

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



CardinalCare
Virginia's Medicaid Program

**Dual Special Needs Plan (D-SNP) Contract
Full Benefit Dual Eligible**

January 1, 2026 to December 31, 2026

Table of Contents

1	SCOPE OF CONTRACT	8
1.1	Applicable Laws and Regulations	8
1.2	Operational Memoranda, Guidance Documents and Department Forms	8
1.3	Department and Dual Eligible Special Needs Plan Collaboration	9
1.4	Required Reporting	9
1.4.1	Service Account	9
1.5	Contractor Requirements to Respond	9
1.6	Department Oversight	10
1.7	Contract Termination	10
2	D-SNP Requirements for Operation	11
2.1	Contracting Requirements	11
2.2	Contact Information	11
2.3	Standards, Licensure and Solvency	11
2.3.1	Financial Stability	11
2.3.2	Statutory State Licensing and Certification Requirements	12
2.3.3	Quality Health Care and Consumer Protections	12
2.3.4	Authorization to Conduct Business in the Commonwealth	12
2.3.5	CMS Approved D-SNP	12
2.4	Policy of Nondiscrimination	12
2.5	Non-Debarment	13
2.6	Plan Design Requirements	13
2.6.1	Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)	13
2.6.2	Applicable Integrated Plan (AIP)	14
2.6.3	D-SNP Only/Single State Contract	14
2.6.4	Option for Additional Plan Benefit Packages	14
3	Covered Populations and Enrollment	15
3.1	Eligible Populations	15
3.1.1	Full Benefit Dual Eligible Enrollees	15
3.2	Excluded Populations	15
3.3	Determining Eligibility and Enrollment Responsibilities	17
3.3.1	Verifying Eligibility	17

3.3.2	Non-Discrimination	17
3.4	Disenrollment and Loss of Medicaid Eligibility	18
3.4.1	Loss of Medicaid Eligibility	18
3.5	Default Enrollment.....	18
3.5.1	Default Enrollment Conditions.....	18
3.5.2	Default Enrollment Process Approval	19
3.5.3	Default Enrollment Process.....	20
4	Integrated Model of Care.....	21
4.1	Model of Care General Requirements	22
4.2	Care Coordination	22
4.3	MCO Member Health Screening (MMHS).....	23
4.3.1	Description of the MMHS	23
4.3.2	Requirements to Screen Members Using MMHS	24
4.4	Care Management	26
4.4.1	Risk Stratification	26
4.4.2	Priority Populations.....	27
4.4.3	Identifying Other Members Needing Care Management	29
4.4.4	Care Manager Staffing Ratios	30
4.4.5	Care Management Contact and Format Requirements.....	30
4.4.6	Restratification.....	31
4.4.7	Triggering Events.....	31
4.4.8	Data Surveillance and Validation of Care Management Assignment	32
4.5	Health Risk Assessments (HRA).....	32
4.5.1	HRA Tool Required Elements	33
4.5.2	HRA Administration Requirements.....	34
4.5.3	HRA Completion Timeframes.....	35
4.5.4	Unable to Contact for HRA.....	36
4.5.5	HRA When Member Refuses.....	36
4.6	Person-Centered Individualized Care Plan (ICP)	37
4.6.1	ICP Required Elements.....	38
4.6.2	ICP Completion Timeframes	40
4.6.3	ICP Revision Completion Timeframes	41
4.7	Interdisciplinary Care Team (ICT).....	41

4.7.1	ICT Membership	41
4.7.2	ICT Communication and Meeting Timeframes	42
4.7.3	ICT Meeting Attendance	43
4.7.4	ICT Meeting Documentation Requirements	43
4.8	Care Manager Staffing	44
4.8.1	Care Manager Qualifications.....	44
4.8.2	Care Management Extenders	45
4.8.3	Care Manager Supervisor.....	45
4.8.4	Care Manager Training.....	46
4.8.5	Care Manager Assignment.....	47
4.8.6	Care Management Staffing Plan	47
4.9	Ongoing Care Management.....	48
4.9.1	General Requirements	48
4.9.2	Local Care Management Requirements.....	50
4.9.3	Care Management Partnerships, Including with Community-Based Organizations.....	50
4.9.4	Referral Requirements.....	51
4.10	Transitional Care Management	51
4.10.1	Regional Transition Care Manager Responsibilities.....	52
4.10.2	Care Manager Responsibilities in Coordination with the Regional Transition Care Manager	52
4.10.3	Transition from NF to the Community.....	53
4.11	Administrative Transitions/Continuity of Care	54
4.12	Care Coordination and Care Management for Specific Subpopulations	54
4.12.1	Foster Care Management	54
4.12.2	Care Management for High-Risk Pregnant Individuals and Infants	57
4.12.3	Care Management for Members Receiving HCBS.....	58
4.12.4	ARTS Care Management	59
4.12.5	Formal Referral and Assistance Process for Members Experiencing Homelessness.....	60
4.13	Electronic Care Coordination System	60
4.14	Disease Management Programs	60
4.15	Health Homes.....	61
4.16	Community & Member Engagement.....	61
4.17	Care Management Collaborative	63

5	Medicare-Medicaid Coordination Requirements	63
5.1	Coordination of Benefits	63
5.1.1	Service Authorization Processing.....	63
5.1.2	Claims Processing.....	63
5.1.3	Timely Filing Deadline	64
5.2	Integrated Appeals and Grievances	64
5.3	Behavioral Health.....	64
5.4	Coordination with the State.....	64
5.5	Staff Training	65
5.6	Provider Training.....	65
5.7	Member Transition	65
5.8	Call Center Requirements	65
6	Member Communications, Marketing and Education.....	65
6.1	Member Materials	66
6.1.1	Use of the Health Plan Management System	66
6.1.2	Required Integrated Materials.....	66
6.2	Marketing and Education.....	67
6.2.1	Requirements For Enrollment Brokers/Agents.....	67
7	Miscellaneous	67
7.1	Contract Oversight and Compliance	67
7.1.1	External Quality Review Organization (EQRO) Activities	67
7.1.2	D-SNP Improvement Plan	68
7.2	Quarterly Meetings.....	68
7.3	Member Advisory Committee.....	68
7.4	Covered Services	68
7.4.1	Medicaid Covered Services	68
7.4.2	Cost Sharing Protections	69
7.4.3	Enhanced Benefits	69
7.5	DMAS Obligations	70
7.5.1	Benefit Information.....	70
7.5.2	Financial Responsibility	70
7.5.3	Medicaid Provider Information.....	70
8	Definitions and Acronyms	70

8.1	Definitions	70
8.2	Acronyms	104
9	Signature Page	109
9.1	Verifying Plan Design	110
9.2	Verifying Service Area	112
10	Covered Services Chart	114
11	Cardinal Care Model of Care Overview	221
12	Virginia Medicaid Aid Category List	225
13	Health Plan Management System (HPMS) Material Review Requirements.....	228

1 SCOPE OF CONTRACT

This Contract, by and between the Virginia Department of Medical Assistance Services (hereinafter referred to as the Department, DMAS or the State), an administrative agency within the executive agency of the Commonwealth of Virginia responsible for operating a program of medical assistance under 42 USC. § 1396a et seq., the Code of Virginia § 32.1-325, et seq., and the Medicare Advantage Dual Eligible Special Needs Plan (herein referred to as the MA D-SNP, D-SNP, or Contractor), a corporation organized under the laws of the Commonwealth of Virginia and having a principal place of business in Virginia. This Contract is effective January 1, 2026 through December 31, 2026.

1.1 Applicable Laws and Regulations

The Contractor must provide the full scope of services and deliverables through an integrated and coordinated system of care as required, described, and detailed herein, consistent with all applicable laws and regulations, and in compliance with service and delivery timelines as specified. Applicable laws and regulations include, but are not limited to:

1. Federal statutes, regulations and guidance documents, as amended;
2. State statutes and regulations, as amended;
3. This Contract, including any Contractor specific terms and conditions negotiated and approved by the Department, and all amendments and attachments;
4. Department issued D-SNP Technical Manual; and
5. Department issued D-SNP memoranda, bulletins and other guidance documents.

The Contractor is also responsible for understanding and incorporating, as necessary, to fulfill the terms of this Contract, the federal and state laws and regulations applying to the Commonwealth's Medicaid program. This includes, but is not limited to:

1. Virginia's State Plans for Medical Assistance Services and State Children's Health Insurance Program (CHIP);
2. The Department's 1915(b) Managed Care Waiver, 1915(c) HCBS Waivers, ARTS 1115 Waiver, and FAMIS MOMS 1115 Waiver;
3. The Cardinal Care Managed Care Contract; and
4. Medicaid memos, bulletins, and guidance as well as Department-issued memos, bulletins, manuals, and other guidance documents.

1.2 Operational Memoranda, Guidance Documents and Department Forms

The Department may issue guidance documents and program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and clarification of coverage. The Contractor must comply with all such program memoranda. In addition, for more information to assist in the coordination with Medicaid, refer to DMAS program policy manuals, Medicaid Memos and forms used in the administration of benefits for Medicaid individuals which are available on the DMAS web portal [at this link](#).

1.3 Department and Dual Eligible Special Needs Plan Collaboration

The Contractor must work collaboratively with the Department on the Commonwealth's initiatives to enhance the D-SNP program as well as all efforts to improve the existing operations of the D-SNP program. This includes, but is not limited to, attending meetings, participating in workgroups, and completing program (including IM systems) revisions within the Departments designated timeframes.

1.4 Required Reporting

The Contractor must adhere to the delivery of all reports established by the Department and noted within the D-SNP Technical Manual and this Contract. The Contractor must refer to the D-SNP Technical Manual for the appropriate reporting formats, instructions, submission timetables, and technical assistance.

The Department may, at its discretion, change the content, format or frequency of reports. In addition, the Department may, at its discretion, require the Contractor to submit additional reports both ad hoc and recurring. If the Department requests any revisions to the reports already submitted, the Contractor must make the changes and re-submit the reports, according to the time period and format required by the Department.

In regards to any references in this Contract pertaining to submission of reports or other requirements, generally, unless specified otherwise, the Contractor may send these to dsnp@dmas.virginia.gov.

1.4.1 Service Account

Unless otherwise noted in this Contract or the D-SNP Technical Manual, the Contractor is required to submit reports to the Department using the Department's prescribed managed file transfer (MFT) process. To use the MFT process, the Contractor must obtain and maintain a service account and regulate which staff can access the account in order to send and retrieve reports. The Contractor should contact the Department D-SNP contract monitor at dsnp@dmas.virginia.gov to create a service account. The Department will not create accounts for individual Contractor staff.

1.5 Contractor Requirements to Respond

The Contractor must acknowledge receipt of the Department's written, electronic, or telephonic requests for assistance, including, but not limited to, care management requests and requests to research and resolve Member complaints, within the following time frames:

1. Within one (1) business day in instances where a potential/actual risk to the Member's health, safety or welfare exists; and
2. In all other instances within no later than two (2) business days of receipt of the request from the Department.

When the last day for submission to the Department of any requested information or reports, per this Section, falls on a Saturday, Sunday, or legal holiday, the information may be delivered on the next day that is not a Saturday, Sunday, or legal holiday.

The Department's requests for care management and/or requests for the Contractor to contact the Member/provider must occur within the time frame set forth by the Department through the written, electronic, or telephonic communication.

The Department's urgent requests for assistance, such as issues involving legislators, other governmental bodies, or as determined necessary by the Department, must be given priority by the Contractor and completed in accordance with Departmental instructions. The Department will provide guidance with respect to any necessary deadlines and requirements, including specifications to be submitted by the Contractor.

For requests involving litigation or legal representation of any type, the Contractor must ensure that all responses are timely, thoroughly detailed, professionally written, and legally sound.

The Contractor may request an extended timeframe for response and resolution of non-urgent requests, after initial acknowledgement of request and prior to the expiration of the original specified timeframe. Request for extension must include the reason for extended response timeframe and the requested date for new response.

1.6 Department Oversight

Throughout the performance of contract monitoring activities, the Department may assess the Contractor's compliance with any requirements set forth in this Contract and in the documents referenced herein. The Department reserves the right to audit, formally and/or informally, for compliance with any term(s) of this Contract, for compliance with the laws and regulations of the Federal Government and the Commonwealth of Virginia, and for compliance in the implementation of any term(s) of this Contract. The right to audit under this Section exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Records must be maintained in a searchable electronic format.

1.7 Contract Termination

This Contract may be terminated under the following conditions:

1. In accordance with Section 2.1, *Contracting Requirements*, and Section 2.5.1, *Fully Integrated Dual Eligible Special Needs Plan*, the Contractor must hold both this Contract and the [Cardinal Care Managed Care \(CCMC\) Contract for Medicaid managed care in Virginia](#). If the Contractor loses the CCMC Contract for any reason, this Contract will terminate the same day the termination of the CCMC is effective.
2. By the Contractor, for convenience, with not less than one hundred eighty (180) calendar days advance written notice; and
3. By the Department, for convenience, with not less than ninety (90) calendar days advance written notice.
4. This Contract will automatically terminate on the final day of the Contract period included in Section 9.0, *Signature Page*, of this Contract.

2 D-SNP Requirements for Operation

2.1 Contracting Requirements

Prior to operating within the Commonwealth, the Contractor must have entered into a Contract with the Department to provide, primary and acute care, behavioral health, nursing facility (NF), HCBS Waiver, and Long-Term Services and Supports (LTSS) to qualified beneficiaries through a CCMC program Contract.

Additionally, prior to operating within the Commonwealth, the Contractor must have entered, or have applied to enter, into a Medicare Advantage Dual-Eligible Special Needs Plan Contract (“MA Contract”) with the Centers for Medicare & Medicaid Services (“CMS”), whereby the Contractor provides or desires to provide Medicare Covered health care benefits to qualified Medicare beneficiaries under a D-SNP in the Commonwealth of Virginia.

In accordance with Chapter 16-B of the Medicare Managed Care Manual, each D-SNP must submit a State Medicaid Agency Contract (SMAC or D-SNP Contract) to CMS for review by the first Monday in July every year for each state in which it seeks to operate for the upcoming contract year. In addition, the Social Security Act and federal regulations require D-SNPs to have a contract with state Medicaid agencies to provide benefits to individuals that are entitled to receive as medical assistance under Title XIX of the Social Security Act (CCMC Contract).

2.2 Contact Information

The Contractor must provide the Department with the name and contact information of those individuals who are responsible for the following duties:

1. D-SNP National Lead;
2. D-SNP State Lead;
3. State Lead for D-SNP care coordination;
4. State Lead for D-SNP coordination with Medicaid Plans;
5. State Lead for D-SNP contracting; and
6. State Lead for D-SNP quality improvement and oversight.

The same individual can fulfill one or more of the roles listed. See the D-SNP Technical Manual for specifications.

2.3 Standards, Licensure and Solvency

The Contractor must obtain and retain each of the following requirements in this Section.

2.3.1 Financial Stability

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed plans in Virginia. The Contractor must comply with all Bureau of Insurance standards. Bureau of Insurance standards may be found on the State Corporation Commission’s website at [this link](#).

2.3.2 Statutory State Licensing and Certification Requirements

The Contractor must retain at all times during the period of this Contract a valid license issued by the Virginia State Corporation Commission and comply with all terms and conditions set forth in the Code of Virginia §§ 38.2-4300 through 38.2-4323, 14 VAC 5-211-10 et. seq., and any and all other applicable laws of the Commonwealth of Virginia, as amended.

2.3.3 Quality Health Care and Consumer Protections

Pursuant to §32.1-137.1 through §32.137.6 Code of Virginia, and 12 VAC 5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the Virginia State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services they deliver.

2.3.4 Authorization to Conduct Business in the Commonwealth

The Contractor, as a stock or non-stock corporation, limited liability company, business trust, limited partnership, or registered as a limited liability partnership, must 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 must 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.

2.3.5 CMS Approved D-SNP

The Contractor must retain at all times during the period of this Contract signed approval by CMS to comply with all rules and regulations set forth in 42 CFR § 422 and 42 CFR § 423 and operate as a MA D-SNP to provide Medicare Covered health care benefits to qualified Medicare beneficiaries under this Contract in the Commonwealth of Virginia.

2.4 Policy of Nondiscrimination

The Contractor and all subcontractors must comply with all applicable Federal and State laws and regulations relating to nondiscrimination and equal employment opportunity, and assure physical and program accessibility of all services to individuals with disabilities pursuant to § 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and with all requirements imposed by applicable regulations in 45 CFR Part 84, Title VI of the Civil Rights Act, the Americans with Disabilities Act of 1990 as amended, title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1967, the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, sexual orientation, gender identity, physical condition, developmental disability, or national origin. Any of the Contractor's contracts with subcontractors must comply with Virginia Code § 2.2-4311.

Furthermore, the Contractor must ensure that its network providers provide contract services to Members under this Contract in the same manner as they provide those services to all non-Medicare Members, including those with limited English proficiency or physical or mental disabilities.

2.5 Non-Debarment

By participating in this procurement, the Contractor certifies that it is not currently debarred by the Commonwealth of Virginia from submitting a response for the type of goods and/or services covered by this solicitation. The Contractor further certifies that it is not debarred from filling any order or accepting any resulting order, or that it is an agent of any person or entity that is currently debarred by the Commonwealth of Virginia.

If a Contractor is created or used for the purpose of circumventing a debarment decision against another Contractor, the non-debarred vendor will be debarred for the same time period as the debarred vendor.

2.6 Plan Design Requirements

2.6.1 Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

In accordance with the 2020 Virginia Acts of Assembly, Chapter 1289, Item 313(E)(2)(n), and notwithstanding the exceptions described in Section 2.6.1.1 *FIDE Exceptions* of this Contract, the Contractor is required to meet CMS standards for FIDE SNP as defined in 42 CFR § 422.2 and be approved by CMS as a FIDE SNP for the contract period. As such, the Contractor must:

1. Provide eligible enrollees access to Medicare and Medicaid benefits under a single entity that holds both this Contract with CMS and the CCMC Contract for Medicaid managed care in Virginia,
2. Possess the CCMC Contract with the Department that includes coverage of the following benefits to individuals eligible to enroll in this FIDE SNP in Virginia:
 - a. Primary care and acute care including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries;
 - b. LTSS, including coverage of nursing facility services for a period of at least 180 days during the plan year;
 - c. Behavioral health services;
 - d. Home health services as defined in § 440.70; and
 - e. Medical supplies, equipment, and appliances, as described in § 440.70(b)(3)
3. Coordinate the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries (See Section 4.0 of this Contract, *Integrated Model of Care*);
4. Employ policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, and quality improvement (See Sections 5.0, *Medicare-Medicaid Coordination Requirements*, Section 6.0, *Member Communications, Marketing and Education*, and Section 7.1, *Contract Oversight and Compliance*, of this Contract);

5. Integrate appeals and grievances in accordance with §§ 422.629 – 422.634, 438.210, 438.400, and 438.402;
6. Operate with exclusively aligned enrollment; and
7. Operate only in localities where it meets Medicaid network standards.

2.6.1.1 [FIDE Exceptions](#)

If the Contractor is not approved by CMS to operate as a FIDE SNP for any reason, they may be permitted to continue to operate in Virginia but must request an exception from the Department as soon as notice from CMS is received and prior to operation. At a minimum, the notification to the Department must explain why the Contractor is unable to become a FIDE SNP and the Contractor's plan and timeline for resolving all barriers. The Department will consider exemption requests on a case-by-case basis and inform the Contractor of its decision within thirty (30) days of receiving a complete request. Requests can be submitted to the Department via traditional mail or email.

2.6.2 [Applicable Integrated Plan \(AIP\)](#)

The Contractor must operate as an AIP as defined at 42 CFR § 422.561. As such, the Contractor must:

1. Operate with exclusively aligned enrollment, and
2. Unless granted an exception (See 2.6.1.1, *FIDE Exceptions*, of this Contract), operate as a FIDE SNP.

To facilitate the exclusively aligned enrollment process, the Department will utilize Medicare enrollment data provided to the Department as part of its existing data exchange with CMS to identify individuals enrolled in the D-SNP and then the Department will auto-enroll the eligible individuals into the Contractor's affiliated CCMC plan. Medicaid enrollments are not processed up to the last days of the month. Any individual that enrolls in the D-SNP after Medicaid enrollments have closed for the month will be auto-assigned to the Contractor's affiliated CCMC plan the following month.

2.6.3 [D-SNP Only/Single State Contract](#)

In accordance with 42 CFR § 422.107(e), the Department has elected to exercise the additional opportunities available to States with AIP FIDE SNP. The Contractor must operate as a "D-SNP Only/Single State Contract" which requires that the Contractor establish and operate a contract with CMS and the Department that only includes D-SNPs and those D-SNPs only operate within the Commonwealth. The Contractor must include notice of this change to CMS as part of the Notice of Intent to Apply (NOIA) per § 422.501.

2.6.4 [Option for Additional Plan Benefit Packages](#)

The Contractor is permitted to operate more than one PBP upon approval by the Department. Any additional PBP must meet the requirements of this Contract. In any instance where the Contractor wishes to offer an additional PBP, the Contractor must notify the Department no later than the final submission of the Notice of Intent to Apply (NOIA) to CMS (typically mid-January). The Department will consider requests for additional PBP's on a case-by-case basis and will approve or deny the request as expeditiously as possible.

