timeframe. D: Total # LOC reviews completed.
I. LOC Determination	Number and percent of completed LOC forms entered into LOCERI system for standardized LOC review.	N: # of completed LOC forms entered into LOCERI system for standardized LOC review. D: Total # LOC reviews forms completed.
I. LOC Determination	Number and percent of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher level review (HLR).	N: # of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher level review (HLR). D: Total # of LOC reviews that LOCERI indicate do not meet LOC criteria.
I. LOC Determination	Number and percent of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any).	N: # of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any). D: Total # of waiver individuals who did not meet LOC criteria after HLR.
II. Service Plans	Number and percent of waiver individuals who have a service plan in the record.	N: # of waiver individual's records whom have a service plans D: total # of waiver individual's records reviewed.
II. Service Plans	Number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment.	N: # of waiver individual's records who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment D: total # of waiver individual's records reviewed which include a service plan

ATTACHMENT L: MLTSS WAIVER ASSURANCES

Waiver Assurance Domain	Measure Description	Numerator and Denominator
II. Service Plans	Number and percent of service plans developed in accordance with the State's regulations and policies.	N: # service plans developed in accordance with State's regulations and policies. D: total # service plans reviewed.
II. Service Plans (EDCD Waiver Only)	Number and percent of waiver individuals whose service plan was updated / revised at least annually.	N: # of individuals whose service plan was updated/revised at least annually. D: Total # records reviewed which include a service plan
II. Service Plans (Tech Waiver Only)	Number and percent of individuals whose service plan was updated / revised at least every 60 days, as specified in the Waiver application.	N: # of individuals whose service plan was updated /revised at least every 60 days. D: Total # records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals whose service plan was revised as needed, to address changing needs.	N: # individuals whose service plan was revised as needed, to address changing needs D: total # individual service plans reviewed where the record indicated a change in needs.
II. Service Plans	Number and percent of waiver individuals who received services of the type specified in the service plan.	N: # individuals who received services of the type specified in the service plan D: total # records reviewed which include a service plan.
II. Service Plans	Number and percent of waiver individuals who received services in the scope specified in the service plan.	N: # individuals who received services in the scope specified in the service plan D: total # records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals who received services in the amount specified in the service plan.	N: # individuals who received amount specified in the service plan D: total number records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals who received services for the duration specified in the service plan.	N: # individuals who received services for the duration, specified in the service plan D: total # records reviewed which include a service plan

ATTACHMENT L: MLTSS WAIVER ASSURANCES

Waiver Assurance Domain	Measure Description	Numerator and Denominator
II. Service Plans	Number and percent of waiver individuals who received services in the frequency specified in the service plan.	N: Number individuals who received services in the frequency specified in the service plan D: total # records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals whose records contain an appropriately completed and signed form that specifies choice was offered between institutional care and waiver services.	N: total # of records that contain documentation of choice between institutional care and waiver services D: total # of records reviewed.
II. Service Plans	Number and percent of waiver individuals whose records contain an appropriately completed and signed form that specifies choice was offered among waiver services.	N: total # of records that contain documentation of choice among waiver services D: total # of records reviewed
II. Service Plans	Number and percent of waiver individuals whose records documented that choice of waiver providers was provided to the individual.	N: total # of records that contain documentation that choice of the waiver providers was offered to the individual D: total # of case management records reviewed.
III. Qualified Providers	Number and percent of licensed/certified waiver agency provider enrollments, for which appropriate licensure/certification were obtained in accordance with law & waiver requirements prior to service provision.	N: # new waiver agency provider enrollments with licensure/certification in accordance with requirements before service provision D: total # new enrolled waiver providers with licensure/certification requirement
III. Qualified Providers	Number and percent of licensed/certified waiver provider agencies continuing to meet applicable licensure/certification following initial enrollment.	N: # licensed/certified providers continuing to meet applicable licensure/certification following initial enrollment D: total # licensed/certified provider agencies reviewed.

ATTACHMENT L: MLTSS WAIVER ASSURANCES

Waiver Assurance Domain	Measure Description	Numerator and Denominator
III. Qualified Providers	Number and percent of licensed/certified waiver provider agency direct support staff who have criminal background checks as specified in policy/regulation with satisfactory results following initial enrollment.	N: # licensed/certified provider direct support staff who have criminal background check as specified in policy/regulation with satisfactory results following initial enrollment D: total # licensed/certified provider agency direct support staff records reviewed.
III. Qualified Providers	Number and percent of new non-licensed/non-certified waiver individual provider enrollments, who initially met waiver provider qualifications.	N: # new non-licensed/non-certified individual provider enrollments, who initially met waiver provider qualifications. D: total # new non-licensed/non-certified individual provider enrollments.
III. Qualified Providers	Number and percent of new non-licensed/non-certified consumer-directed employees who meet requirements.	N: # of new consumer-directed attendants who meet requirements D: total # of new consumer-directed employees.
III. Qualified Providers (EDCD Waiver Only)	Number and percent of new consumer-directed employees who have a criminal background check at initial enrollment.	N: # of new consumer-directed employees who have a criminal background check at initial enrollment D: total # new consumer-directed employees enrolled.
III. Qualified Providers (EDCD Waiver Only)	Number and percent of consumer-directed employees with a failed criminal background check that are barred from employment.	N: # of consumer-directed employees who have a failed criminal background who are barred from employment D: total # consumer-directed employees who have a failed criminal background check.
III. Qualified Providers	Number and percent of waiver provider staff meeting provider staff training requirements.	N: # provider staff meeting provider staff training requirements D: total # provider staff records reviewed

ATTACHMENT L: MLTSS WAIVER ASSURANCES

Waiver Assurance Domain	Measure Description	Numerator and Denominator
III. Qualified Providers (EDCD Waiver Only)	Number and percent of consumer-directed employers trained, as required, regarding employee management and training.	N: # of consumer-directed employers for new enrollees during the review period trained trained, as required, regarding employee management and training D: total # of consumer-directed employer training records for new enrollees during the review period trained reviewed.
IV. Health and Welfare	Number and percent of waiver individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken.	N: # of individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken ; D: Total # of individual's records with indications of abuse, neglect or exploitation.
IV. Health and Welfare	Number and percent of waiver individual's records with indications of safety concerns documenting appropriate actions taken.	N: # of individual's records with indications of safety concerns documenting appropriate actions taken ; D: Total # of individual's records with indications of safety concerns.
IV. Health and Welfare	Number and percent of waiver individual's records with indications of risk in the physical environment documenting appropriate actions taken.	N: # of individual's records with indications of risk in the physical environment documenting appropriate actions taken ; D: Total # of individual's records with indications of risk in the physical environment.
IV. Health and Welfare	Data-bridge captures types of incidents, location of incidents and services offered/accepted. Non-disability waivers take less time to respond.	N: # of individuals that were offered services as a result of substantiated report; D: Total # of reports made that were substantiated.
IV. Health and Welfare		Licensing entities monitor the prohibition of restraints or seclusion for agency-directed providers during scheduled licensing reviews.

ATTACHMENT L: MLTSS WAIVER ASSURANCES

Waiver Assurance Domain	Measure Description	Numerator and Denominator
V. Administrative Authority	Number and percent of satisfactory IAA/MOU/contract evaluations.	N: # of satisfactory IAA/MOU/contract evaluations; D: Total # of IAA/ MOU/ contracts with entities performing functions related to the waiver.
VI. Financial Accountability	Number and percent of adjudicated waiver claims submitted to Participating Plans that were paid within the timely filing requirements.	N: # of adjudicated claims submitted using the correct rate. D: Total # of adjudicated claims