2.6.4.1 [Partial Dual Eligible Enrollees](#)

The Contractor is granted the option to offer a D-SNP enrollment option to partial benefit dual eligible individuals. Requirements for D-SNPs enrolling partial benefit dual eligibles are described in a separate contract that will be provided by the Department.

3 Covered Populations and Enrollment

3.1 Eligible Populations

3.1.1 Full Benefit Dual Eligible Enrollees

With this signed Contract between the Contractor and the Department, the Contractor must offer their D-SNP to individuals who are entitled to benefits under Medicare Parts A, B and D, are receiving full Medicaid benefits, and are not included in the excluded populations in Section 3.2 of this Contract, *Excluded Populations*. Examples of eligible full benefit dual eligible enrollees include:

1. Qualified Medicare Beneficiary Plus (QMB+),
2. Special Low Income Medicare Beneficiary Plus (SLMB+), and
3. Other Full-Benefit Dual Eligible (FBDE).

3.2 Excluded Populations

The Contractor is prohibited from enrolling individuals into a Full Benefit D-SNP who meet any of the following criteria:

1. Any individual who is not enrolled in the CCMC program. These individuals are described in Section 3.2, *Excluded Populations*, in the CCMC Contract and in the following list.
2. Individuals enrolled in a Program of All-inclusive Care for the Elderly (PACE) program (however, PACE participants may enroll with the Contractor if they choose to disenroll from their PACE provider);
3. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program or the FAMIS Select program;
4. Individuals with temporary eligibility coverage [less than three (3) months], retroactive eligibility coverage (other than newborns per Section 3.7 of the CCMC Contract, *Enrollment Process for Newborns*), enrolled in presumptive eligibility groups, or who are Medicaid-eligible in limited coverage groups, including:
 - a. Individuals enrolled in Plan First (the Department's family planning program for coverage of limited benefits surrounding pregnancy prevention)
 - b. Individuals in Medicare-Related Covered Groups (Medicare Savings Plans or MSPs) for whom Medicaid pays the Medicare costs on behalf of these beneficiaries. These individuals do not have full Medicaid benefits, and include, Qualified Medicare Beneficiaries (QMBs), Special Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), or, Qualifying Individuals (QIs);
5. Medically Needy (spenddown) individuals who have a limited period of full coverage; (Medically Needy LTSS participants who meet their spenddown and maintain ongoing eligibility are eligible);

6. Other individuals with temporary or limited Medicaid eligibility coverage;
7. Individuals who elect hospice benefits while enrolled in Medicaid fee-for-service will not be enrolled into CCMC. However, a CCMC enrolled individual who subsequently enters a hospice program will remain Managed Care enrolled;
8. Individuals who live in areas where less than two Medicaid MCOs participate, such as Tangier Island;
9. Individuals under age twenty-one (21) years of age who are approved for admission to a VA Medicaid Psychiatric Residential Treatment Facility (PRTF) program);
10. Individuals in fee-for-service with end stage renal disease (ESRD) will be enrolled into CCMC unless the individual requests to be excluded from CCMC participation within the individual's first ninety (90) days of CCMC enrollment. Individuals who do not request exclusion within the first ninety (90) days or who develop ESRD while enrolled in CCMC, will remain in CCMC;
11. Individuals of any age who are institutionalized in State or private ICF/ID and State ICF/MH facilities (a State acute care facility is not excluded);
12. Individuals receiving care in a Christian Science Sanatoria Facility. Individuals will be excluded from CCMC when admitted to a Christian Science Sanatoria and services will be covered under the Medicaid fee-for-service program within Department-established criteria and guidelines, per 12 VAC 30-50-300 (Christian Science Nursing Services are not covered);
13. Individuals aged twenty-one (21) to sixty-four (64) who are hospitalized in a State or private institution for mental disease (IMD), other than individuals admitted to an IMD as part of a Contractor approved admission, in lieu of an acute care hospital (psychiatric unit), consistent with 42 CFR § 438.6(e) and Section 5.5.1.2 of the CCMC Contract, *IMD Enhanced and State Plan Substituted (In Lieu of) Services for Certain Medicaid Members*;
14. Individuals who reside at Piedmont, Hiram Davis, and Hancock State facilities operated by DBHDS;
15. Individuals who reside in nursing facilities operated by the U.S. Department of Veterans Affairs, the Virginia Home Nursing Facility, local government-owned nursing homes, and individuals authorized by the Department to receive care/treatment in facilities located outside of Virginia. These include the following nursing facilities:
 - a. Bedford County Nursing Home;
 - b. Birmingham Green;
 - c. Dogwood Village of Orange County Health;
 - d. Lake Taylor Transitional Care Hospital (Different from Lake Taylor Long-Stay Hospital);
 - e. Lucy Corr Nursing Home;
 - f. The Virginia Home Nursing Facility;
 - g. Virginia Veterans Care Center; and
 - h. Sitter and Barfoot Veterans Care Center
16. Individuals who are incarcerated (individuals on house arrest are not considered incarcerated);
17. Individuals enrolled in the Birth Injury Fund, and
18. Except for the Contractor whose affiliated Medicaid Managed Care plan has been awarded the Foster Care Specialty Plan through RFP 13330, all individuals in aid categories 70, 72 and 76.

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

3.3 Determining Eligibility and Enrollment Responsibilities

3.3.1 Verifying Eligibility

The Contractor is responsible for accurately verifying both Medicare and Medicaid eligibility of potential and enrolled Members. The Contractor will be provided with the means to verify Medicaid eligibility by the Department as defined in this Contract.

The Department will provide the Contractor access to real-time, or near real-time, Medicaid eligibility information through both phone-based and online systems operated by the Department or its contractor. The Department recommends that the Contractor use the [Virginia Medicaid Enterprise System \(MES\) Provider Portal](#) or the 270/271 batch lookup process. More information on how to access the 270/271 process can be found on MES [here](#).

In the event the real-time online system is not operational, the Department will provide an alternative method if possible. The Department will respond to all eligibility inquiries in no less than five (5) business days.

If the Contractor is not able to utilize the real-time online system through no fault of the Department, the Department may, but is not obligated to, provide an alternative method.

The Contractor and the Department each acknowledge that the Contractor is a “Covered Entity,” as defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (the “Privacy Rule”). Access to the eligibility data is conditioned on the Contractor’s Contract to abide by the requirements of HIPAA, the Health Information Technology for Economic and Clinical Health Act of 2009.

3.3.2 Non-Discrimination

Unless a Dual Eligible Individual is otherwise excluded under federal Medicare Advantage plan rules or does not meet dual eligible Medicaid eligibility as described in Section 3.0, *Covered Populations and Enrollment*, the Contractor will accept all Dual Eligible Individuals who select the Contractor’s D-SNP without regard to physical or mental condition, health status, or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation (pursuant to Governor’s Executive Order #1 and § 3.12 of the Department of General Services [Agency Procurement and Surplus Property Manual](#)), national origin, race, color, or religion. Furthermore, the Contractor will not implement any policy or practice that has the effect of such discrimination.

3.4 Disenrollment and Loss of Medicaid Eligibility

3.4.1 Loss of Medicaid Eligibility

When a Member loses Medicaid eligibility and the Contractor determines the individual is likely to regain Medicaid eligibility within six (6) months of the termination date, the Contractor must retain the Member for the full six (6) months. The Contractor must apply the criteria used to determine if an individual is likely to regain Medicaid eligibility consistently to all Members and must fully inform all Members of its policy. See CMS' *Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment* for guidance on determining if an individual is likely to regain eligibility.

3.5 Default Enrollment

Pursuant to 42 CFR § 422.66(c)(2)(i)(B) and 42 CFR § 422.107, the Department approves the Contractor's implementation of the default enrollment process subject to CMS' prior approval as per the requirements of 42 CFR § 422.66(c)(2)(i)(E), (F), and (G) inclusive; 422.66(c)(ii); and other CMS-published sub-regulatory guidance as applicable.

The Contractor must perform the default enrollment process as provided by 42 CFR § 422.66 and § 422.68 for those currently enrolled, categorically eligible Virginia Medicaid Members who meet all of the following criteria:

1. The Member receives full medical assistance benefits;
2. The Member becomes newly Medicare eligible either by age or disability; and
3. The Member's eligibility results in Full Benefit Dual Eligible status for such Member.

The Department must provide the Contractor with the information necessary to identify those Virginia Medicaid categorically eligible Members who are or will be in their Medicare Initial Coverage Election Period.

If CMS rejects the Contractor's Default Enrollment Process proposal, the Contractor must notify the Department within three (3) days of receiving the initial or renewal rejection notification. Not being approved for default enrollment will not end the Contractor's contract with the state.

3.5.1 Default Enrollment Conditions

The conditions of default enrollment in 42 CFR § 422.66 are listed below. The Contractor must ensure that the following conditions are met before initiating default enrollment activities, including enrolling individuals into a D-SNP.

1. During an individual's initial coverage election period, an individual may be deemed to have elected a MA Special Needs Plan for individuals entitled to medical assistance under a State plan under Title XIX (including a FIDE SNP as defined in § 422.2) offered by the organization provided all the following conditions are met:
 - a. At the time of the deemed election, the Member remains enrolled in an affiliated Medicaid Managed Care plan. For purposes of this Section, an affiliated Medicaid Managed Care plan is one that is offered by the MA organization that offers the dual

- eligible MA Special Needs Plan or is offered by an entity that shares a parent organization with such MA organization;
- b. The state has approved the use of the default enrollment process in the contract described in § 422.107 and provides the information that is necessary for the MA organization to identify individuals who are in their initial coverage election period;
 - c. The MA organization offering the MA Special Needs Plan has issued the notice described in paragraph (c)(2)(iv) of § 422.66 and in Section 3.5.2.1, *Default Enrollment Notice*, to the individual;
 - d. Prior to the effective date described in paragraph (c)(2)(iii) of this Section, the individual does not decline the default enrollment and does not elect to receive coverage other than through the MA organization;
 - e. CMS has approved the MA organization to use default enrollment under paragraph (c)(2)(ii) of this Section;
 - f. The MA organization has a minimum overall quality rating from the most recently issued ratings, under the rating system described in §§ 422.160 through 422.166, of at least three (3) stars or is a low enrollment contract or new MA plan as defined in § 422.252; and
 - g. The MA organization does not have any prohibition on new enrollment imposed by CMS.

3.5.2 Default Enrollment Process Approval

In accordance with 42 CFR § 422.66, (c)(2)(ii.), an MA organization must obtain approval from CMS before implementing any default enrollment. The Contractor must coordinate with the Department regarding those activities necessary to obtain such CMS prior approval. The Contractor must forward to the Department a copy of CMS's notice approving the Contractor's default enrollment process within five (5) calendar days of receipt, in accordance with the requirements in the D-SNP Technical Manual. The Contractor must forward to the Department, within five (5) days of receipt, any written correspondence from CMS in which CMS has indicated concerns with the Contractor's default enrollment plan that may result in denial of the Contractor's Default Enrollment participation.

CMS approval for the Contractor's default enrollment process will be for a period not to exceed five (5) years, although CMS may suspend or rescind approval prior to the expiration of this period if CMS determines the MA organization is not in compliance with requirements.

3.5.2.1 Default Enrollment Notice

As set forth in 42 CFR § 422.66 and 42 CFR § 422.68, the Contractor must provide an enrollment notice to Members who meet all of the criteria cited above in Section 3.5.1, *Default Enrollment Conditions* (a. – c.). The Contractor must send the individual the notice no later than sixty (60) days before the Member's effective date. The notice must include:

1. Information on the differences in premium, benefits and cost sharing between the individual's current Medicaid managed care plan and the dual eligible Medicare Advantage Special Needs Plan and the process for accessing care under the Medicare Advantage plan;

2. The individual's ability to decline the enrollment, up to and including the day prior to the enrollment effective date, and either enroll in original Medicare or choose another Medicare Advantage plan; and
3. A general description of alternative Medicare health and drug coverage options available to an individual in his or her Initial Coverage Election Period.

The Department will send an enrollment notice to individuals who meet all of the criteria above in Section 3.5.1, *Default Enrollment Conditions* (a. – c.) ninety (90) days before the Member's effective date. Upon request by the Department, the Contractor must provide information necessary for the ninety (90) day notice.

The Department will provide a template letter for the Contractor's use for the sixty (60) day notice. The Contractor must have and use its own current and updated addresses for all of its individuals who it intends to enroll into its D-SNP through the default enrollment process. Should the address that the Contractor uses be incorrect, the Contractor must use the address listed on the Department's file that will be submitted to the Contractor. If the Contractor sends the sixty (60) day notice to the Member but the notice is returned to the Contractor, the Contractor may continue to default-enroll the Member, however the Contractor must conduct additional outreach efforts in order to ensure the Member receives the notice. In accordance with 42 CFR § 422.66 (c)(2)(ii), the Contractor must receive approval from CMS on its sixty (60)-day notice to individuals prior to use.

Prior to starting default enrollment, and upon any change, the Contractor must submit to the Department, for prior review thirty (30) days before use, the Contractor's enrollment notice that will be provided to default enrollment individuals, pursuant to 42 CFR § 422.66(c)(2)(iv).

3.5.3 Default Enrollment Process

To effectuate default enrollment, the Department will:

1. Use a combination of the Medicare Modernization Act (MMA) file exchange and the Territory Batch Query (TBQ) file to identify individuals eligible for Default Enrollment.
2. The Department will check eligibility at least monthly.
3. The Department will create a file that includes all individuals eligible for Default Enrollment with the Contractor and will transmit the file to the Contractor via the MFT.
4. The Department will transmit the file of eligible individuals monthly. The file will be transmitted approximately ninety (90) days, but no later than seventy-five (75) days, prior to the Medicare enrollment effective date.
5. The file will, at a minimum, include the following the data elements:
 - a. Medicaid Enrollee ID #,
 - b. Medicare Enrollee ID #,
 - c. First Name and Last Name,
 - d. Date of Birth
 - e. Address including street number, City, State and Zip Code,
 - f. Current Medicaid MCO, and
 - g. Medicare Begin Date.

4 Integrated Model of Care

The Contractor must submit to the Department a copy of the Model of Care (MOC) summary document required by CMS. This summary document must be submitted to the Department upon approval by CMS and upon any significant change. Refer to the D-SNP Technical Manual for reporting requirements.

The Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medicaid, including when Medicaid benefits are delivered via fee-for-service. The Contractor is responsible for coordinating the enrollee's Medicare and Medicaid benefits, including, but not limited to discharge planning, disease management, and care management.

The Contractor must integrate the D-SNP and CCMC MOC to ensure all Members receive a single MOC. The Contractor must do this by adopting the CCMC MOC as the single integrated MOC. In general, this means that Members must receive one (1) Health Risk Assessment (HRA), one (1) Individualized Care Plan (ICP) that captures the Member's needs, and one (1) Care Manager who can assist the Member with understanding and accessing their Medicare and Medicaid services in accordance with the requirements described in this Contract and the CCMC Contract. The provisions, which originate in Section 8.0 of the [CCMC Contract](#), are detailed below. Additional information about the CCMC MOC, including a full list of priority populations and other important information, can be found in Section 13.0 of this Contract, *Cardinal Care Model of Care Overview*.

Regardless of the MOC requirements in this Contract, the Contractor must ensure it at least meets the CMS MOC requirements at 42 CFR § 422.101(f).

The MOC provided in this Contract may include processes that conflict with CMS requirements. In any case where the MOC in this Contract conflicts with CMS requirements by being "less stringent" the Contractor can deviate from this MOC but must notify the Department when doing so. Notification to the Department can be provided via email to dsn@dm.virginia.gov. As an example of "less stringent", the MOC in this Contract allows for some individuals to not receive a HRA within ninety (90) days of enrollment, but that conflicts with CMS' HRA requirements. In this instance the MOC requirement in this Contract would not allow the D-SNP to meet CMS requirements and therefore the D-SNP can deviate from this MOC requirement. This is as opposed to where the MOC in this Contract requires some enrollees to receive the HRA within sixty (60) days while CMS requirements require all HRAs to be completed with ninety (90) days. Since sixty (60) days is a "more stringent" requirement, and because the Contract can still meet the CMS ninety (90) day requirement if the HRA is completed within sixty (60) days, the Contractor must follow the HRA timeliness requirement provided in this Contract. The Contractor will not be subject to compliance actions in any instance where the Contractor has deviated from the MOC requirements in this Contract because the requirement is less stringent than the CMS requirement.

The Contractor is not responsible for delivering MOC services, as described in Section 4 of this Contract, to Members who are not eligible for full-Medicaid benefits and will not be subject to compliance action by the Department for providing care coordination for non-dual eligible individuals.

The Contractor is granted the flexibility to deviate from the MOC requirements if necessary to accommodate CMS MOC filing requirements and processes but must notify the Department when doing so. Notification to the Department can be provided via email.

4.1 Model of Care General Requirements

The Contractor's MOC must support the Department's goals to ensure all Members have access to equitable, high-quality care and to provide Care Coordination and Care Management services that are responsive to Members' needs and risks, which may change over time. In addition, the Contractor's MOC must prioritize continuity of care and seamless transitions for Members across the full continuum of physical health, behavioral health, pharmacy, LTSS, and social service needs, factoring in both Medicare and Medicaid covered services. The Contractor's MOC must include effective advanced analytics and methods to target interventions and maximize the use of Care Management resources, including using data-informed solutions for identifying and stratifying populations by Member need and level of risk. The Contractor's MOC must also enable opportunities for comprehensive proactive care planning and prevention of crisis and emergency services. In general, the Department expects the Contractor's MOC to serve as part of the foundation for ensuring the delivery of high value care at the right place and right time while protecting the health, safety and welfare of Members. The Contractor must demonstrate to the Department's satisfaction that its MOC, including its system of advanced analytics, meets or exceeds the contractual standards described in this Section. See Section 13.0, *Cardinal Care Model of Care Overview*, for additional details on the Department's MOC design.

The Contractor's MOC required elements must include, but are not limited to the following:

1. Provide the full scope of care coordination services for all Members and Care Management for select populations as defined by the Department and other Members identified by the Contractor based on their level of need and risk;
2. Identify, assess, and stratify Members with ongoing, emerging and changing needs for Care Management at various intensity levels;
3. Include comprehensive HRAs, individualized care planning, and interdisciplinary care team involvement for Members receiving Care Management services;
4. Integrate physical health, behavioral health, pharmacy, LTSS and social service needs into the approach to the provision of Care Management services;
5. Be responsive to the Member's needs and preferences, and take into account the Member's health, safety, and welfare;
6. Include staff and provider network training (in conjunction with the Department whenever possible) on the Cardinal Care MOC to ensure Members receive person-centered, culturally competent care through trained Care Managers; and
7. Include processes and systems of care that engage Members and family members in person-centered, culturally competent care and ensure seamless transitions between levels of care and care settings, addressing all barriers to accessing appropriate services to support Member health.

4.2 Care Coordination

The Contractor must establish policies and procedures to deliver care to, and coordinate services for, all Members, regardless of risk or need, including ensuring adherence to all provisions noted in 42 CFR § 438.208.

For all Members, the Contractor must:

1. Ensure that each Member has an ongoing source of Primary Care appropriate to his or her needs and a Provider formally designated as primarily responsible for coordinating the health care services furnished to the Member. See Section 7.1.3 of the CCMC contract, *Primary Care Provider Assignment*;
 - a. The Contractor must provide information to the Member on how to contact the designated PCP.
2. Ensure that each Provider furnishing services to the Member maintains, shares and exchanges (e.g., with the Contractor, other Providers, etc.) a Member Health Record in accordance with professional standards;
3. Implement procedures to ensure Continuity of Care and to coordinate all appropriate services the Contractor provides or anticipates providing to the Member:
 - a. Between settings of care, including appropriate discharge planning for short-term and long-term Hospital and institutional states and for Members' utilizing behavioral health crisis services;
 - b. With the services the Member receives from any other MCO, Contractor or payer;
 - c. With the services the Member receives in FFS Virginia Medicaid;
4. Coordinate with services provided by community and social support Providers, and provide linkages and facilitate Access to needed community resources (e.g., food banks/nutrition resources, housing resources, employment supports, and other federal and state safety net programs such as the Supplemental Nutritional Assistance Program);
5. Provide Enrollment support for Members eligible for WIC, including making connections to application assistance resources. See Section 5.13.3.6, *Women, Infants and Children Referrals*; and
6. Make referrals to 1915(c) waiver programs, as appropriate.

In addition to the federally required Care Coordination provisions above, the Contractor must meet all of the Department's MOC standards, including performing screenings, HRAs, and health risk stratification, development and maintenance of care plans, and providing Care Management services as described in this Section of the Contract.

4.3 MCO Member Health Screening (MMHS)

4.3.1 Description of the MMHS

The MMHS is the Department's screening tool. The MMHS is a two-part questionnaire that MCOs must administer to all newly enrolled Cardinal Care Members. Results from completed questionnaires provide initial insight on Members entering the program and the associated population, and identify opportunities for supports, offering potential clinical pathways to improved health outcomes.

The MMHS has two (2) parts:

1. Part 1 of the MMHS contains questions related to Member's medical or behavioral health conditions, functional impairments, and intellectual or developmental disabilities.

2. Part 2 of the MMHS contains questions regarding social determinants of health, and in conjunction with Part 1, is used to determine whether the Member receives Care Coordination or Care Management and the appropriate level of Care Management intensity (if applicable).

The MMHS has two (2) functions:

1. To determine medical complexity, which is related to the capitation rate paid to the Contractor for the MAGI adult (Medicaid Expansion) Members, as described in Section 3.0, *Covered Populations and Enrollment*; and
2. To provide the Contractor with more information as to whether the Member should be in a Priority Population and may require Care Management and their specific needs. As specified in the Cardinal Care Technical Manual, the Contractor must send the screening information via batch file to the Medicaid system.

4.3.2 Requirements to Screen Members Using MMHS

4.3.2.1 MMHS Recipients and Completion Timeframe

In accordance with 42 CFR § 438.208(b)(3), the Contractor must make best efforts, as described in the CCMC Contract Section 8.3.2.3, *Unable to Contact for MMHS*, to complete the MMHS for all newly enrolling Members within ninety (90) calendar days of the Member's enrollment with the Contractor. The Contractor is not required to re-administer the MMHS for Members who newly enroll if the Member had an MMHS completed within the previous twelve (12) months. See CCMC Contract Section 8.11.1, *Continuity of Care Upon Enrollment*.

The Contractor must also identify Members who would benefit from receiving the MMHS sooner than ninety (90) calendar days. The Contractor must complete the MMHS for Members who are ventilator-dependent or Members receiving private duty nursing services within thirty (30) days of enrollment. The Contractor must submit the results of the MMHS to the Department within five (5) calendar days of the date on which the screening was completed, upon the third (3rd) instance of the inability to contact the Member, or the date on which the Member refused to participate. The Contractor must share results of the MMHS with the Member's Care Manager and other internal departments (as applicable) and is encouraged to share results of the MMHS with the Member's assigned PCP.

If the Member cannot be reached for completion of the MMHS after three (3) reasonable attempts, the Contractor must mail the MMHS form to the Member for completion. Robocalls or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting Members. All mailed MMHS forms must meet the following conditions:

1. The content of the MMHS must be maintained. If the Contractor wishes to make any changes to the MMHS the Contractor must submit the proposed changes to the Department for review and approval thirty (30) calendar days prior to its use. The Department will review and approve any proposed changes according to applicable contract requirements.
2. The Contractor must include with each mailed MMHS a cover letter that meets state and federal requirements for readability. The cover letter and MMHS are considered documentation critical to obtaining services, therefore must include the appropriate taglines. The Department reserves the right to review and require adjustments to the Contractor's cover letter templates before initial use and as revised by the Contractor.

3. A mailed MMHS is considered completed by the Member on the date the Contractor receives it back from the Member. A mailed MMHS must also meet the contractually required completion timeframe, as described in this section.
4. If a Member returns the MMHS and has selected either, "Other chronic (long-term) disabling condition" under Part 1, Question 1 or "Other chronic (long-term) mental health condition" under Part 1, Question 3, the Contractor must complete a Member Complexity Attestation, and check the "Member Complexity Attestation Completed" check box. In these instances, the MMHS is not considered completed until the attestation is completed confirming the Member's information. The Contractor must maintain the status of and the Member Complexity Attestation in the Member's record for review upon audit or DMAS request.
5. All mailed MMHS forms must include a self-addressed, postage paid return envelope.

4.3.2.2 [Administration Requirements](#)

At a minimum, the Contractor must ask the Member or the Member's representative(s) all of the questions in Parts 1 and 2 when administering the MMHS. If additional questions are necessary to determine a Member's needs or risk level, the Contractor may ask additional questions as necessary.

The Department will give the Contractor one hundred twenty (120) calendar days' notice before making changes to the MMHS unless mandated by law.

The Contractor must make accommodations available at no charge to the Member that address the needs of Members with communication impairments (e.g., hearing and vision limitations) and Members with limited English proficiency, in a culturally and developmentally appropriate manner and must consider a Member's physical and cognitive abilities and level of literacy in the screening process.

The Contractor's staff conducting the MMHS must have the demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.

The Contractor must document efforts made to outreach and conduct the MMHS for Members whom the Contractor has difficulty locating. The Contractor must document the number of attempts, types of attempts, and date(s) of attempts made to contact the Member in the Member record.

The MMHS may be conducted telephonically or via videoconference unless the Member's health condition(s) or place of residence requires in-person contact or where the Contractor identifies through claims or other data that telephonic/videoconference administration is not feasible.

When conducted face-to-face, the Contractor must conduct the MMHS in a location that meets the needs of the Member.

As necessary, the Contractor must use relevant and comprehensive data sources (including the Member, providers, family/caregivers, etc.) in the completion of the MMHS.

Elements from the MMHS must be considered and incorporated into the ICP.

The Department reserves the right to require the Contractor to conduct rescreenings as deemed necessary.

The Contractor must maintain all Member Complexity Attestation documents in the respective Member's record for review upon audit or DMAS request.

4.3.2.3 Unable to Contact for MMHS

The Contractor must make reasonable efforts to contact the Member in-person, by telephone, videoconference, or by mail to complete the MMHS. “Reasonable efforts” are defined as at least three (3) attempts across more than one day, with more than one method of contact being employed. The Contractor must document each attempt, including what method was used on what date. If the Contractor is unable to reach the Member after reasonable efforts, the Contractor must place the Member in the Unable to Contact (“UTC”) category for the MMHS.

If the Contractor is unable to contact the Member or Member’s authorized representative to administer the MMHS or if the Member refuses to participate in the MMHS in its entirety, the Contractor must note this on the MMHS and the Member is assumed to be not medically complex and in Care Coordination, as defined in Section 11, *Definitions*, and as identified according to Section 4.1, *Care Coordination*.

4.4 Care Management

The Contractor, in coordination with its affiliated CCMC plan, must determine which Members should receive Care Management, including identifying:

1. Individuals who meet Department-defined criteria for “Priority Populations”, to include Mandatory High, Mandatory Priority and MCO-Determined Priority Populations, as described in Section 4.4.2 of this Contract, *Priority Populations*;
2. Other individuals who would benefit from Care Management based on the Contractor’s assessment of Member need and risk, beyond those identified as Priority Populations, as described in Section 4.4.3 of this Contract, *Identifying Other Members Needing Care Management*.

For Members in Mandatory Priority Populations and MCO-Determined Priority Populations, the Contractor must also determine the appropriate level of Care Management intensity (i.e., low, moderate or high).

Regardless of one (1) and (2) above, in accordance with 42 CFR § 422.101(f), the Contractor must provide care management to all individuals enrolled in the D-SNP.

4.4.1 Risk Stratification

To determine if a Member is part of a Priority Population (Mandatory High Priority, Mandatory Priority or MCO-Determined Priority) and the Member’s Care Management intensity level assignment (i.e., Low, Moderate or High), the Contractor must develop and utilize a risk scoring and stratification methodology. The Contractor’s risk stratification/scoring methodology should use, as available, the following data sources:

1. Completed MMHS results, including medically complex status;
2. Historical claims analysis;
3. Aid category, e.g. to identify at-risk populations such as foster care, aged, blind and disabled individuals, pregnant individuals;
4. Previous CCC Plus Managed Care enrollment;

5. Enrollment in a LTSS program, including: the Commonwealth Coordinated Care Plus Waiver, one of the Department's Developmental Disabilities Waivers, nursing facility, long-stay hospital, hospice, personal care services through the Medicaid Works program;
6. Enrollment in the Early Intervention benefit program;
7. Pharmacy data;
8. Immunizations;
9. Lab results;
10. Admission, Discharge, Transfer (ADT) feed information;
11. Provider referrals;
12. Referrals from social services;
13. Member's zip code;
14. Member's race and ethnicity;
15. Member or caregiver request for care management;
16. Information from a Medical Transition Report;
17. Any relevant information from Complaints, Grievances and Appeals; and
18. Any known involvement from educational or judicial systems

4.4.2 Priority Populations

Members may be identified as one of three Priority Population groups for assignment to Care Management (or Care Coordination, as appropriate): Mandatory High Priority, Mandatory Priority Populations and MCO Determined Priority.

1. **Mandatory High Priority Populations:** The Contractor must assign each Member identified as Mandatory High Priority to High Intensity Care Management. For Members who are assigned to the Mandatory High Priority population on a time-limited basis, the Contractor may re-stratify and move those individuals to lower intensity levels of Care Management based on the Member's need/risk and/or at the Contractor's discretion.
2. **Mandatory Priority Populations:** The Contractor must assign each Member identified as a Mandatory Priority Population to either Low, Moderate, or High Intensity Care Management, depending on the Member's needs and risk level. The Contractor is not permitted to assign the Member to Care Coordination.
3. **MCO-Determined Priority Populations:** The Contractor has discretion to assign MCO-Determined Priority Populations to Care Coordination or Care Management. If the Contractor determines a Member in this population requires Care Management, the Contractor has discretion to assign the Care Management intensity level it deems appropriate based on the Member's needs and risks. The Contractor may use the data sources outlined above in Section 8.4.1, Risk Stratification, to identify Members for assignment to either Care Management or Care Coordination, as appropriate.

Mandatory High Priority populations include Members who meet any of the following criteria:

1. Members covered under the Commonwealth Coordinated Care Plus Waiver who are receiving private duty nursing (PDN);

2. Members transitioning from NF to the community (for a minimum of three (3) months prior to the transition and six (6) months after the transition, or longer if determined necessary by the Contractor);
3. Children receiving PDN through EPSDT;
4. Ventilator-dependent individuals;
5. Individuals in foster care or former foster youth for three (3) months after enrollment into the Medicaid program, the child welfare system or a new foster care home;
6. Individuals in foster care three (3) months prior to aging out of the child welfare system;
7. Former foster youth for the first three (3) months after aging out of the child welfare system; and,
8. For a minimum of the first three (3) months following identification as being part of one of the following populations:
 - a. Substance-exposed infants;
 - b. Neonatal abstinence syndrome infants (following diagnosis or identification as part of this population, whichever is later); and,
 - c. Infants admitted to the neonatal ICU (NICU Level 3).

Mandatory Priority populations include Members who meet any of the following criteria:

1. Members Enrolled in Waivers
 - a. Members enrolled in the DD Waivers (Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers;
 - b. Members covered under the Commonwealth Coordinated Care Plus Waiver without PDN; and
 - c. Members with intellectual/developmental disabilities.
2. Members with Behavioral Health (MH/SUD), Brain Injuries, Disabilities
 - a. Members with serious mental illnesses (SMI) and serious emotional disturbances (institutional and community dwelling);
 - b. Members who receive Mental Health Services, as reflected in the Cardinal care Summary of Covered Benefits Chart, Part 2B (Attachment E);
 - c. Members with intellectual/developmental disabilities (I/DD);
 - d. Members with cognitive or memory problems (e.g., dementia);
 - e. Members with brain injuries; and
 - f. Members with physical or sensory disabilities.
3. Members in Hospice/Nursing Facilities (NFs)
 - a. Members receiving hospice benefits;
 - b. NF Members (except for NF Members in the “Mandatory High Priority Population”); and
 - c. Members with cognitive or memory conditions.
4. Individuals in foster care and former foster youth who are not in the “Mandatory High Priority Population”.

MCO-Determined Priority populations include Members who meet any of the following criteria:

1. Pregnant Women and Children with High Needs/Risk
 - a. Members with a high-risk pregnancy, as defined by the Contractor;
 - b. Children and Youth with Special Health Care Needs;

- c. Children identified as at-risk for developing developmental disabilities or delays (who should be enrolled in the early intervention program);
- 2. Members with Other Complex/Chronic Conditions
 - a. Members with other complex or multiple chronic conditions (e.g., respiratory conditions, heart disease/heart failure, diabetes, cancer, etc.);
 - b. Members with end stage renal disease;
 - c. Members with physical or sensory disabilities.
- 3. Members Meeting Utilization-Based Criteria
 - a. Patient Utilization Management and Safety (PUMS) Program Members;
 - b. Members with three (3) or more ED visits or hospitalizations related to their chronic medical and/or physical health condition in the past three (3) months;
 - c. Members with one (1) or more ED visits or hospitalizations related to their behavioral health or substance use condition in the past three (3) months;
 - d. Members eighteen (18) years of age or older who have had two (2) or more falls resulting in an ED visit, hospitalization, or physician office visit within the past three (3) months;
- 4. Members with Behavioral Health Needs
 - a. Members with behavioral health and substance use disorders;
- 5. Members with High Social Needs
 - a. Members experiencing homelessness;
 - b. Justice-involved populations, which includes individuals who have a history of incarceration, detention, probation or parole supervision; and
 - c. Members who have other high social needs that pose a significant risk to their health, safety and welfare, as determined by the Contractor.
- 6. Other Populations Based on MCO Discretion

The Department reserves the right to conduct its own data analysis to identify Members in need of Care Management and to review the Contractor's risk stratification results in order to validate that the Contractor's model of care and advanced analytics system identifies Priority populations in accordance with the Department's contractual standards. See Section 4.4.8, of this Contract, *Data Surveillance and Validation of Care Management Assignment*.

4.4.3 Identifying Other Members Needing Care Management

In addition to the Priority populations described above, the Contractor must identify other Members who would benefit from Care Management based on the range of information the Contractor has on the individual (including the data sources described above) and the Contractor's assessment of their need and risk. The Contractor may determine which tier of Care Management Intensity (i.e., Low, Moderate, or High) to assign the Member. Care Management level assignments may be temporary based on a Member's changing needs and progress towards stability working with treating providers and living in the community.

In future contract revisions, the Department may establish a minimum required percentage of Members that should be assigned to Care Management.

Regardless of the above requirement, in accordance with 42 CFR § 422.101(f), the Contractor must provide care management to all individuals enrolled in the D-SNP.

4.4.4 Care Manager Staffing Ratios

The Contractor must comply with minimum Care Manager staffing ratios to ensure that it fulfills all Care Management requirements specified in this Contract. The Contractor must maintain the minimum required caseload ratios, as described in the table below, at all times. Lower staffing ratios may be utilized as clinical caseloads may warrant.

Care Management Staffing Ratios by Population		
Low Intensity	Moderate Intensity	High Intensity
1:500	1:175	1:70

Care Managers may have a “blended” caseload, comprised of Members in more than one subpopulation or different Care Management Intensity levels to meet business operational needs or provide continuity of care for Members as long as the minimum ratio thresholds are met. However, Care Managers serving Members receiving private duty nursing services through 1) the CCC Plus Waiver (LTSS level of care A) and 2) through EPSDT, must be excluded from blended caseloads. Caseloads must be adjusted according to employment status of full or part time hours per week (i.e., a 0.5 staff position would equate to 0.5 of the standard ratio). Multiple percentage split variations may occur to make up a total 100% caseload among various populations, but the assignments must not exceed the total combined established ratio. If there are not enough Members receiving private duty nursing to support a full caseload, the Care Manager may work with other vent-dependent members identified in the community, hospital or NF.

As described in Section 4.8.2, of this Contract, *Care Management Extenders*, staffing ratios may be adjusted to account for Care Management extenders employed by (or subcontracted with) the Contractor. This will allow an FTE Care Manager to serve more than the maximum number of Members described above.

4.4.5 Care Management Contact and Format Requirements

For all Care Management intensity levels, the Contractor must provide Care Management services as frequently and expeditiously as a Member needs. The Contractor must ensure Care Managers establish a schedule of contacts to regularly monitor and address a Member’s needs in a timely way on an ongoing basis. All in-person contacts should occur at the location and time of the Member’s preference. The Contractor may always deliver a contact in-person rather than by telephone call/videoconference if appropriate. The Department may waive in-person contact requirements (including for routine contacts, HRAs, or any other care management activity) in extenuating circumstances, such as a pandemic.

The Contractor must ensure that Care Managers deliver a minimum number of contacts to each Member according to their Care Management intensity level as follows:

1. Members in Low Intensity Care Management must be contacted as frequently and expeditiously as the Member’s medical condition and social needs require, but at a minimum receive two (2)

Care Management contacts per year. Contacts may be conducted in-person, telephonically, or via videoconference.

2. Members in Moderate Intensity Care Management must be contacted as frequently and expeditiously as the Member's medical condition and social needs require, but at a minimum receive one (1) Care Management contact per three (3) months. Contacts may be conducted in-person, telephonically, or via videoconference.
3. Members in High Intensity Care Management must be contacted as frequently and expeditiously as the Member's medical condition and social needs require, but at a minimum receive one (1) Care Management contact per month.
 - a. The Member's initial contact and at least one contact in every subsequent six (6) month period must be in-person. All other contacts may be conducted via telephone or videoconference at the Contractor's discretion based on Member preference or need as appropriate.
 - b. The Contractor may, in limited circumstances, use telephonic or videoconference contact modes for infants in High Intensity Care Management if an in-person visit is not feasible or appropriate; however, the Care Manager must document the reason the visit could not be conducted in person. DMAS encourages the MCO to use in-person contacts as a best practice.

The contact requirements listed above apply unless the Member expresses a preference for an alternative frequency. All contacts, including those associated with the HRA, ICT meeting, ICP completion, or other routine contacts, must occur at a place and time of the member's choosing (i.e., the Contractor may not require that the Member travel to a particular location to receive in-person contacts).

4.4.6 Restratification

The Contractor must conduct routine restratification for all of its Members at least every three (3) months to determine if there has been a change in any Member's need or risk status or whether the Member may benefit from a different level of Care Management than originally assigned. Whenever a Member clearly meets criteria for a different level of Care Management (e.g. PDN services initiated through the Waiver or EPSDT) the Contractor must re-stratify the Member within 30 calendar days. For members who were previously identified as requiring Care Management but had to be placed in "Unable to Contact", the Contractor is not required to follow "reasonable efforts" requirements as described in Section 4.5.4, of this Contract, *Unable to Contact for HRA*, during a quarterly restratification if the Member's health status and risk has not changed.

The Contractor must use all the sources of data above, as available, and may use additional sources of data to support Member restratification. Assigned Care Managers must provide input into the restratification process.

4.4.7 Triggering Events

For the purposes of Health Risk Assessment, Individualized Care Plan, and Interdisciplinary Care Team requirements, the Department defines a Triggering Event as any occurrence that suggests a change in Member's condition or status that places the Member at a higher risk of harm or jeopardizes their

health, safety and welfare. Examples of occurrences are listed but not limited to one or more of the following:

1. Inpatient hospitalization or Emergency Department Visit;
2. Involuntary treatment episode;
3. Use of behavioral health crisis services;
4. Law enforcement involvement;
5. Pregnancy;
6. Transition from an NF or PRTF to the community;
7. Loss of informal supports;
8. Change in functional status;
9. Loss of housing;
10. Child welfare, child protective services or Adult Protective Services involvement; or,
11. Foster care involvement; and
12. Critical incidents, as defined in CCMC contract Section 16, of the CCMC Contract, *Critical Incident Reporting*.

In addition to the above Triggering Events, the Contractor must consider additional events that may warrant an HRA reassessment, ICP revision, or ICT meeting. For more information about HRAs after Triggering Events, see Section 4.5.3, of this Contract, *HRA Completion Timeframes*.

4.4.8 Data Surveillance and Validation of Care Management Assignment

The Department may perform statistical sampling and other data analysis techniques to audit the Contractor to ensure that all Members are being appropriately identified for inclusion in a Priority Population and placed in the appropriate level of Care Management, as described in Section 4.4.2, of this Contract, *Priority Populations*. The Department may use available data sources including claims/encounters and Member responses to the MMHS to validate that the Contractor is placing each Member in the appropriate population and level of Care Management intensity. Identification of instances of the Contractor failing to identify a Member in a Priority Population category or placing a Member in an inappropriate level of Care Management may result in the Contractor being required to conduct additional screenings or to reassign the Member to a different level of Care Management or Care Coordination. The Department also reserves the right to interview Members and conduct specialized record reviews and audits as deemed necessary based on Member and provider complaints.

4.5 Health Risk Assessments (HRA)

The Contractor must ensure that all Members in Care Management receive a Health Risk Assessment (HRA). The Contractor must use the HRA as a tool to:

1. Identify Member physical and behavioral health status, needs, and risk factors along with their social, economic and housing needs;
2. Assist in the development of the Member's comprehensive, person-centered Individualized Care Plan (ICP) (see Section 4.6, *Person-Centered Individualized Care Plan (ICP)*); and
3. Assist in identifying the appropriate level of Care Management intensity for the Member.

The goal of both the HRA and ICP is to develop Member-centered care strategies among the Member's interdisciplinary care team and ultimately aid in the improvement of Member health outcomes and overall social and economic independence.

4.5.1 HRA Tool Required Elements

At a minimum, the Contractor's HRA must effectively identify:

1. The Member's functional, medical, behavioral, cognitive, LTSS, wellness and preventive, and social needs (such as housing, informal supports, and employment) in addition to any other unmet needs;
2. The Member's strengths and goals;
3. The Member's need for any specialists;
4. Community resources used or available for the Member;
5. Advance directive information and documentation (as appropriate); and
6. The Member's desires related to their health care needs (as appropriate).

The Contractor's HRA must also:

1. Document that during the initial HRA, the Member was informed of Cardinal Care covered benefits and the role of the Care Manager.
2. Document the source of information for the HRA (e.g., the Member, providers, facility staff, family/caregivers) and location of completion (in-person, telephonic, or via videoconference; if in-person, the Contractor must provide the physical location).

The Contractor may, at times, use an abbreviated version of the HRA that focuses only on the changes in the Member's health status, conditions, need and risks for reassessments. All abbreviated HRA templates and a description of the circumstances under which the Contractor would use the abbreviated form must be submitted to and approved by DMAS prior to use. Information captured in an abbreviated HRA must be incorporated into or available as part of the full HRA in the Contractor's system.

4.5.1.1 [HRA for Individuals Enrolled in the Commonwealth Coordinated Care Plus Waiver](#)

For CCC Plus Waiver Members, in addition to the required elements above, the HRA must also include and account for the following elements:

1. Pertinent information from the Medicaid LTSS Screening when available, as described in Section CCMC contract section 5.12.1, of the CCMC Contract, *LTSS Screening Requirements*;
2. Information to evaluate if LTSS criteria continue to be met;
3. Discussion with Member/caregiver regarding satisfaction with services received;
4. Evaluation of the environment for appropriateness, safety, and Member welfare;
5. Confirmation of the Member's needs;
6. Confirmation that the Member/caregiver understands and agrees with the care plan, the delivery of waiver services, limitations, and rights and responsibilities of everyone involved in providing care;

7. Confirmation that the waiver provider(s) is working to meet Member's care plan as written and that there is a means to communicate any and all deficiencies to the assigned Care Manager immediately; and
8. Confirmation that all appropriate documentation is available in the home (i.e., Plan of Care).

4.5.1.2 [HRA for Members Receiving Private Duty Nursing Services](#)

For Members who are receiving private duty nursing services, in addition to the required elements above, the Contractor's HRA must also include the following elements:

1. Determination that appropriate medical equipment is available;
2. Confirmation that medical needs are as described on the DMAS 108/109 and/or 62 forms;
3. Confirmation that the Private Duty Nursing provider is working to deliver on the Member's care plan as written; and
4. Confirmation that all appropriate documentation is available in the home (i.e., physicians' orders, Home Health Certification and Plan of Care (CMS-485), nursing care and medication administration documentation, etc.).

4.5.1.3 [HRA for NF Members](#)

For Members who reside in a NF, in addition to the required elements above, the Contractor's HRA must also include the following elements:

1. All pertinent information from the Minimum Data Set (MDS);
2. Information from the MDS Section Q, in addition to separate documentation of the Member's interest and desire for transition to the community and available resources and barriers to doing so;
3. The transition process including any identified health, safety or welfare needs, which may result in the Member's inability or a barrier to transition to the community; and
4. Pertinent information from the LTSS screening, when available.

The Department reserves the right, providing the Contractor with at least sixty (60) calendar days advance notice, to require the Contractor to add additional elements to its HRA.

4.5.2 [HRA Administration Requirements](#)

4.5.2.1 [Mode of Administration and Accommodations](#)

1. The Contractor must conduct the HRA in-person for Members in High Intensity Care Management. The Department may waive in-person contact requirements in extenuating circumstances, such as a pandemic.
2. For most Members in Low and Moderate Intensity Care Management, the Contractor is encouraged to conduct the HRA in-person but may utilize videoconferencing or telephone if necessary and appropriate. The Contractor must ensure that any telephonic or videoconferencing mechanisms are secure, effective and appropriate based upon the Member's condition, communication abilities, and preferences.
 - a. For CCC Plus Waiver and NF Members in all Care Management Intensity levels, the initial HRA and annual LOC review must be conducted in-person. Other contacts may be conducted via telephone or videoconference.

3. The Contractor must obtain the Member's consent to record audio of the HRA. The Contractor must provide the audio recording including the Member's consent to the Department upon request.
4. The Contractor's Care Managers must make accommodations available at no charge to the Member that address the needs of Members with communication impairments (e.g., hearing and vision limitations) and Members with limited English proficiency, in a culturally and developmentally appropriate manner and must consider a Member's physical and cognitive abilities and level of literacy in the assessment process.
5. The Contractor must conduct HRAs in a location that meets the needs of the Member.
6. The Contractor's Care Manager must have the demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.
7. The Contractor's Care Managers must document efforts made to outreach and conduct HRAs for Members the Contractor has difficulty locating. Care Managers must work with providers and the Member's care team to reach the Member or work with acute and subacute hospital settings to communicate with a Member as needed.

4.5.2.2 [Data Sharing](#)

1. The Contractor must use appropriate documentation (e.g., MTR data, early intervention individualized family service plan, MDS, LTSS screening when current/relevant, and MMHS) to complete HRA elements in order to avoid unnecessary burden to the Member, caregiver or provider.
2. The Contractor must continuously monitor data elements that may trigger HRA reassessment (e.g. ADT information, functional status assessment, etc.), as described in Section 4.4.7, of this Contract, *Triggering Events*).

4.5.3 HRA Completion Timeframes

Care Managers must complete an initial Health Risk Assessment (HRA) within sixty (60) calendar days from MMHS completion and/or identification that the member needs Care Management services, or within ninety (90) days of enrollment into the D-SNP as required in the Medicare Managed Care Manual, whichever is earlier. The Contractor must accelerate the HRA completion timeframe, as appropriate, if necessary to effectively manage the Member's condition.

Following the initial HRA, Care Managers must complete an HRA reassessment or update an existing HRA for any individual receiving Care Management:

1. At least every twelve (12) months;
2. Within thirty (30) calendar days of a triggering event but not more frequently than every quarter, unless deemed necessary based on a change in the Member's condition, as defined in Section 4.4.7, of this Contract, *Triggering Events*.
 - a. The Contractor is strongly encouraged to conduct the reassessment within ten (10) calendar days and, if the reassessment takes place beyond the ten (10)-day timeframe, must document the reason(s) why this occurred.
 - b. The completion of an HRA following a triggering event resets the twelve (12) month HRA reassessment timeframe; and

3. At any other time between required timeframes if it is deemed necessary based on a change in a Member's condition, need or risk.

HRA reassessment can be completed in parallel or as part of other Care Management processes such as discharge planning and ICT meetings. For foster care or former foster care, the timeframe for responding to the triggering event begins at the time the Contractor is notified that the Member's aid category has changed to a foster care aid category, (i.e., on the end of the month 834 enrollment file).

The Contractor is not required to conduct a new HRA for Members transitioning from Medicaid fee-for-service or another Contractor unless the Member has experienced a triggering event, as defined in Section 4.4.7, of this Contract, *Triggering Events*, or a new HRA is due. This also applies in the event that a Member is disenrolled and reenrolled with the Contractor.

4.5.4 Unable to Contact for HRA

The Contractor must place non-LTSS Members in the "Unable to Contact" (UTC) category, as described in Section 8.1, of this Contract, *Definitions*, with the exception of Commonwealth Coordinated Care Plus Waiver and NF Members, for the initial HRA if the Contractor is unsuccessful in reaching the Member following reasonable efforts to contact the Member in-person or by telephone, videoconference, or mail immediately upon completion of the MMHS. "Reasonable efforts" are defined as at least three (3) documented attempts with more than one (1) method of contact being employed over more than one day. The Contractor is encouraged to reach out to the Member's PCP and other treating providers, supports or DSS Medicaid workers to establish contact with a Member for status updates. Robocalls or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting Members and must not count as a valid attempt to contact or communicate with a Member.

A Commonwealth Coordinated Care Plus Waiver or NF Member must not be placed in the "Unable to Contact" category. The Contractor must ensure reasonable effort is made in contacting Commonwealth Coordinated Care Plus Waiver or NF Members. "Reasonable efforts" for contact of CCC Plus Waiver or NF Members include at least three (3) documented attempts prior to the HRA due date that may be made via phone, mail, or through home or facility visits; however, at least one (1) attempt must be a home visit. In addition, "reasonable efforts" for contacting Commonwealth Coordinated Care Plus Waiver and NF Members must include contact with existing LTSS service providers (or prior providers if not currently receiving services). If no escalation of needs or risks has been uncovered, the Contractor must conduct quarterly outreach to Commonwealth Coordinated Care Plus Waiver or NF Members unable to be contacted after the initial three (3) documented attempts described in this Section. This quarterly outreach may be via phone or mail. The Contractor must monitor returned mail for invalid Member addresses to resolve the failed outreach attempt.

4.5.5 HRA When Member Refuses

The Contractor must oversee, coordinate and manage quality services for Members identified as requiring Care Management to the greatest extent possible even in the absence of a completed HRA or communication with the Member. For Members in Mandatory High Priority and Mandatory Priority Populations, if a Member refuses to participate in the HRA or it cannot be conducted for other reasons, a fully completed HRA is not required. Rather, in order to adequately manage the case and ensure

appropriateness of care to the maximum extent possible, the Contractor must complete a Comprehensive Care Review (CCR). The comprehensive care review must include:

1. The Member's conditions and diagnoses, current needs and services, identified risks, concerns related to nonadherence, access to care and contradictory provider treatment plans and Contractor recommendations; and
2. The sources of information the contractor used to develop the CCR.

The CCR may be based on the following data sources, as appropriate (in addition to others identified by the Contractor):

1. Available clinical information from rendering providers or caregivers;
2. Information received from transition reports, service authorizations (SAs), and claims;
3. MDS;
4. LTSS screening; and,
5. Early intervention individualized family service plan.

The Department reserves the right to request CCRs from the Contractor.

To the maximum extent possible considering Member lack of engagement, the Contractor must develop a Comprehensive Care Plan (CCP) based on the outcome of the CCR. The Contractor must document internally in the CCP for the Member why the HRA was not completed.

The Contractor must not submit CCRs as completed HRAs or CCPs as completed ICPs to CRMS. See Section 4.11, of this Contract, *Administrative Transitions*.

4.6 Person-Centered Individualized Care Plan (ICP)

The Contractor must develop a person-centered, culturally competent ICP for Members engaged in Care Management. The Contractor must tailor the person-centered ICP to the Member's needs and preferences and complete it in the timeframes specified in this Contract and based, at a minimum, on the results of the Contractor's assessment of Member need, risk, and qualifying criteria for services.

The Contractor's Care Manager must:

1. Engage each Member in the ICP process. The Contractor is encouraged to conduct the ICP face-to-face but may utilize videoconferencing or telephone if necessary and appropriate. The Contractor must ensure that any telephonic or videoconference communication processes are secure and are effective and appropriate options based upon the Member's condition, communication abilities, and preferences. The Contractor must submit any ICP protocols related to telephonic/videoconference contact to the Department for approval prior to implementation;
2. Ensure that the Member receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process that includes ICT participation and person-centered ICP development;
3. Develop and maintain the ICP and make the ICP or information related to the ICP accessible to treating providers and Members as needed and upon request;
4. Revise the ICP based on triggering events, as described in Section 4.4.7, *Triggering Events*, such as hospitalizations or a decline or improvement in health or functional status;

5. Communicate any ICP revisions to the Member, ICT, and other pertinent providers;
6. Ensure information is secured for privacy and confidentiality in accordance with all applicable State and Federal requirements;
7. Obtain Member's or their representative's signature on the initial ICP and all subsequent revisions. Where the ICP is conducted via telephone or videoconference, if the audio is recorded, the Contractor must have the Member's consent for the audio recording. Also document all efforts when Members or their representatives refuse to sign, including a clear explanation of the reason for the Member's refusal;
8. Develop and implement the ICP 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; and
9. To avoid duplication and burden on the Member, for children enrolled in the Early Intervention Program, the Contractor must coordinate the ICP with the EI Service Coordinator as part of the Multidisciplinary team and IFSP process.

4.6.1 ICP Required Elements

The Contractor must include the following elements in each Member's ICP. Other elements may also be necessary depending upon the Member's circumstances.

4.6.1.1 Member Goals, Needs and Preferences

1. ICP Completion date; ICP attainable goals and objectives with start date; target end dates; completion dates; and outcome measures based assessments;
2. MMHS responses;
3. Prioritized list of concerns, preferences, needs, goals, and strengths, as identified with the Member;
4. Strategies and actions to address all needs of the Member, including functional, medical, behavioral, cognitive, social, LTSS, safety, wellness and preventive needs.
5. Strategies to address social needs may include providing linkages to community-based resources and information on service providers and referrals (social needs are related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and informational supports, and personal goals (e.g., attend school, have a job));
6. Actions to address Member needs must include who is attending to the needs such as treating providers, community entities, referrals to other resources, etc.;
7. Documentation within the ICP regarding all conditions, which must be updated regularly; progress towards goal completion noting successes; rationale for extending target end goal dates; new goals; and any barriers or obstacles;
8. Documentation of the Member's carved-out services (as appropriate) (Refer to CCMC Contract Section 5.2, Carved-Out Services);
9. Advance directive information, as described in CCMC Contract Section 4.1.5, *Advanced Directives*, including education needs of the Member about advance directives and obtaining any advance directive documentation and filing them in the Member's file. The status of advance directives must be reviewed at annual assessments and with a significant change in health or functional status and must be included in the ICP. Also included is documentation of

information regarding the inability to provide information regarding advance directives and the reasons why the advanced directives were not obtained.

4.6.1.2 [Member's Providers and Other Supports](#)

1. Identification of ICT Members, treating providers and parties responsible for providing services (e.g., name, title, contact information), including the Member's primary care provider, specialists, LTSS and social service providers;
2. Inventory of the Member's other care managers or case managers;
3. Relevant MCO contacts in addition to the Care Manager (e.g., a housing coordinator);
4. Member's informal support network and services;

4.6.1.3 [Plans to Respond to Member Needs or Prevent Service Disruption](#)

1. Plans for transition coordination and services for Members in nursing facilities who wish to move to the community;
2. Back-up and safety plans as appropriate for Commonwealth Coordinated Care Plus Waiver Members in the event that the primary caregiver is unable to provide care. If applicable, trained backup caregivers, and facility admission may be required. All Members receiving Private Duty Nursing Services must have a trained primary caregiver who accepts responsibility for providing care whenever nursing is not in the home and, if applicable, Members must have a back-up plan if personal care services cannot be rendered as planned;
3. Crisis plans for Members with behavioral health needs. For crisis plans, describe how the Contractor will assist the Member to identify and select individuals or agencies that will provide support, comprehensive crisis services or other services (including peer recovery support services) to assist the Member in managing the crisis and to minimize emergency room or inpatient needs;
4. Safety plans for all Members, particularly those who face challenges living alone; and
5. Plan to access needed and desired community resources and non-covered services.

4.6.1.4 [Waiver, LTSS and other Specialized Services](#)

Commonwealth Coordinated Care Plus Waiver, private duty nursing through EPSDT, and other covered services to be provided until the next person-centered ICP review;

1. Member's choice of services (including model of service delivery for personal care and respite – consumer-directed vs. agency-directed when appropriate for Commonwealth Coordinated Care Plus Waiver Members who are eligible for consumer-directed services);
2. Elements included in the Provider Plan of Care (DMAS-97AB) for Commonwealth Coordinated Care Plus Waiver Members receiving personal care services, the DMAS-7A for Members receiving personal care services through EPSDT and the DMAS-301 for Members receiving ADHC;
3. Elements included in the Home Health Plan of Care (CMS-485) for Members receiving private duty nursing;
4. Elements included in the DMAS 62 for Members receiving private duty nursing through EPSDT;
5. Elements included in the DMAS 99, DMAS 108 or DMAS 109 for Members receiving private duty nursing through the Commonwealth Coordinated Care Plus Waiver;

6. Elements included in the IFSP for Members receiving early intervention; and
7. Any other carved-out services.

Contractors may submit an abbreviated ICP form for Department approval, but all ICP required elements must be included in the abbreviated form.

Contractors are responsible for ensuring results from a Member's ICP and any updated ICPs are shared with other internal MCO departments as necessary for continued service authorizations and potential provider network needs.

For Members receiving HCBS, the Contractor's ICP must comply with federal requirements per 42 CFR § 441.301(c) in the CMS Home- and Community-Based Settings Final Rule; additional guidance is located at <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html>.

4.6.2 ICP Completion Timeframes

Following completion of the HRA, the Care Manager must develop the Member's initial ICP prior to the first ICT meeting. The Care Manager must not wait until after the ICT meeting to complete the ICP. As appropriate, the Care Manager can develop the initial ICP during the HRA process and obtain the Member's signature at that time. The ICP is considered complete upon Member signature. Electronic signatures are acceptable within federal requirements and, with the Member's agreement, when obtained over the phone (for Members not in the Commonwealth Coordinated Care Plus Waiver or NF populations). The Contractor's Care Manager must complete the ICP according to the following timeframes:

1. For Low Intensity Care Management Members, the Contractor must ensure that ICPs are completed within sixty (60) calendar days of completion of the HRA (or enrollment with the Contractor, if an HRA was previously completed).
2. For Moderate Intensity Care Management Members, the Contractor must ensure that ICPs are completed within thirty (30) calendar days of completion of the HRA (or enrollment with the Contractor, if an HRA was previously completed).
3. For High Intensity Care Management Members, the Contractor must ensure that ICPs are completed within seven (7) calendar days of completion of the HRA (or enrollment with the Contractor, if an HRA was previously completed).

In the event the ICP Completion Timeframes cannot be met, the Contractor must document in the Member's record the reason for the delay and the expected completion date. Efforts to complete the ICP must also be documented such as education to the Member and/or family regarding role of Care Manager, coordination with treating providers, etc. Any barriers to completing the ICP in a timely manner (e.g., lack of communication with or response from another involved state agency), may be reported to DMAS for assistance.

For Members transitioning from another Contractor or Medicaid fee-for-service with an existing ICP in place, the Contractor will not be required to develop a new ICP if all elements are current and accurate. The previous ICP must be in the Member record and reviewed for accuracy prior to the ICP due date. As applicable, the Contractor must revise the ICP in accordance with requirements set forth in Section 4.6.3, of this Contract, *ICP Revision Completion Timeframes*.

4.6.3 ICP Revision Completion Timeframes

Following completion of the initial ICP, the Contractor's Care Manager must revise the ICP according to the timeframes set forth below:

1. The Contractor must work with the Member to revise the ICP every six (6) months following the initial ICP. The Contractor may utilize video conferencing or telephone if necessary and appropriate but is encouraged to make revisions in-person.
2. The Contractor must revise ICP for each Member within ten (10) calendar days following any triggering event, as described in Section 4.4.7, of this Contract, *Triggering Events*, or as expeditiously as the Member's condition requires.

The Member must agree to and sign revisions/updates to the ICP as indicated above for initial ICP.

4.7 Interdisciplinary Care Team (ICT)

The Contractor must define for each Member, in a manner that respects the needs and preferences of the Member, the individuals who make up the Member's interdisciplinary care team (ICT). The Contractor must ensure that each Member's care (including any services addressing medical, behavioral health, substance use, LTSS, early intervention, and social needs) is integrated and coordinated within the framework of an ICT and that each ICT Member has a defined role appropriate to their licensure and relationship with the Member as identified in the ICP. The Contractor must encourage the Member to identify individuals that they would like to participate on their care team. The ICT must be person-centered, built on the Member's specific preferences and needs, and conducted with transparency, individualization, respect, linguistic and cultural competence, and dignity. The Care Manager must lead the ICT and ensure that ICT meetings and conference calls, when applicable, are held periodically, as described below, and ensure that ICT members are kept up-to-date and informed of the Member's care and needs, to include when they are not able to attend meetings. To avoid duplication and burden on the Member, for children enrolled in the Early Intervention Program, the Contractor must coordinate the ICT with the EI Service Coordinator as part of the Early Intervention Multidisciplinary Team and Individualized Family Service Plan (IFSP) processes.

4.7.1 ICT Membership

The Contractor must ensure that the ICT includes the Member and/or their authorized representative(s). The Care Manager must attempt to include in the ICT all entities rendering care and services as identified in the Member's ICP and any of the following participants, at a minimum:

1. PCP (please note that per CCMC contract section 7.1.3, *Primary Care Provider Assignment*, the Member can choose an alternative specialty provider, such as their OB/GYN or internist, as their PCP);
2. Other treating providers, as applicable;
3. Behavioral health clinician, as applicable;
4. LTSS provider(s) when the Member is receiving LTSS;
5. Personal Care (PC)/PDN provider for Members receiving PC or PDN services under EPSDT;
6. Targeted case manager, if the Member is receiving targeted care management services;
7. D-SNP or other plan care coordinator, as applicable; and

8. Pharmacist, as applicable.

As appropriate and at the discretion of the Member, the ICT also may include any or all of the following participants:

1. A representative from the Medicare plan, if applicable;
2. Registered nurse;
3. Specialist clinician;
4. Other professional and support disciplines, including social workers, community health workers, and qualified peers;
5. Family members;
6. Other informal caregivers or supports;
7. Advocates; and/or
8. State agency or other case managers.

4.7.2 ICT Communication and Meeting Timeframes

The Contractor must ensure a secure means of communicating among all ICT Members. For Members at all Care Management Intensity levels, the Contractor must have a system that enables the Care Manager to provide the Member's ICT members critical and ongoing information on the Member's condition, as appropriate, and the Care Manager must use this communication system to provide this information to all ICT members.

For most Members in Low and Moderate High Intensity Care Management, the Care Manager is not required to conduct ICT meetings, but should do so if the Care Manager or an ICT member requests it and must do so at Member request.

For LTSS Members at all Care Management Intensity levels and all Members in High Intensity Care Management, the Care Manager must conduct ICT meetings. The Care Manager must conduct an initial ICT meeting within thirty (30) calendar days of completion of the ICP.

The Contractor must have a system that enables the Care Manager to securely communicate with the Member's ICT members and provide critical and ongoing information on the Member's condition, as appropriate. The Care Manager must develop a documented and agreed upon Communication Plan with the Member and the Member's ICT members, must comply with the communication requirements as described in the Communication Plan, and must inform the Member and ICT members on how to access secure communications within the Contractor's system.

The Contractor is required to conduct ICT meetings as follows:

1. For most Members in Low and Moderate Intensity Care Management, the Care Manager is not required to conduct ICT meetings but should do so if the Care Manager or an ICT member requests it and must do so at Member request.
2. For Commonwealth Coordinated Care Plus Waiver and Members in NFs at all Care Management Intensity levels and all Members in High Intensity Care Management, the Care Manager must conduct ICT meetings. The initial ICT meeting must take place within thirty (30) calendar days of completion of the ICP. Care Managers must also convene ICT meetings within thirty (30) calendar days of the following:

- a. HRA reassessments;
- b. Triggering events, as defined in Section 4.4.7, of this Contract, *Triggering Events*, requiring significant changes to the Member's ICP;
- c. Readmissions to acute or psychiatric hospitals or NF within thirty (30) calendar days of discharge; and
- d. Upon Member request.

For these Members who are transitioning from another Contractor or Medicaid fee-for-service for whom there is documented evidence of an ICT meeting, the Contractor will not be required to facilitate a new ICT meeting.

4.7.3 ICT Meeting Attendance

The Care Manager must attend all ICT meetings. The Care Manager must provide reasonable and sufficient notice in advance of an ICT meeting to the Member and other required attendees in order to maximize participation for planned ICT meetings. The Contractor must ensure that input is requested for inclusion in the ICT discussion from ICT Members who are unable to attend the ICT in-person or via telephone or videoconference.

The Care Manager must include the Member or his/her authorized representative in ICT meetings unless a Member refuses or is unable to participate. Alternate forms of soliciting input from the Member are not acceptable unless there is clear documentation of the Member's refusal to participate with the stated reason.

If the Care Manager makes best efforts to have all required and encouraged ICT Members attend but is unable to do so, the Care Manager should proceed with ICT meetings and provide a summary of the meeting to all ICT Members that were unable to attend within thirty (30) calendar days of the meeting as described in Section 4.7.4, of this Contract, *ICT Meeting Documentation Requirements*.

4.7.4 ICT Meeting Documentation Requirements

Following each ICT meeting and in accordance with the Communication Plan, the Contractor must ensure that there is documented evidence in the Member record accessible to all ICT Members within thirty (30) calendar days of the meeting summarizing the ICT meeting with the following information:

1. The names, titles, and roles of each ICT participant in attendance for each meeting;
2. The names, titles, and roles of invitees that were not in attendance;
3. Solicited input from required participants who were unable to participate in the ICT meeting and information provided through alternate means;
4. Information discussed, outcomes of the ICT meeting and any additional information obtained through alternate means;
5. When applicable, the Member's active refusal to participate in the ICT;
6. Review and discussion of the initial ICP, and any updates to it, developed by the Care Manager with the Member; and
7. Identification of any next steps such as referrals or follow-up appointments or any information necessary for the purpose of Care Coordination or administration of benefits.

In accordance with the Communication Plan, the Care Manager must send a summary of the meeting to ICT members who are unable to attend the meeting and must ensure the summary is available electronically to members and providers.

4.8 Care Manager Staffing

4.8.1 Care Manager Qualifications

The Contractor’s Care Management staff listed in the table below must have the following qualifications to deliver Care Management services.

	Care Manager Position	Required Credentials*	Required Experience
1	Care Managers serving Members in: <ul style="list-style-type: none"> Low or Moderate Intensity Care Management High Intensity Care Management except for populations listed in rows 2 and 3 below 	Bachelor’s degree in a health or human services field, LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW	One year of experience working directly with individuals who meet the Cardinal Care Priority Population criteria.
2	Care Managers serving Members in High Intensity Care Management with the conditions listed below: <ul style="list-style-type: none"> Members receiving private duty nursing services; Life-sustaining Ventilator-dependent Members; Vulnerable infant Members, including those diagnosed with neonatal abstinence syndrome, classified as substance-exposed, or admitted to the NICU Level 3. 	RN	One year of experience working directly with Members who meet the conditions listed in this row.
3	Care Managers serving Members in High Intensity Care Management who are in Foster Care	LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW	One year of experience working directly with individuals involved in the foster care/Child Protective Services system and/or former foster youth.
4	ARTS Care Manager	LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW,	One year of experience working directly with individuals with SUD.

	Care Manager Position	Required Credentials*	Required Experience
		CSAC, CSAC-Assistant	
5	Care Manager Supervisor	LMHP or RN	Two years of experience working directly with individuals who meet the Cardinal Care Priority Population criteria.

*Credentials that require licensure or certification must be current/active in Virginia. RN/LPNs must be licensed in Virginia or hold an RN/LPN license with multi-state privilege recognized by Virginia.

4.8.2 Care Management Extenders

The Contractor is encouraged to utilize staff Care Management “extenders” who are not required to meet the minimum qualifications of a Care Manager but are qualified to complete select non-clinical, Care Management activities such as appointment scheduling, coordinating social services, and completing specific non-clinical paperwork/documentation, problem solving in response to complaints and concerns as well as leveraging any specialized expertise and experience in building trusted, authentic relationships with Members. Care Management Extenders must work under the supervision of the Care Manager. Care Management extenders may include Virginia Board of Certification-certified Community Health Workers, DBHDS-certified Peer Support Specialists, and non-specialized administrative staff employed by or under contract with the Contractor. Extenders may not render clinical assessments or deliver clinical care to Members, and the Contractor must ensure the extenders receive adequate oversight and supervision from qualified Care Managers.

In order to account for staffing efficiencies generated by employing extenders, the Contractor will have the opportunity to reduce Care Manager staffing levels based on the number of employed extenders. For each FTE-equivalent extender employed by (or subcontracted with) the Contractor, the maximum number of Members for the Care Manager staffing ratios described in Section 4.4.4, of this Contract, *Care Manager Staffing Ratios*, will be increased by 20% for a corresponding FTE Care Manager. For example, if a Contractor employs two FTE extenders, two corresponding FTE Care Managers will be permitted serve 20% more Members. The Contractor will be permitted to apply extender staffing ratio “credits” on a blended basis.

4.8.3 Care Manager Supervisor

All Care Managers must have oversight by a Care Manager Supervisor. One Care Manager Supervisor must not oversee more than fifteen (15) Care Managers. Care Manager Supervisors must meet the qualifications described in the Table above (Section 4.8.1 of this Contract, *Care Manager Qualifications*.) All supervisors must have access to the Contractor’s Medical Director for review of cases. Care Manager Supervisors must have experience working in health care delivery systems and must have demonstrated ability to communicate with Members who have complex medical or social needs and who may have communication barriers.

4.8.4 Care Manager Training

The Contractor must ensure all Care Managers and Care Manager Supervisors serving all Cardinal Care Members have access to and complete training appropriate to the sub-population being served as it relates to their duties and responsibilities. Curriculum must include:

1. Educational information about Members' various medical/behavioral health needs and common comorbidities, environmental risk factors (e.g., tobacco smoke, e-cigarette aerosols), and training in specialized areas (e.g., motivational interviewing, dementia, substance use disorders);
2. The Medicaid services described in the Cardinal Care Covered Services Chart (see Section 12.0, *Covered Services Chart*, of this contract) and all Medicare covered services;
3. Person-centered practices including needs assessment and care planning, addressing LTSS and other needs;
4. Understanding and addressing social and other unmet health-related social needs, including identifying, utilizing, and helping the Member navigate available social supports and resources at the Member's local level;
5. Understanding and addressing ACEs, trauma, and trauma-informed care;
6. Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, non-white populations, and forms of bias that may affect Members;
7. Skills to support community integration (e.g. independent living skills, diversion from congregate care settings, detention, institutional settings or correctional facilities, supportive housing/tenancy support programs, employment supports and resources);
8. Health promotion techniques (e.g., self-management, self-help recovery, tobacco use intervention, motivational interviewing);
9. Transitional Care Management best practices;
10. Preparing Members for and assisting them during emergencies and natural disasters;
11. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training Members on proper practices, particularly for Members receiving care in the home or community settings, or as Members transition across care settings;
12. General understanding of telehealth applications in order to assist Members in using the tools;
13. Understanding and navigating the Medicare program for coordination purposes, including preparation for Medicare eligibility and enrollment and other programs that may serve dually eligible Members, such as D-SNPs and PACE;
14. Involuntary psychiatric admissions related to emergency custody orders and temporary detention orders; including when to initiate the process with the Community Services Boards.
15. Providing assistance to Members in crisis;
16. Adult Protective Services (APS) and Child Protective Services (CPS) reporting processes; and
17. Understanding needs of the justice-involved population, which includes individuals who have a history of incarceration, detention, probation or parole supervision.

For more information on Provider training requirements, see Section CCMC contract section 7.4.5, *Provider Training, Technical Assistance, and Education*.

The Department reserves the right to request and review Care Manager training materials as necessary. Contractors are encouraged to allow staff to participate in external training opportunities available through the Department or other state agencies.

4.8.5 Care Manager Assignment

The Contractor must assign Care Managers based on an assessment of the Member's needs and the qualifications of the Care Manager. The Contractor must include a description of its process for assigning Members to Care Managers, which must take into consideration the Care Manager's experience working with populations with physical disabilities, developmental disabilities, serious mental illness, traumatic brain injury, the elderly, or other populations with unique needs in its Care Management Staffing Plan, described below.

Non-LTSS Members who have been determined to be "unable to contact" may be assigned to a Care Manager that does not meet the specified qualification above. Once the Member has been contacted, they must be reassigned to a Care Manager that meets the minimum qualifications above within one (1) week. See Section 4.5.4, of this Contract, *Unable to Contact for HRA*.

The Contractor must assign Members in High intensity Care Management a Care Manager on or before the Member's MCO enrollment effective date with the Contractor. The Contractor must send a notice to the Member within fourteen (14) calendar days following MCO enrollment with the Contractor providing the name and contact information for their assigned Care Manager. For Members who are assigned to Low or Moderate intensity Care Management, the Contractor must send a notice to the Member within fourteen (14) calendar days following enrollment of the Member into Care Management, providing the name and contact information for their assigned Care Manager. Upon request by the Department, the Contractor must provide the name and contact number of the Care Manager assigned to a particular Member. The Contractor must keep changes to Care Manager assignments at a minimum and must coordinate a transition to a new Care Manager with prompt notification to the Member of the new Care Manager. The Contractor must conduct outreach by telephone or videoconference within fourteen (14) calendar days to inform the Member of the new Care Manager assignment and contact information. If unable to contact the Member via telephone or videoconference, the Contractor must mail this information to the Member.

4.8.6 Care Management Staffing Plan

The Contractor must submit a Care Management Staffing Plan to the Department for approval prior to implementation, upon revision, or upon request. This must include a description of staff positions that will be involved in Care Management operations, including but not limited to, Care Manager Supervisors, Care Managers, Care Management support staff and extenders, and administrative staff support. The Contractor must also identify the role/function(s) of each Care Management staff role as well as the required educational requirements, clinical licensure standards, certification, and relevant experience with Care Management standards and/or activities. The staffing plan must also include all training each role is required to complete during onboarding and ongoing employment as a health plan Care Manager. The Department reserves the right to train the Contractor's Care Management staff in relation to the Cardinal Care program requirements and expectations. The Department will inform the Contractor of any mandatory training as learning needs are identified.

4.9 Ongoing Care Management

4.9.1 General Requirements

The Contractor must ensure that each Member who is actively engaged in Care Management receives services according to their ICP. The Contractor must ensure that Care Management includes:

4.9.1.1 [Access to the Care Manager](#)

1. Meeting face-to-face requirements as outlined in this Contract;
2. Accommodating any Member request or need for face-to-face visits;
3. Ensuring that Members have ongoing access (e.g., telephone number, email address) to their Care Manager. The Member must have all current and accurate contact information for their assigned Care Manager at all times. Should the Care Manager not be available for an extended period of time, the Contractor must identify back-up coverage from the Contractor's staff;
4. Notifying Members if there is a change in their assigned Care Manager and ensuring continuity of care during the transition process to a new Care Manager, if applicable; and,
5. Ensuring that the Member's Care Manager maintains regular contact with other care managers/case managers assigned to the Member.

4.9.1.2 [Coordination of Member Services and Providers Across the Continuum](#)

1. Engaging Members in Care Management activities;
2. Coordinating and providing assessment, referral, information, and assistance in obtaining and maintaining the following types of Medicaid services, including those covered by either the Contractor or FFS:
 - a. Physical Health;
 - b. Behavioral Health;
 - c. I/DD;
 - d. LTSS;
 - e. TBI;
 - f. Pharmacy;
 - g. Vision;
 - h. Dental; and
 - i. Peer Supports/Recovery Services.
3. Supporting Members to ensure they receive all medically necessary services as expeditiously as the Member's condition requires, including scheduling appointments and coordinating referrals. In particular, Care Managers must support Members as expeditiously as required following a triggering event, as defined in Section 4.4.7, of this Contract, *Triggering Events*, and when Members face challenges finding in-network providers;
4. Referring Members to and coordinating social services provided by community and social providers, including disability benefits, food and income supports, housing, transportation, employment services, education, child welfare services, domestic violence services, legal services, and services for justice-involved populations;
 - a. If a Member is identified as experiencing homelessness or at-risk of imminent homelessness, the Contractor must support facilitating and coordinating emergency housing placements.

5. Coordinating Medicare services for Members dually eligible for Medicare and Medicaid, by assisting with referrals and access to Medicare-covered services as requested by the Member when the need is identified. These services should be included in the ICP;
6. For Members with disabilities, providing effective communication with health care providers and participate in assistance with decision making with respect to treatment options;
7. Coordination with early intervention providers. Care Managers must provide this coordination for children who “age-out” of the early intervention program and need to continue receiving services and ensure that services are transitioned to non-early intervention providers (PT, OT, speech, etc.);
8. Connecting Members to services that promote community living and help avoid premature or avoidable NF or other residential placements or inpatient hospitalizations (medical or psychiatric);
9. Working with nursing facilities and community-based LTSS providers to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the LTSS benefit;
10. Communicating and consulting with other providers and the Member and the Member’s supports, including family, informal, and formal caregivers, as appropriate; and
11. Facilitating timely communication across the care team, including case conferencing.

4.9.1.3 [Monitoring and Supporting Member Health](#)

1. Providing enhanced monitoring of functional and health status. The Contractor must design programs to proactively provide the support needed to improve or maintain current health status and avoid functional decline;
2. Ensuring that Members have scheduled annual physical exams, or well-child visits based on the appropriate age-related frequency;
3. Ensuring that Members have a postpartum visit with a provider within fifty-six (56) calendar days of delivery to assess for signs of postpartum depression, as applicable;
4. Conducting the HRA at least every twelve (12) months, or as otherwise required, according to the requirements in Section 4.5, of this Contract, *Health Risk Assessments*;
5. Conducting continuous monitoring of progress toward goals identified in the ICP through in-person contacts with the Member and the Member’s supports, including family, informal, and formal caregivers and routine care team reviews. Contacts may be conducted in-person, by videoconference, or telephonically. See Section 4.4.5, of this Contract, *Care Management Contact and Format Requirements*;
6. Conducting medication management, including regular medication reconciliation (conducted by appropriate ICT Member) and support of medication adherence;
7. Supporting the Member’s adherence to prescribed treatment regimens and wellness activities;
8. Following up on referrals and setting up appointments, as appropriate;
9. Making available twenty-four (24) hours a day, seven (7) days a week Member support for referrals and consultations, including determining Members’ service needs, discussing service options and providing appropriate triage and referral, as appropriate. See CCMC contract Section 2.12.2, *Clinical Triage Line Requirements*;
10. Connecting the Member to evidence-based patient education programs;
11. Arranging transportation to medical appointments, as needed;

12. Developing behavioral health crisis and safety plans as appropriate for Members with behavioral health needs. The plan must describe how the Contractor and the Care Manager will assist the Member to identify and select individuals or agencies that will provide support, crisis intervention, crisis stabilization or other services (including peer recovery support services) to assist the Member in managing the crisis and to minimize emergency room or inpatient needs;
13. Developing safety plans for Members with chronic medical conditions;
14. Conducting transitional Care Management as described in Section 4.10, of this Contract, *Transitional Care Management*; and
15. Ensuring that Care Managers support assigned Members through administrative transitions, as described in Section 4.11, of this Contract, *Administrative Transitions*, and proactively make best efforts to ensure that Members do not lose their Medicaid eligibility at renewal periods unnecessarily due to administrative reasons.

4.9.2 Local Care Management Requirements

The Contractor must ensure that Care Management is locally and regionally based (and not limited only to outreach by telephone or videoconference). Care Managers assigned to conduct face-to-face Care Management activities must be located in each of the contracted regions to the extent possible. All Care Managers, including those providing centralized telephonic/videoconference Care Management and those located throughout the regions must be aware of region-specific community resources. The Contractor may accomplish this through innovative partnerships with community-based organizations that perform local Care Management functions. See Section 4.9.3, of this Contract, *Care Management Partnerships, Including with Community-Based Organizations*.

4.9.3 Care Management Partnerships, Including with Community-Based Organizations

When requested by the Department, the Contractor must participate in collaborative planning with the Department and its community partners. Partnering organizations may include, but are not limited to, Centers for Independent Living (CILs), CSBs, AAAs, adult day health care centers (ADCCs), health systems, Early Intervention Local Lead Agencies and nursing facilities.

Contractors may form innovative partnerships with Community-Based Organizations (CBOs) that perform Care Management or Care Management Extender functions and offer support services to Cardinal Care Members, such as options counseling and facilitating transitions from an institution to the community.

The Contractor must ensure that CBO Care Management staff and supervisors meet all contractual standards and Federal conflict of interest requirements, particularly in the area of functional eligibility assessments. Administrative firewalls should exist to ensure that staff within the contracted CBOs who perform direct care services, such as personal care, are not the same staff who provide Care Management services.

The Contractor must ensure that documentation of all CBO Care Management activities are available within the Contractor's systems and that required reporting can be provided (HRA, ICP data, etc.) to DMAS as required. The Contractor must also maintain accurate records of CBO Care Manager assignments, both current and historical.

CMS and the Department do not consider case management to be a direct care service and therefore, case managers are not prohibited from performing Care Coordination and Care Management functions. Additional guidance is available from CMS at <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series/index.html#conflict>.

4.9.4 Referral Requirements

In addition to the referral requirements set forth elsewhere in this Contract, the Contractor must:

1. Establish referral mechanisms to link Members with providers and programs not covered through Cardinal Care or Medicaid;
2. Establish relationships with key state partners and community-based partnerships;
3. Maintain a current list of providers, agencies, and programs and provide that list to Members who have needs for those programs;
4. Refer Members to the Department for carved-out and excluded services pursuant to CCMC contract Section 5.2, *Carved-Out Services*; and
5. Refer Members to the Department who are transitioning to residential treatment.

In accordance with 42 CFR § 457.1201, the Contractor must guarantee that it will not avoid costs for services covered in this Contract by referring enrollees to publicly supported health care resources.

4.10 Transitional Care Management

The Contractor must oversee care transitions for Members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i).

The Contractor may have one (1) or more dedicated Regional Transition Care Managers in each region to be available to Care Managers, at a Care Manager's discretion, to assist Members with care transitions. Care transitions include (1) transitioning Members between NFs, hospitals and other acute care settings, inpatient rehabilitation, or other institutional settings, (2) transitioning Members from any of these settings into the community, and (3) assisting individuals who desire to remain in their community setting. In instances when a Care Manager elects to bring a Regional Transition Care Manager onto the care team, the Regional Transition Care Manager must work in tandem with the Member, the Member's Care Manager and all ICT Members to ensure safe and effective transitions between clinical settings and from nursing facilities to the community. See Section 4.10.3, *Transition from NF to the Community*. The Contractor and the Care Manager must ensure that the Regional Transition Care Manager does not duplicate the efforts and activities of the Member's Care Manager. Care Managers must not fully delegate Care Management responsibility to a Regional Transition Care Manager but rather may leverage their expertise to assist with various Transitional Care Management functions in coordination with the lead assigned Care Manager.

The Regional Transition Care Manager must not have a caseload other than individuals in transition and must meet the qualifications of a Care Manager as described in Section 4.8.1, of this Contract, *Care Manager Qualifications*.

4.10.1 Regional Transition Care Manager Responsibilities

The Regional Transition Care Manager, when engaged by the Care Manager, must work in tandem with the Member, the Member's Care Manager and all ICT Members to ensure safe and effective transitions between levels of care. The Regional Transition Care Manager must:

1. Participate in discharge planning for Members transitioning from acute institutional settings to lower levels of care, including involuntary psychiatric admissions, Long-Stay Hospitals, Nursing Facilities, and the community. Single, non-recurrent (within thirty (30) calendar days) medical stays of two nights or less do not require the participation of the Regional Transition Care Manager unless indicated by the Member's needs and circumstances;
2. Coordinate with the assigned Care Manager in discharge planning activities to ensure a safe transition that meets the Member's needs and preferences, including assisting with scheduling of discharge/aftercare appointments and identifying non-clinical supports and the role they serve in the Member's treatment and aftercare plans;
3. Coordinate with the Contractor's Utilization Management staff, as indicated, regarding discharge planning;
4. Coordinate with NF staff, the Member's assigned Care Manager, and the Member when it is identified that the Member wishes to transition from NF care to the community;
5. Use HRA information and work with NF staff (including obtaining MDS Section Q data), hospital staff, community care providers, screening teams, and the state Long-Term Care Ombudsman to facilitate transitions to the community. This includes utilizing local contact agencies in order to facilitate transitions and linking with other community resources that provide support (including housing and employment options) to individuals and their families/caregivers, such as CILs, CSBs, and local Area Agencies on Aging;
6. Provide support to the Care Manager to maintain Members in the community in lieu of transitioning to institutional settings, as needed; and
7. For dual-eligible Members enrolled in a D-SNP, work with the D-SNP Care Coordinator upon approval of the Member, to coordinate the above activities.

4.10.2 Care Manager Responsibilities in Coordination with the Regional Transition Care Manager

Collaboration between the Regional Transition Care Manager and the Care Manager is vital for ensuring smooth transitions to and from hospitals, nursing facilities, other institutions, and the community. The Member's Care Manager must work with the Regional Transition Care Manager to:

1. Support transitions across the continuum of care and ensure Member's needs and preferences are met, including:
 - a. Ensuring that admissions and lengths of stay are appropriate to the Member's needs;
 - b. Ensuring services are provided in the least restrictive environment;
 - c. Upon notification of a hospital or NF admission or discharge, ensuring that communication of the hospital or NF admission or discharge is conveyed to the PCP and community-based providers within 24 hours;
 - d. Ensuring that there is timely and adequate discharge planning and medication reconciliation;

- e. Working to reduce the need for hospital transfers and emergency room use;
 - f. Communicating with providers of waiver services when an admission has occurred and sharing the tentative discharge date once available; and
 - g. Documenting all efforts related to these activities, including the Member's active participation in discharge planning.
2. Ensure completion of the HRA and ICP following discharge in accordance with required timeframes, as described in Section 4.5.3, of this Contract, *HRA Completion Timeframes*, and Section 4.6.2, *ICP Revision Completion Timeframes*;
 3. Work with facility staff and the Transition Care Manager to make ICP revisions; ICP revisions must include descriptions of detailed Care Management interventions and strategies employed to provide seamless transitions and avoid delays in services and supports;
 4. Ensure the ICT meeting is scheduled and held as required and includes a discussion of discharge planning, coordination, and reassessment, as needed;
 5. Ensure that the appropriate behavioral health providers provide a discharge plan to ICT Members following any behavioral health admissions;
 6. Ensure that Members who require medication monitoring will have access to such services within fourteen (14) calendar days of discharge from a behavioral health inpatient setting or as medically advised;
 7. For dual-eligible Members enrolled in a D-SNP, coordinate with the D-SNP Care Coordinator upon the approval of the Member;
 8. Provide outreach to providers of Medicare services regarding the role of the Care Manager related to transitions of care and the model of care;
 9. Provide education to Members, authorized representatives, family/caregivers, and providers regarding the importance of notifying the Care Manager of any inpatient admissions to ensure the Care Manager can help effectuate successful transitions; and
 10. Comply with continuity of care provisions described in Section 4.11, of this Contract, *Administrative Transitions*, to the extent applicable.

4.10.3 Transition from NF to the Community

The Contractor's Regional Transition Care Managers must, if engaged to assist with transitional Care Management by the Care Manager, provide transition support to Members who have the desire to and can safely transition from NFs to the community (and maintain or improve their health status). Care Managers should work closely with LTSS Care Managers to facilitate the transition.

The scope of transition services that the Contractor must provide includes assessing not only medical/health needs but also assessing the Member's social determinants of health (e.g., housing, transportation, social interactions, etc.). The Contractor must develop an inclusive and realistic transition plan for the Member and assist in addressing all components of the transition plan (e.g., assisting with finding housing, setting up non-medical transportation, helping the individual integrate into the community through clubs, volunteering/work, and faith organizations). The Contractor must provide consistent follow-up during the first year after discharge and must make adjustments to the transition plan to assure acclimation and integration into the community as needed by the Member.

NF transitional Care Management must include, but is not limited to:

1. The development of a transition plan;
2. The provision of information about services that may be needed, in accordance with the timeframes specified in this Contract, prior to the discharge date, during and after transition;
3. The coordination of community-based services with the Care Manager. This includes the identification of needed CCC Plus Waiver-covered Transition Services if the Member will be enrolled in the CCC Plus Waiver; and
4. Linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation.

The Contractor and Care Manager must determine the appropriate staffing mix between the Care Manager and the Regional Transition Care Manager to support NF Transitional Care Management.

The Contractor is encouraged to utilize Transitional Care Management resources in acute discharge planning efforts and in the Virginia Emergency Department Care Coordination Program to support overall Care Management resources. See CCMC contract Section 5.7.6, *Virginia Emergency Department Care Coordination Program*. This particularly applies to Members in Moderate to High Intensity Care Management.

4.11 Administrative Transitions/Continuity of Care

The Contractor must work closely with its affiliated CCMC plan and the Department to ensure continuity of Medicaid covered services and care for Members whose enrollment changes between the affiliated CCMC plan and Medicaid fee-for-service or another CCMC contracted plan. These enrollment changes are referred to as “administrative transitions.” See Section 8.1, *Administrative Transitions*, of the CCMC Contract for specific requirements.

4.12 Care Coordination and Care Management for Specific Subpopulations

4.12.1 Foster Care Management

4.12.1.1 General Requirements

The Contractor must provide specialized Care Management to all children and youth in foster care and former foster youth according to the following requirements. See Section 4.4.2, of this Contract, *Priority Populations*, for more information:

1. Members in foster care and former foster youth must be assigned to High Intensity Care Management for a minimum of three (3) months following enrollment in Medicaid, entry into the child welfare system or a new home;
2. Members aging out of foster care must be assigned to High Intensity Care Management for three (3) months after aging out of the child welfare system; and,
3. Outside of these three (3) month periods, Members in the groups above must receive either Low, Moderate or High Intensity Care Management.

The Contractor must document on a case-by-case basis the reason(s) for assigning a Member in foster care or who is a former foster youth to a specific Care Management intensity tier (i.e., Low, Moderate,

or High). The Contractor must also document the reason(s) for re-assigning a member to a different Care Management tier upon restratification or following a triggering event.

In addition to receiving Low, Moderate or High Intensity Care Management, the Contractor must:

1. Support the efforts of the LDSS social worker and/or the foster care parents during initial outreach to ensure that Members in foster care receive both a PCP and a dental visit within thirty (30) days of enrollment with the Contractor, unless their social worker attests that they have recently seen a provider within three (3) months prior to enrollment;
2. Ensure in the event that the Member has seen an out-of-network PCP and/or a dentist prior to enrollment, that the Member is assigned to an in-network PCP and/or Smiles for Children dentist for future ongoing care;
3. Provide prompt medication management/reconciliation upon enrollment on the basis of foster care status or if a Member is known to have entered the foster care system while already enrolled in Medicaid; and,
4. Ensure that Members in Treatment Foster Care Case Management or Residential Treatment services consisting of Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) have access to transportation and pharmacy services related to the delivery of these carved-out services, as necessary.

[4.12.1.2 Foster Care Transition Planning](#)

The Contractor must develop and maintain transition of care policies and procedures for children in foster care who are transitioning out the child welfare system. The policies and procedures must include provisions for convening a comprehensive treatment team meeting prior to Member leaving the child welfare system to discuss the services and supports the Member's needs post-separation. If the services are not covered, the Contractor must inform the Member, or their authorized representative, of available community programs that may be able to meet their needs and make the necessary referrals, as needed. If the Member has an ICP, the Contractor must include transition needs in the updated ICP.

The Contractor must establish a process to notify youth in foster care who are approaching age seventeen (17) of the programs that provide continued health care coverage, specifically former foster care and Fostering Futures. The Contractor must ensure Care Management continues during this transition period.

The Contractor must start transition planning one (1) year prior to the expected date upon which an enrollee will age-out of the child welfare system or immediately upon notification that an enrollee has achieved permanency status. The Contractor must assist the Member with all aspects of the eligibility determination process and coordinate with the local Department of Social Services to ensure transition to Aid Category 70, former Foster Care children and youth in Fostering Futures.

The Contractor must provide youth aging out of foster care with a "health summary" consolidating key medical information (e.g., providers, appointments, prescriptions) and providing resources to assist with transitioning to adulthood and managing their own medical decisions.

4.12.1.3 [Compliance with Other Federal and State Requirements](#)

The Contractor must work collaboratively with the Department and Department of Social Services in meeting the Federal requirements related to the Virginia Health Care Oversight and Coordination Plan, the provision of health care services as outlined in the VDSS Five Year State Plan for Child and Family Services, and the VDSS Child and Family Services Manuals for children in foster care. The Contractor must comply with the following rules:

1. Care Coordination and Care Management
 - a. The Contractor must work with DSS in all areas of Care Management and Care Coordination;
 - b. For decisions regarding the foster care child's medical care, the Contractor must 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 (AA) child's medical care, the Contractor must work directly with the adoptive parent;
 - c. For decisions regarding the medical care of former foster care or Fostering Futures Members (AC 070), the Contractor must work directly with the former foster care Members;
2. Covered Services
 - a. The Contractor must provide coverage for all contractual covered services until the Department disenrolls the child from the Contractor's plan. This includes circumstances where a child moves out of the Contractor's service area;
 - b. Coverage must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, even out of area;
3. Enrollment and Plan Selection
 - a. Foster care children are not restricted to their health plan selection following the initial three (3) month enrollment period;
 - b. The DSS social worker will be responsible for all changes to MCO enrollment for foster care children. The adoptive parent will be responsible for all changes to MCO enrollment for adoption assistance children. An enrollment change can be requested through the Enrollment Broker at any time that the child is placed in an area not serviced by the MCO where the child is enrolled; and,
 - c. The former foster care or Fostering Futures Members (AC 070) must be responsible for all changes regarding their MCO enrollment; and,
4. Other
 - a. The Contractor must participate in child welfare stakeholder collaboration work groups as requested by the Department. See CCMC contract Section 1.3.2, *Child Welfare Stakeholder Collaboration*.

4.12.1.4 [Foster Care/Adoption Assistance Reporting Requirements](#)

The Contractor must report monthly to the Department any barriers identified in contacting and/or providing care to foster care children. The Department will use the Barrier Report to assist the Contractor in resolving the barriers reported. Refer to the Cardinal Care Technical Manual for Barrier Report specifications.

The Contractor agrees to adhere to all additional reporting requirements related to the foster care and adoption assistance population, as outlined in the Cardinal Care Technical Manual.

4.12.2 Care Management for High-Risk Pregnant Individuals and Infants

In addition to ensuring that high-risk pregnant individuals and infants receive Care Management services appropriate to their Priority Population status. See Section 4.4.2, of this Contract, *Priority Populations*) and Care Management Intensity level as described throughout Section 4.0, of this Contract, *Integrated Model of Care*, the Contractor must comply with the following enhanced requirements.

4.12.2.1 [High-Risk Pregnancy Requirements](#)

The Contractor must have written policies and procedures that outline how the Contractor differentiates pregnant individuals according to risk status. The methods applied to assess the risk of a pregnant Member must be evidence-based and developed in accordance with guidance set forth by organizations such as the American Congress of Obstetricians and Gynecologists (ACOG). At a minimum, the process must consider:

1. The presence of co-morbid or chronic conditions, sexually transmitted infections, etc.;
2. Previous pregnancy complications and adverse birth outcomes;
3. History of or current substance use (e.g., alcohol, tobacco, prescription or recreational drug use);
4. History of, or a current positive screen for, depression, anxiety and/or other behavioral health concerns; and
5. The Member's personal safety (e.g., housing situation, violence).

The Contractor must provide Care Management services for its high-risk pregnant individuals and infants per Section 4.4, of this Contract, *Care Management*. Care management services must be coordinated with Contractor-reimbursed high-risk prenatal and infant targeted case management services.

Within three (3) business days of a Member being identified as high-risk, the Contractor should make its best effort to contact the Member and/or the Member's physicians to identify and assess the specialized needs of the Member (medical, psychosocial, nutritional, etc.). The Contractor must have methods in place to monitor Members who are deemed by the Contractor as being "high-risk maternity." The Contractor must also continue to monitor, as deemed appropriate, the risk status of pregnant Members not originally considered "high-risk maternity" for potential enrollment in the Contractor's high-risk maternity programs.

4.12.2.2 [Substance-Exposed Infants \(SEIs\) and Neonatal Abstinence Syndrome \(NAS\) Infants](#)

The Contractor must also have methods in place to monitor infants who are deemed by the Contractor as being "high-risk". At a minimum, high-risk infants include all newborns/infants admitted to the NICU (Nursery Level 3/NICU) for neonatal intensive care and Substance-Exposed Infants (SEIs) and Neonatal Abstinence Syndrome (NAS) Infants.

To best support SEIs/NAS infants, the Contractor must develop specialized Care Management interventions to address the medical and psychosocial needs of the infant and the infant's mother along with creating a plan of safe care for the SEI/NAS infant. These interventions must be delivered with the

objective of ensuring that the SEI/NAS infant is receiving care in conjunction with the substance use recovery Care Management provided for his or her mother.

The Contractor must provide Care Management services to each family parenting an identified SEI/NAS infant. SEIs/NAS infants must be identified through both their own health status and their biological mother's risk factors for drug use including their prenatal substance use history. These Care Management services must include parental psychosocial education on the potential developmental needs of SEIs/NAS infants, trauma-informed services for both the parents of SEIs/NAS infants and the SEI/NAS infant, as developmentally appropriate, a plan of safe care developed for the SEI/NAS infant with a licensed behavioral health professional and the SEI's/NAS infant's care giver and substance use treatment Care Management services for the biological parents of SEIs, as applicable. Adoptive parents parenting an SEI/NAS infant who qualifies for Medicaid through adoption assistance must also have the option of receiving these Care Management services, as clinically appropriate and requested. See Section 4.4.2, of this Contract, *Priority Populations*.

4.12.2.3 [Service Plans for High-Risk Pregnant Women and Infants](#)

For all high-risk pregnant women and infants, and the Contractor must develop service plans that include individualized descriptions of what services and resources are needed and how to access those services and resources. See Section 4.6, of this Contract, *Person-Centered Individualized Care Plan*.

Refer to CCMC Contract Section 5.13, *Maternal and Infant Health Services*, for general coverage requirements for Maternal and Infant Care Programs.

4.12.3 [Care Management for Members Receiving HCBS](#)

For members with special health care needs or those who need LTSS, in accordance with 42 CFR § 438.208(c), the Contractor must:

1. Develop processes for identifying and assessing the needs of individuals who need LTSS or who have special health care needs.
2. Produce treatment/service plans (known in this contract as individualized care plans or ICPs) for individuals who require LTSS. Care plans must be:
 - a. Developed by an individual qualified to coordinate LTSS service requirements with Member participation, and in consultation with any providers caring for the Member;
 - b. Developed by a person trained in person-centered planning using a person-centered process and care plan as defined in 42 CFR § 441.301(c);
 - c. Approved by the Contractor in a timely manner;
 - d. In accordance with any applicable State quality assurance and utilization review standards; and
 - e. Reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

The Contractor must fully comply with federal requirements around person-centered planning at 42 CFR § 441.301(c)(1) and (2) and CMS guidance documents.

4.12.4 ARTS Care Management

In addition to ensuring that individuals with SUD receive the minimum levels of Care Management available to other Members, the Contractor, consistent with Federal and State confidentiality requirements, must implement structured Care Management plans for achieving seamless transitions of care for individuals with SUD. These plans will address overall care coordination for the ARTS benefit, transitions between all ASAM Levels of Care, transitions between ARTS service providers, transitions between delivery systems (i.e., moving from FFS to Managed Care), collaboration between behavioral health and physical health systems, and collaboration between the health plans and the Department Fee-for-Service contractor. The Contractor must emphasize Care Management for any Member with SUD transitioning from emergency departments, residential or inpatient stays as well as correctional settings. The Contractor must make every effort to provide outreach and Care Management to Members who are at higher risk for a fatal overdose including those discharged from an inpatient setting including correctional settings within seven (7) calendar days of notice of discharge. At minimum, this outreach must include ensuring access to naloxone prescriptions through working with the Member and their providers and information on how to get prescriptions filled by in-network pharmacies. The plan of care post-discharge will be developed by the provider and can be updated by the Contractor.

The Contractor must use data from multiple sources (including utilization data, health risk assessments, state agency aid categories, demographic information, Emergency Department Care Coordination Reports and Health Department epidemiology reports) to identify Members with complex health needs, including Members who need help navigating the health system to receive appropriate delivery of care and services. When clinically indicated, the Contractor will assign each Member to an ARTS Care Manager to provide Care Management support throughout the course of substance use disorder treatment, ensuring that all relevant information is shared with the treating providers through care transitions.

The Contractor must develop Care Management structures to manage pregnant and postpartum populations with histories of or current substance use, focusing on planning strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches.

The Contractor must provide ongoing education to providers regarding the requirement to engage in discharge planning for all Members, including coordination with the provider at the next level of care, to ensure the new provider is aware of the progress from the prior level of care. The Contractor must conduct chart reviews to ensure compliance and identify opportunities to improve quality of care and ensure alignment with identified Department quality priorities. See CCMC Contract Section 10, *Quality Improvement*. The Contractor must facilitate the transfer of clinical information between treating practitioners to foster continuity of care and progress towards recovery.

In order to minimize barriers to care, the Contractor must ensure that its network includes behavioral health professionals performing addiction and recovery treatment service assessments, treatment and recovery services via telehealth (where available). Services provided via telehealth must be consistent with State regulations. ARTS Care Managers must be knowledgeable about the telehealth delivery system in Virginia and must refer Members in rural and other hard to access areas to these systems in order to receive an assessment and needed services for treatment and recovery. It is expected that

there will be some Members who will not be able to access these assessments or needed services through telehealth or an office visit due to transportation, psychosocial, or health issues, thus the Contractor must contract with a subset of providers for an assessment in the Member's home in order to accommodate the needs of these Members.

The ARTS Care Manager must coordinate information with the Member's assigned Care Manager to ensure integration of all care and comprehensive care planning.

4.12.5 Formal Referral and Assistance Process for Members Experiencing Homelessness

The Contractor must develop formal referral and assistance processes and procedures in its Care Management policies and processes and case management programs that identify Members experiencing homelessness. The Contractor must provide members with information and referrals to the homeless crisis response system and provide individualized assistance as the member's situation and condition warrants. Communities maintain homeless crisis response systems and provide listings of the local homeless point of entry, which is the starting point for anyone who is homeless and in need of shelter and services. The Contractor must work collaboratively with any identified housing providers to ensure non-Medicaid resources are leveraged to support the Member. The Contractor must work to ensure access to needed medical services and that continuity of care is supported.

4.13 Electronic Care Coordination System

The Contractor must utilize an electronic Care Coordination/management system that maximizes the opportunity to share and integrate data and information among the Contractor, its multiple service areas, helplines, providers, Members, and Care Managers quickly and efficiently. The system must allow staff (e.g., customer service, nurse helpline, medical management) who may be contacted by a Member regarding Care Management to have immediate access to the most recent case-specific information within the Contractor's electronic system. The data contained within the electronic system may include the following: administrative data, call center notes, helpline notes, provider service notes, a Member's Care Management notes, and any recent inpatient or emergency department utilization. The system must also have the capability to share or access relevant information (i.e., ICP, utilization reports, care treatment plans, etc.) with the Member, Member's provider(s), and Care Managers. The Contractor must also send and receive relevant data with subcontractors (i.e., to/from the Contractor's Care Management or other systems) to facilitate effective Care Management and transitions of care.

The Contractor must provide utilization management, health risk assessment, individualized care plan and Care Coordination data to the CRMS as described in the Cardinal Care and CRMS Technical Manuals. The Contractor must work collaboratively with the Department to continue to refine CRMS data exchange processes to facilitate efficiencies and enhance care coordination and continuity of care efforts.

4.14 Disease Management Programs

The Contractor must work collaboratively with its affiliated CCMC plan to develop Disease Management programs available to all Members that, at a minimum, focus on identifying and improving the health status of Members diagnosed with the following focus conditions:

1. Respiratory Conditions such as Asthma & Chronic Obstructive Pulmonary Disease (COPD) (pediatrics and adults);
2. Heart disease, including Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF);
3. Diabetes (pediatrics and adults); and
4. Cancer.

4.15 Health Homes

The Contractor may establish health homes for Members 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.

4.16 Community & Member Engagement

The Contractor must develop programs, establish partnerships, to engage Members and provide Care Coordination efforts that identify, address and track Member needs across different categories of Health Related Social Needs (HRSN), with a priority focus on housing stability and food security. The Department will identify a single standard HRSN question set to be used by the Contractor for screening. The Department intends to utilize a subset of standard HRSN questions and responses from a standardized tool, such as the Accountable Health Communities (AHC) HRSN Screening tool or Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool. The Department will focus primarily on HRSN questions designed to Assess housing stability and food security. The Contractor should also align the HRSN screening questions in its HRA with the standard questions and responses identified by the Department.

The Contractor must participate in, and support, Department's efforts to Assess prevalent HRSN in communities and work to engage Members and community partners to improve Outcomes and reduce Health Disparities across the state.

The Department encourages the Contractor to focus HRSN programs and partnerships on addressing needs of the following populations:

1. **Transitions of care:** Members transitioning from the Hospital to the community, from the NF or PRTF to the community, and from incarceration or detention to the community;
2. **High-risk populations:** Members who are considered high Emergency Department (ED) utilizers, pregnant and women who are up to twelve (12) months postpartum, and children with asthma;
3. **Substance Use/Opioid Use Disorders:** Members with SUD and/or OUD especially pregnant individuals with SUD and/or OUD and those transitioning from an institutional stay (i.e. inpatient hospitalization, Emergency Department, residential facility, detention, incarceration); and
4. **Unemployed populations:** Individuals who are potentially unemployed or underemployed requiring referrals to employment, training, education assistance and other related support services, including to Virginia Career Works.

As described in Section 8.4.2 of the CCMC Contract, *Priority Populations*, Members with high Social Needs are part of the MCO-Determined Priority Population and should be considered for Care

Management at an intensity level at the Contractor's discretion based on a Member's needs and risks. Additionally, as described in Section 8.4.1 of the CCMC Contract, *Risk Stratification*, referrals from social service agencies are a data source the Contractor must use, when available, in its risk stratification/scoring methodology.

As part of its community Assessment and Member engagement work, the Contractor must develop and implement an HRSN Plan designed to identify and seek to address non-medical drivers of health that exist among the Contractor's Members. The HRSN Plan must be developed in alignment with the Contractor's MOC, the Medicaid Managed Care Quality Strategy, and related state initiatives to address HRSN and account for regional variances in needs and opportunities across the Commonwealth, and partnerships with community based organizations.

The Contractor's HRSN Plan must describe the Contractor's process to develop, and over time refine, its community Assessment, Member engagement and related HRSN approach. The HRSN Plan must include an action plan for Contract Year One and beyond consisting of specific measurable objectives related to addressing housing stability and food security needs of Members based on individual and community needs, including engaging Members, partnering with CBOs and utilizing Community Health Workers and other Care Management extenders. The Contractor's HRSN Strategic Plan must include how the Contractor plans to facilitate and document closed-loop referrals for Members with identified needs. As an example, the Contractor's HRSN Plan should specifically identify how it will work to engage pregnant and postpartum women, identify HRSNs, and connect Members with Contractor, as well as local and state resources to improve maternal health and birth outcomes and reduce geographic and racial disparities in access to care and outcomes. The HRSN Plan must also describe the Contractor's process to enable effective Member communication and engagement, for example how the Contractor will use different modes of communication, including digital modes where appropriate, to ensure Members are aware of the resources available to them and resolve barriers to accessing them.

The Contractor must submit its HRSN Plan to the Department as part of Readiness Review. The Contractor must provide updates to Department on implementation of its HRSN Plan in an annual report of its progress on meeting HRSN Plan objectives, findings and proposed approaches and modifications for future Contract Years.

The Contractor's annual report must detail how it is identifying, addressing (i.e. via programs and partnerships), and tracking HRSN such as housing instability, food insecurity, and for specifically addressing HRSN of pregnant and postpartum women and infants. The Contractor should refer to the Cardinal Care Technical Manual for additional information on requirements related to the Contractor's HRSN Plan and corresponding annual reports.

The Department has the discretion to expand the HRSN reporting criteria throughout future Contract years, to include specific data for key areas noted above or additional areas as necessary. At a future date, the Department may also consider identifying a statewide community referral platform to help identify resources, generate referrals and close the loop on Members being referred to community organizations for HRSNs and make related Amendments to this Contract.

4.17 Care Management Collaborative

The Contractor must participate in Care Management Collaborative meetings with the Department in-person, unless otherwise permitted by the Department. The Department's representatives will meet with the Contractor's nursing/medical Care Management and behavioral health Care Management leadership to review cases and scenarios that offer integrated care opportunities and to clarify the expectations around Care Management. The Department will advise the Contractor of any required documentation in preparation and advance of each meeting. The clinical work group meetings will be held on a frequency as determined by the Department.

5 Medicare-Medicaid Coordination Requirements

5.1 Coordination of Benefits

5.1.1 Service Authorization Processing

The Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or LTSS needs.

When reviewing a service authorization request for a service that is covered by both Medicare and Medicaid, the Contractor must first adjudicate the request utilizing its Medicare medical necessity criteria. If the resulting decision is to deny the request, in whole or in part, then, prior to notifying the requestor, the Contractor must adjudicate the request using its Medicaid medical necessity criteria. After adjudicating the request using both the Medicare and Medicaid the Contractor must notify the requestor of the decision. See Section 5.2, of this Contract, *Integrated Appeals and Grievances*.

See CCMC Contract Section 6.1, *Service Authorizations*, for service authorization processing requirements of Medicaid services.

The Contractor must develop a policy and procedures document describing its integrated service authorization processes. This document must include a flowchart/workflow visualization of the integrated service authorization processes from initiation to final disposition. This document must be provided to the Department for review at initiation of the processes and upon revision.

5.1.2 Claims Processing

The Contractor, in cooperation and coordination with the Contractor's Virginia Medicaid MCO, must develop and operate an integrated process for the payment of member's coinsurance and deductible for Medicare crossover claims. At a minimum, the Contractor must not require the provider to submit a claim to the Medicaid MCO for the crossover amount. Instead, the Contractor must pay the full amount (amount owed for the provision of the service and the crossover amount) in one (1) transaction.

The Contractor must pay the identified coinsurance and deductible for Medicare crossover claims up to the Medicaid Fee Schedule amount. If there is no corresponding fee for the service in the Medicaid Fee Schedule, the Contractor must pay the full amount identified in the coinsurance and deductible.

The Contractor must develop a policy and procedures document describing its integrated claims processing processes. This document must include a flowchart/workflow visualization of the crossover claims processes from initiation to final disposition. This document must be provided to the Department for review at initiation of the processes and upon revision.

5.1.3 Timely Filing Deadline

The Contractor's timely filing requirements for all providers (in and out-of-network) must not be less than three (3) months and not more than twelve (12) months from the date of service. The Contractor's DSNP timely filing deadline for services that are Medicaid covered (in part or in full) must match the Contractor's CCMC timely filing requirements.

5.2 Integrated Appeals and Grievances

The Contractor must implement a grievance and appeal system and process grievances and appeals in compliance with the terms of 42 CFR §§ 422.629 – 422.634, 438.210, 438.400, and 438.402. This includes:

1. Grievances and appeals systems that meet the standards described in §422.629;
2. An integrated grievance process that complies with §422.630;
3. A process for making integrated organization determinations consistent with §422.631;
4. Continuation of benefits while an integrated reconsideration is pending consistent with §422.632;
5. A process for making integrated reconsiderations consistent with §422.633; and
6. A process for effectuation of decisions consistent with §422.634.

The Contractor must develop a policy and procedures document describing its integrated appeals and grievances process. This document must include a flowchart/workflow visualization of the member appeals and grievances processes from initiation to final disposition. This document must be provided to the Department for review at initiation of the processes and upon revision.

5.3 Behavioral Health

The Contractor must coordinate all carved out or excluded behavioral health benefits with the State's contractor, Acentra Health, when appropriate and until those services are included in the Managed Care program. More information on Acentra is available at <https://vamedicaid.dmas.virginia.gov/sa>.

5.4 Coordination with the State

The Contractor must meet with the Department at the Department's request in person or by phone regarding dual eligible Members and provide the Department with all requested data in a timely manner.

During the Contract year, the Contractor must be required to meet, discuss, collaborate with the Department and other DMAS contracted MA D-SNPs, and implement ways to simplify processes and/or notifications to Members who are enrolled in the Contractor's CCMC plan and the D-SNP.

5.5 Staff Training

The Contractor must train its Care Coordinators and other related staff on available Medicare and Medicaid benefits and coordination of Medicare and Medicaid benefits.

The Contractor must train staff on topics as requested by the Department and within a timeframe designated by the Department. The Contractor will also be required to allow the Department to provide targeted training to their staff.

5.6 Provider Training

The Contractor must train network providers on available D-SNP and CCMC program benefits and services as requested by a provider or provider association. To reduce burden on providers, the Contractor must coordinate with and participate in CCMC required trainings with its affiliated CCMC plan as the Contractor determines necessary or as requested by the Department.

5.7 Member Transition

The Contractor is required to participate in all activities as directed by the Department which relate to Member transition as a result of termination of this Contract. This applies to terminations directed from the Department, CMS or the Contractor.

5.8 Call Center Requirements

The Contractor must integrate all member and provider call centers by ensuring all member and provider call centers can either address a caller's Medicare and/or Medicaid questions or be able to complete a warm-transfer to another internal staff member that can answer the caller's Medicare and/or Medicaid questions.

The Contractor must meet all member and provider call center requirements described throughout the CCMC Contract. See CCMC Contract Section, 2.12, *Member and Provider Call Centers*, and the sections cross-referenced in 2.12. This includes but is not limited to call center performance standards, required components and hours of operation, staff training and the types of lines (for example, General Customer Service line, Clinical Triage line, and Provider Services).

The Department is developing integrated call center reporting requirements. The Contractor must comply with these requirements when published by the Department. The Department will provide a period of time to implement the new reporting requirements.

6 Member Communications, Marketing and Education

The Contractor must communicate and market to Members in accordance with all applicable rules under 42 CFR Parts 422 and 423 the Medicare Communications and Marketing Guidelines and all CMS

issued guidance. The Contractor is required to provide Members with all applicable materials as described in 42 CFR §§ 422.2267 and 423.2267 and Chapter 3 of the Medicare Managed Care Manual. The Contractor must communicate and market to Members in accordance with CCMC Contract requirements. See Section 4.0, *Member Services and Communications*, of the CCMC Contract. In every instance where the CCMC Contract requirements conflict with requirements within 42 CFR §§ 422 and 423 as well as all CMS issued Medicare Communications and Marketing Guidelines, the Contractor must follow the CFR and CMS guidelines.

6.1 Member Materials

The Department considers “member materials” to be any communication (Summary of Benefit document, letter, email, etc.) sent to existing members.

The Contractor is required to cobrand all materials provided to prospective and existing members that are created specifically for use in the Virginia market. Materials created for the national market do not require cobranding. The Contractor is encouraged to cobrand materials provided to all prospective and/or existing members using the Contractor logo, the CCMC logo and tagline “Medicare and Medicaid Working Together” or other approved tagline. The Department will review Contractor materials in accordance with this section and may request cobranding or other edits if deemed necessary.

6.1.1 Use of the Health Plan Management System

The Contractor must submit all required member communication and marketing materials (see Section 15 of this Contract) to the CMS Health Plan Management System (HPMS), including materials requiring state review only. The materials must include the Contractor’s Medicare Advantage contract ID number. If CMS review and approval is required under 42 CFR § 422.2261, the Contractor must obtain approval from both CMS and the Department before making the aforementioned materials available to enrollees or prospective enrollees. The Department will review and provide approval or disapproval of the materials requiring **state review only** no later than thirty (30) days after the Contractor submits the materials in HPMS. The Department will review materials requiring both CMS and Department review within the prescribed timeframe identified in HPMS. If the Contractor needs expedited review of any materials they should contact the Department via an email to dsnp@dmas.virginia.gov to request a review.

6.1.2 Required Integrated Materials

In accordance with 42 CFR § 422.107(e)(ii), the Contractor must use the templates provided by the Department and CMS for the following documents:

1. Summary of Benefits;
2. List of Covered Drugs/Formulary;
3. Pharmacy and Provider Directory; and
4. Member Identification Card.

Additionally, as an AIP, the Contractor must also use CMS’ Coverage Decision Letter which can be found [here](#). See Section 5.2, *Integrated Appeals and Grievances*.

6.2 Marketing and Education

As this Contract requires the Contractor to operate as an AIP with exclusively aligned enrollment, the Contractor must comply with CCMC Contract Section 4.4, *Marketing Requirements*.

Marketing or education activities that are intended for the general public and are generally designed to make people aware of the D-SNP, such as TV commercials and billboards, cannot include the CCMC logo.

6.2.1 Requirements For Enrollment Brokers/Agents

A broker/agent is a trained insurance professional who helps individuals enroll in the D-SNP. Brokers/Agents may be employees of the Contractor or a subcontractor of the Contractor including those that represent several insurance companies.

All brokers/agents must complete the Department's enrollment broker video training prior to working in Virginia. The broker/agent must complete updated trainings in order to ensure they are aware of important policy changes that may affect members. The Contractor must ensure each broker has completed the training and, upon request, must provide proof of completion to the Department.

The Department will update the enrollment broker training for the upcoming plan year on an annual basis if needed, and will make the video available to view online at the DMAS YouTube channel. The Department will provide the Contractor with the active link to the updated training video each year when it becomes available. The Contractor must ensure all Brokers/Agents complete the updated trainings prior to selling the Contractor's D-SNP products for the coming contract year. If no updates are needed to the video training for the coming plan year, the Department will notify the Contractor accordingly. If the training video has not been updated, brokers must view the existing video prior to selling the Contractor's D-SNP products for the coming contract year.

The Contractor is required to track member satisfaction with the enrollment process. At a minimum, this will include Member's satisfaction by agent type (Contractor employee and independent agent, as an example). See reporting requirements in the D-SNP Technical Manual.

7 Miscellaneous

7.1 Contract Oversight and Compliance

7.1.1 External Quality Review Organization (EQRO) Activities

Since the Contractor is required under this Contract to integrate the delivery of Medicare and Medicaid services and benefits with its affiliated CCMC health plan, the Contractor is subject to external independent reviews by the Department's EQRO. The Contractor must submit requested information from the Department and/or EQRO for all federally mandated and optional EQRO tasks according to 42 CFR § 438.358, including but not limited to Performance Measure Validation, Performance Improvement Projects, and Comprehensive or Modified Operational Systems Reviews as described in Section 10.11, *EQRO Quality Activities* of the CCMC contract by the due date provided by the EQRO or as communicated by the Department. If an extension is required, the request must be made by the Contractor to the Department at least one (1) week prior to the requested due date unless otherwise agreed to by the Department.

7.1.2 D-SNP Improvement Plan

The Contractor is subject to performance evaluation by the Department. Performance reviews may be conducted at the discretion of the Department upon reasonable prior written notice to the Contractor and may relate to any responsibility and/or requirement of the Contractor under this Contract.

If, at any time, the Department reasonably determines that the Contractor is deficient in the performance of its obligations under this Contract, the Department may require the Contractor to develop and submit a D-SNP Improvement Plan (DIP) that is designed to correct such deficiencies. The DIP gives the Contractor the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and State/Federal regulations. The Department will approve, disapprove, or require modifications to the DIP based on its reasonable judgment as to whether the DIP will correct the deficiency.

Failure to implement the DIP may subject the Contractor to termination of the Contract by the Department as described in Section 1.6, *Contract Termination* of this Contract.

7.2 Quarterly Meetings

The Contractor must participate in individual and group (all contracted D-SNPs) quarterly meetings with the Department. The Department will set the dates of these meetings and the Contractor and Department will collaborate in developing the meeting agenda. The Contractor must ensure the appropriate staff attend the meeting based on the agenda item(s) discussed at the meeting.

7.3 Member Advisory Committee

In accordance with 42 CFR § 422.107(f), the Contractor must establish and maintain one (1) or more enrollee advisory committees. The advisory committee must, at a minimum, solicit input on ways to improve access to covered services, coordination of services, and health equity among underserved populations. The Contractor must invite the Department's D-SNP leads to the advisory committee meetings.

The enrollee advisory committee must include at least a reasonably representative sample of the population enrolled in the D-SNP or D-SNPs, or other individuals representing those enrollees, and solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations.

The Contractor must ensure staff with Medicaid expertise in Medicaid services attend and participate in the advisory committee meetings. At a minimum, the Contractor staff must include, but not be limited to, staff with Medicaid expertise in Medicaid only mental health services, Medicaid only substance use disorder services, and LTSS.

7.4 Covered Services

7.4.1 Medicaid Covered Services

The Contractor is not responsible for the provision or reimbursement of any Medicaid benefits. Medicaid benefits will be provided and reimbursed by the Department or through a separate contract.

The Contractor is required to maintain knowledge and familiarity with current Medicaid covered services as described in Section 12.0, of this Contract, *Covered Services Chart*, and through ongoing review of state laws, rules, policies, health plan contracts, guidance as well as through information posted on its website.

7.4.2 Cost Sharing Protections

The Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the Virginia State Plan for Medical Assistance.

The Contractor must ensure that its contracts with participating providers contain provisions that require such participating providers to accept the Contractor's payment as payment in full, or bill the appropriate Medicaid health plan for additional payments that may be reimbursed under Medicaid through the Virginia State Medicaid plan.

7.4.3 Enhanced Benefits

The Contractor must integrate and coordinate the creation and delivery of enhanced benefits with its affiliated CCMC health plan. The Contractor must report to the Department a comprehensive list of enhanced benefits offered through this Contract no later than October 1st each year. The Contractor must meet the following criteria:

1. The Contractor cannot offer the same enhanced benefit through this Contract that is offered through the CCMC Contract but can offer enhanced benefits that complement enhanced benefits offered through the CCMC Contract.
 - a. For example, if the Contractor's affiliated CCMC plan offers two (2) routine dental cleanings per year as an enhanced benefit, the Contractor cannot offer two (2) routine dental cleanings through this Contract. However, the Contractor could offer \$500 towards dentures.
2. The Contractor cannot offer an enhanced benefit that is a covered service under the CCMC Contract unless the enhanced benefit is designed to extend services that are limited in amount, duration or scope.
 - a. For example, since the CCMC Contract covers Non-Emergency Transportation Services (NEMT) the Contractor cannot offer NEMT as an enhanced benefit unless the enhanced benefit covers a greater distance, covers trips to places not allowed under CCMC (grocery store, church, etc.), or covers forms of transportation that aren't covered under CCMC.
 - b. To offer an additional example, the CCMC Contract covers respite services for certain Members but is limited to 480 hours per Member per year. The Contractor could offer additional hours to eligible individuals as an enhanced benefit through this Contract. However, if the Contractor does extend service limits beyond the CCMC amount, duration or scope, the Contractor must exhaust the Medicare enhanced benefit before utilizing the CCMC coverage.

7.5 DMAS Obligations

7.5.1 Benefit Information

The Department will provide the Contractor with information regarding the services offered under the Virginia State Plan and Medicaid Managed Care on an annual basis. The latest table of these services can be found in Attachment E of the CCMC Contract and is also included in this document as Section 12.0, *Covered Services Chart*.

7.5.2 Financial Responsibility

The Department, or its contractors, must retain financial responsibility for applicable Medicaid cost sharing obligations including premium payments, coinsurance and/or copayments to healthcare providers. The State's obligation must be no greater than it would be if Members were not enrolled in the Contractor's D-SNP.

7.5.3 Medicaid Provider Information

Upon request of the Contractor, the Department will provide the Contractor with information on Medicaid provider participation on an annual basis.

8 Definitions and Acronyms

Listed below are the Definitions and Acronyms used in this Contract. The following terms, when used in this Contract, must be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, other sections of this Contract, or sections of the CCMC Contract, the specific language in this Contract (the Cardinal Care Dual-Eligible Special Needs Plan Contract – FBDE) must govern.

8.1 Definitions

Acceptance – The written acknowledgement by The Department of successful delivery and performance by the Contractor of its contractual commitments at the location(s) designated in the applicable order or Statement of Work (“SOW”), including completed and successful acceptance testing in conformance with the Requirements as determined by The Department and set forth in the applicable order or SOW.

Accreditation – The process of evaluating an organization against a set number of measures of performance, quality, and Outcomes by an industry recognized 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. Also see Instrumental Activities of Daily Living (IADLs).

Acute Care – Preventive care, Primary Care, and other inpatient and outpatient medical care and behavioral health care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital – Includes an acute care Hospital, a rehabilitation Hospital, a rehabilitation unit in an acute care Hospital, or a psychiatric unit in an acute care Hospital.

Addiction and Recovery Treatment Services (ARTS) – A comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. This includes:

1. Inpatient services to include withdrawal management services;
2. Residential treatment services;
3. Partial hospitalization;
4. Intensive outpatient treatment;
5. Outpatient treatment including Medication Assisted Treatment (MAT);
6. Substance use Case Management;
7. Opioid use treatment service; and
8. Peer recovery support services.

Providers will be credentialed and trained to deliver these services consistent with ASAM’s published criteria and the Department’s Medical Necessity criteria using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

Administrative Transitions – The process of assisting a Member with a transition to a different MCO, between Managed Care and FFS (including transitions that result in Disenrollment from Managed Care), and/or between Providers upon a Provider’s termination from an MCO’s network.

Adoption Assistance (AA) – A social services program, under Title XX of the Social Security Act, that provides the adoptive parents with the necessary assistance to adopt and care for the child who has special needs and who meets eligibility criteria. It is not intended to cover the full cost of raising the child. Rather, it supplements the resources of the adoptive parents.

Adult Day Health Care (ADHC) Services – 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 waiver individuals who are elderly or who have a disability and who are at-risk of placement in a Nursing Facility. ADHC Centers are federal, state or local licensed or approved centers which provide day care services to waiver individuals who are elderly or who have a disability and who are at-risk of placement in a Nursing Facility.

Agency-Directed (AD) 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.

Ameliorate – To make better or more tolerable.

American Indian/Alaska Native – An individual, defined at Title 25 of the U.S.C. Sections 1603(c), 1603(f), 1679(b) who has been determined eligible, as an Indian, pursuant to 42 CFR §136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian Health Care Providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services. Also refer to the population referenced in 42 CFR §438.14.

Annual – For the purposes of this Contract, occurring once every year. **Appeal** – Means:

1. For Members, in accordance with 42 CFR § 438.400, a Member appeal is defined as a request to the Department for a State Fair Hearing of a Contractor’s Internal Appeal decision to uphold the Contractor’s Adverse Benefit Determination. After a Member exhausts the Contractor’s one-step Internal Appeal process, the Member may appeal to the Department. Member appeals to the Department will be conducted in accordance with regulations at 42 CFR §431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
2. For Providers, a Provider appeal is a request made by a Provider (in-network or Out-of-Network) to review the Contractor’s Reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a Provider exhausts the Contractor’s Reconsideration process, Virginia Medicaid affords the Provider the right to two (2) administrative levels of appeal (informal appeal and formal appeal) with the Department in accordance with the Virginia Administrative Process Act, Code of Virginia § 2.2-4000 et seq., and Virginia Medicaid’s Provider appeal regulations, 12 VAC 30-20-500 et seq.

Applicable Law – Without limitation, all Federal and State law, and the regulations, policies, procedures, and instructions of CMS and the Department all as existing now or during the term of this Contract.

Applicable Integrated Plan (AIP) – According to 42 CFR § 422.561::

1. A fully integrated dual-eligible special needs plan with exclusively aligned enrollment or a highly integrated dual-eligible special needs plan with exclusively aligned enrollment, and
2. The Medicaid MCO, as defined in Section 1903(m) of the Act, through which such dual-eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual-eligible special needs plan and such Medicaid MCO.

Applied Behavior Analysis (ABA) – Means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Assertive Community Treatment (ACT) – Means intensive nonresidential treatment and rehabilitative mental health services provided in accordance with the fidelity model of ACT. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation and support needs for clients with Serious Mental Illness (SMI) whose needs have not been well met by more traditional service delivery approaches.

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 person-centered Individualized Care Plan (ICP) and the determination of whether an individual requires HCBS waiver services.

Assistive Technology (AT) – 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 medical needs and deficits. Assistive Technology items are expected to be portable.

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 eighteen (18) years of age or older. Parents and other caretaker relatives are able to act on behalf of persons under eighteen (18) years of age.

Bachelor’s-Level Social Worker (BSW) – A person who holds a Bachelor’s degree from an accredited school of social work. Individual is not currently licensed and may or may not be working toward meeting licensure requirements.

Behavioral Health Inpatient Services – Acute psychiatric or substance use disorder treatment services provided to Members in a psychiatric unit of a general Acute Care Hospital, a free-standing psychiatric setting (state or private).

Behavioral Health Outpatient Services – Non-acute psychiatric services that are provided to Members in a variety of non-facility-based settings including community settings.

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

Building Independence (BI) Waiver – The CMS-approved HCBS § 1915(c) waiver whose purpose is to provide support in the community for individuals eighteen (18) years of age or older who live in their own homes/apartments with BI waiver supports. Services may be complemented by non-waiver funded rent subsidies and/or other types of support. The Building Independence Waiver is administered collaboratively by the Department and DBHDS.

Birth Injury Fund – Virginia Birth-Related Neurological Injury Compensation Fund is commonly known as the Birth Injury Fund. More information can be found on the Virginia Department of Health website.

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 CFR §160.103.

Business Days or “Days” – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Time, except for Legal Holidays and unless otherwise stated.

Capitation Payment – A payment the Department makes periodically to the Contractor on behalf of each Member enrolled under the Contract for the provision of services under the State Plan or waivers, regardless of whether the Member receives services during the period covered by the payment. Any and all costs incurred by the Contractor in excess of the Capitation Payment must be borne in full by the Contractor.

Capitation Rate – The monthly amount, payable to the Contractor, per Member, for the provision of contract services as defined herein. The Contractor must 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 and all administrative costs associated therewith, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

Cardinal Care Managed Care (CCMC) – The program name for Virginia’s mandatory integrated Medicaid Managed Care program. Cardinal Care Managed Care replaces Virginia’s current Medicaid Managed Care programs, Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus. Also referred to in this contract ‘Medicaid Managed Care Program’ and ‘Managed Care program’.

Cardinal Care Technical Manual – A document developed by the Department that provides the technical specifications for the submission of Encounters and other Contract deliverables, including Monthly, quarterly, annual, and other required reports from MCOs. In addition, it supplies technical information on Enrollment and payment files, Department-generated files, and Departmental processes such as the processing of incarcerated Members and the reconciliation of payments for newborn Members.

Case Management – As described in the Social Security Act, § 1915(g)(2), case management services include those assisting individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred. Payments for case management services may not duplicate payments made to public agencies under other program authorities for the same service.**Care Coordination** – The act of organizing patient care activities, available for all MCO members including those not identified for ongoing care management. Activities include ensuring an ongoing source of care, coordinating services between settings/delivery systems and conducting initial screenings in accordance 42 CFR § 438.208.

Care Management – Team-based, person-centered approach to effectively managing patients’ medical, social and behavioral conditions with consideration given to utilization trends, quality factors and provider performance.

Care Management Contacts – Instances where a Care Manager engages the Member (or their guardian/caretaker, as appropriate) in one or more Care Management interventions. Contacts that are not required to be in-person may be telephonic or via videoconference.

Care Management Intensity – Describes Level of Care Management services provided to the Member and reflects Care Manager caseload requirements, assessment modality (e.g., in-person, telephonic or via videoconference), and Care Management contact requirements.

Care Manager – Individual with primary responsibility for delivering Care Management to Members.

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

Carved-Out Services – The subset of Medicaid Covered Services for which the Contractor will not be responsible under the CCMC Managed Care Contract.

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

Children and Youth with Special Health Care Needs (CYSHCN) – Children and youth with special needs that have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child’s age. These include, but are not limited to, the children in the eligibility categories of FC and AA (aid category 076 and 072), youth who have aged out of the FC system (Aid Category 70), children identified as EI participants, Members identified as experiencing Childhood Obesity and others as identified through the Contractor’s assessment or by the Department.

Children’s Health Insurance Program (CHIP) – Insurance program established and administered by a State, jointly funded with the Federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program.

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.

Clinical Laboratory Improvement Amendments (CLIA) – A Laboratory testing program regulated by the Centers for Medicare and Medicaid Services (CMS) and implemented by the Division of Laboratory Services under the Center for Clinical Standards and Quality. CLIA covers approximately 254,000 Laboratory entities. CLIA defines a clinical Laboratory as any facility which performs Laboratory testing on specimens obtained from humans for the purpose of providing information for health assessment and for the diagnosis, prevention, or treatment of disease or impairment.

Clinical Trial (Qualifying Clinical Trial) – In accordance with [SMD # 21-005](#) this includes a Clinical Trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition, as further defined in SMD#21-005.

Code – The Code of Virginia, as in effect and amended from time-to-time.

Coinsurance – A percentage of the costs normally paid for covered services by members of a MA D-SNP. Coinsurance amounts must comply with the terms of the MA Contract.

Commonwealth or State – The Commonwealth of Virginia.

Commonwealth Coordinated Care Plus (former) Managed Care Program Participants – Individuals in the Aged, Blind and Disabled (ABD), LTSS, and Medically Complex MAGI Adult Covered Population Groups.

Commonwealth Coordinated Care (CCC) Plus Waiver – The Department’s Home- and Community-Based waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a Nursing Facility, or a prolonged stay in a hospital or specialized care Nursing Facility. The CCC Plus Waiver has two (2) benefit plans: the standard benefit plan and the technology assisted benefit plan. Individuals who are enrolled in the technology assisted benefit plan are technology dependent and have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care. Individuals in this waiver are eligible to participate in the Cardinal Care Managed Care program.

Community-Based Organization (CBO) – Local community partners that provide an array of supports to assist members with identifying and navigation through local state and federal resources. Some of the resources include social services, care management, nutrition support and supportive housing services. Partnering with CBOs is an efficient and effective means of providing essential social care benefits to health plan members, many of whom face significant structural and social barriers, including racism, poverty and isolation.

Community Living (CL) Waiver – The CMS-approved HCBS §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have DD and meet the ICF/IID Level of Care criteria. Residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs are included in this waiver.

Community Service Board (CSB)/Behavioral Health Authority (BHA) – A citizens' board established pursuant to Code of Virginia §37.2-500 and §37.2-600 that provides mental health, DD 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).

Community Stabilization – Short-term services designed to support an individual and their natural support system following contact with an initial crisis response service. Interventions may include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate

natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services.

Complaint – An expression of Provider dissatisfaction about any matter other than an Adverse Action. Possible subjects for complaints include, but are not limited to, Claims or Service Authorization processing time, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Contractor staff or employee, or failure to respect the Member’s Grievance.

Comprehensive Care Review (CCR) – An assessment completed by the Contractor for Members in the Mandatory High Priority and Mandatory Populations in circumstances where an HRA is not required. A CCR consists of review of the Member's conditions and diagnoses, current needs and services, identified risks, concerns related to nonadherence, access to care and contradictory provider treatment plans and Contractor recommendations and the CCR must also include the sources of information the Contractor used to develop the CCR. See Section 4.5.5, *HRA When Member Refuses* of this Contract and Section 8.5.5.2 of the CCMC Contract, *CCR Data Sources* for more information.

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 a CCC Plus HCBS waiver individual who is receiving services through the CD model or their representative to provide approved personal care, companion services, or respite care, or any combination of these three (3) services, and who is exempt in Virginia from Workers’ Compensation.

Consumer-Directed (CD) Services – HCBS (Personal Care and Respite Services) for which the CCC Plus HCBS waiver individual or his or her 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 CCC Plus HCBS waiver Member or his or her representative, as appropriate, by ensuring the development and monitoring of the ICP, providing attendant management training, and completing ongoing review activities as required by the Department for CCC Plus HCBS waiver Members who are consumer-directing Personal Care and Respite Services.

Continuity of Care – Activities to ensure a Member’s safe and effective transitions that do not result in a disruption of care between Medicaid fee-for-service, Managed Care contractors, and/or contracted providers. **Contract** – This signed and executed D-SNP program document issued, including all Attachments or documents incorporated by reference.

Contract Amendment or Contract Modification – Any changes, modifications or amendments to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations. **Contractor** – By execution of this Contract as a Dual Eligible Special Needs Plan (D-SNP), is contracted with CMS as a Medicare Advantage health plan to provide Medicare part A, B and D benefits to individuals who are dual eligible for both Medicare and Medicaid, and is also contracted with the Department of Medical Assistance Services to provide services

under the Cardinal Care Managed Care program. The Contractor is not required to be the same “single entity” or “legal entity” that is contracted with the Department for the Cardinal Care Managed Care program but must be owned by the same parent organization. **Co-payments** – Fixed dollar amounts that a MA Health Plan Member normally must pay for a medical service provided under a Medicare Advantage Product. Co-payments amounts must comply with the terms of the MA Contract.

Cost Sharing – A global term that encompasses Coinsurance, Deductibles, patient pay, and Copayments. **Coverage Decision Letter (CDL)** – Describes the actions required by the enrollee and the enrollee's rights in the unified appeals process, including the date the determination was made, the date the determination will take effect, and language on continuation of benefits during appeal, as required under 42 CFR § 422.631.

Covered Services – Services that the Contractor must cover for its enrolled Members.

Credentialing / Recredentialing – 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 Support Services – Services designed for individuals experiencing circumstances such as

1. Marked reduction in psychiatric, adaptive, or behavioral functioning;
2. An increase in emotional distress;
3. Needing continuous intervention to maintain stability; or
4. Causing harm to themselves or others.

Crisis Support Service means intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention, and crisis stabilization for an individual who is experiencing an episodic behavioral or psychiatric event in the community that has the potential to jeopardize the current community living situation. This service is designed to prevent the individual from experiencing an episodic crisis that has the potential to jeopardize his current community living situation, to intervene in such a crisis, or to stabilize the individual after the crisis. This service must prevent escalation of a crisis, maintain safety, stabilize the individual, and strengthen the current living situation so that the individual can be supported in the community beyond the crisis period.

Critical Incident – A Critical Incident is any actual or alleged event or situation that threatens or impacts the physical, psychological, or emotional health, safety, or wellbeing of the Member. Critical Incidents include, but are not limited to, the following incidents: medication errors, theft, suspected physical, mental, verbal or sexual abuse or neglect, financial exploitation, and Sentinel Events.

Cultural Competence – The ability of health care Providers and health care organizations to understand and respond effectively to a patient's cultural health beliefs, preferred languages, health literacy levels and communication needs.

Days - Business days, unless otherwise specified.

Deductible – Fixed dollar amounts that a MA D-SNP Member normally must pay out-of-pocket before the costs of services are covered by the Contractor. Deductibles must comply with the terms of the MA Contract.

Default Enrollment – An Enrollment process that permits the automatic Enrollment of a newly eligible dually-eligible beneficiary into a D-SNP if the Enrollee is enrolled in an affiliated Medicaid Managed Care Plan and will remain enrolled in an affiliated Managed Care Plan upon becoming Medicare eligible.

Department of Behavioral Health and Developmental Services (DBHDS) – The state agency responsible for coordination of behavioral health, developmental disabilities, and substance use services through the local community services boards (CSBs). This agency has responsibility for the day-to-day operations of the Community Living (CL) Waiver, Family and Individual Supports (FIS) Waiver, and the Building Independence Waiver. DBHDS also serves as the state Lead Agency for Virginia’s EI system and is responsible for certification of EI Providers and service coordinators/case managers.

Department of Medical Assistance Services (DMAS / 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.

Developmental Disability (DD) Waivers – The CMS-approved HCBS §1915(c) waivers for individuals with developmental disabilities. The individuals are enrolled in either the Building Independence (BI), Community Living (CL), or the Family and Individual Supports (FIS) Waivers.

Disease Management – System of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.

Disenrollment – The process of changing Enrollment from one (1) Contractor to another. This term does not refer to termination of eligibility in a Medicaid program.

Doula or “Community-Based Doula” – An individual based in the community who is trained to provide extended, culturally congruent support to families throughout pregnancy to include antepartum, intrapartum, during labor and birth, and up to one (1) year postpartum. Community-based doulas provide an expanded set of services and play a crucial role in improving Outcomes and experiences for communities most affected by discrimination and disparities in health Outcomes.

D-SNP Improvement Plan (DIP) – A plan with structures, processes, and related activities designed to correct deficiencies performed by the Contractor which are determined by the Department. Improvements are achieved by the Contractor analyzing and identifying the root causes of the identified findings, observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and State/Federal regulations.**Dual Eligible Individuals** – Individuals who are eligible for coverage from Medicare (Medicare Part A, Part B, or both) and Virginia Medicaid. (See Full Benefit Dual Eligible and Partial Benefit Dual Eligible).

Dual Eligible Special Needs Plan (Also “MA Special Needs Plan”) (D-SNP, or MA D-SNP) – A type of Medicare Advantage (MA) plan that only enrolls individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX). (See definition for Contractor.)

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – A benefit under the Social Security Act that includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under twenty-one (21) years of age. EPSDT also requires coverage of services, products, or procedures for children, if those items are determined to be Medically Necessary to “correct or Ameliorate” a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service under the State Plan. **Early Intervention (EI) Services** – Provided through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR §440.130(d). EI services are designed to meet the developmental needs of children and families and to enhance the development of children from birth through the day before the third (3rd) birthday who have:

1. A twenty-five percent (25%) developmental delay in one (1) or more areas of development;
2. Atypical development; or
3. A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

Per 12 VAC 35-225-70 children are not eligible to receive EI services on or after their third (3rd) birthday. EI Services provided in the child's natural environment to the maximum extent appropriate. EI services are covered by this Contract.

Early Intervention Individualized Family Service Plan (IFSP) – A written plan developed by the Member’s interdisciplinary team for providing EI supports and services to eligible children and families that:

1. Is based on evaluation for eligibility determination and assessment for service planning;
2. Includes information based on the child's evaluation and assessments, family information, results or Outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or Outcomes; and
3. Is implemented as soon as possible once parental consent is obtained.

The IFSP requires a physician signature for the initial IFSP, annual IFSP and anytime a service is added or services change (as determined through the IFSP Review process). Medical Necessity is established by the IFSP combined with physician certification and must serve as the authorization for the identified EI Services. No additional Service Authorizations must be required for EI services.

Emergency Custody Order (ECO) – 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 CFR §441.150 and Code of Virginia, § 16.1- 335 et seq, § 37.2-808, § 16.1-340 (Juvenile), § 37.2-1103 (Medical), and § 16-1.340 (Court). 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 Department Care Coordination – Real time communication and collaboration among Hospital Emergency Departments, physicians, other health care Providers, and Health Plan clinical and Care Management personnel to improve Outcomes for populations with high utilization of EDs as

required by state law through the Virginia Emergency Department Care Coordination Program. **Emergency Medical Transportation** – Medically Necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.

Emergency Room (also known as “Emergency Department”) – A Hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency Services – Covered inpatient and outpatient services that are:

1. Rendered by participating or Non-Participating Providers qualified to furnish these services; and
2. Needed to evaluate or stabilize an emergency medical condition pursuant to 42 CFR §438.114.

Encounter – Any covered or enhanced service received by a Member through the Contractor or its Subcontractor.

Encounter Data – Data collected by the Contractor that documents all of the health care and related services provided to a Member. These services include, but are not limited to, professional services, medical supplies or equipment, and medications. Encounter data is collected on an individual Member level and includes the person’s Medicaid ID number. It is also specific in terms of the Provider, the medical procedure, and the date the service was provided. The Department 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.

Enhanced Benefits or Services – Services offered by the Contractor to Members in addition to services covered by this Contract. The Department will not pay for Enhanced Services.

Enrollment – The completion of approved Enrollment forms by or on behalf of an eligible person and assignment of a Member to an MCO by the Department in accordance with the terms of this Contract.

Enrollment Broker – An independent entity who enrolls Members in the Health Plan and who is responsible for the operation and documentation of a toll-free Member service helpline. The responsibilities of the Enrollment Broker include, but are not limited to: Member education and Enrollment, assistance with and tracking of Member’s Grievance resolution, and may include Member Marketing and outreach.

Enrollment Period – The period of time that a Member is enrolled with a Health Plan.

Excluded Services – Services that are not covered under the Medicaid benefit.

External Quality Review (EQR) – Analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a MCO or their contractors furnish to Medicaid Members, as defined in 42 CFR §438.320.

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

Family and Individual Supports (FIS) Waiver – The CMS-approved HCBS§1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have a DD and meet the ICF/IID Level of Care criteria. This waiver supports children and adults living with families, friends, or in their own homes, including supports for those with some medical or behavioral needs.

Family Planning – Services that delay or prevent pregnancy. Coverage of such services must not include services to treat infertility or services to promote fertility. Family Planning services must not cover payment for abortion services and no funds will be used to perform, assist, encourage, or make direct referrals for abortions.

FAMIS Children – Comprehensive health coverage for uninsured children ages 0 – 18 not eligible for Medicaid, with family income at or below two hundred percent (200%) of the FPL (plus a five percent (5%) disregard). FAMIS is the Commonwealth’s CHIP program, also referred to as Title XXI, administered by the Department and jointly funded by the state and federal governments.

FAMIS MOMS – FAMIS MOMS are uninsured, pregnant and postpartum Members of any age, ineligible for Medicaid, with family income at or below two hundred percent (200%) of the federal poverty level (plus a five percent (5%) disregard). FAMIS MOMS is part of Virginia’s CHIP program and authorized under a Section 1115 CHIP waiver. The benefit package is aligned with that of Medicaid pregnant individuals.

FAMIS Select Program – FAMIS Select is a voluntary component for families that have access to Health Insurance through their employer.

Fee-for-Service (also “Medicaid Fee-For-Service” or “Cardinal Care Fee-For-Service”) – The traditional health care payment system in which physicians and other Providers receive a payment for each unit of service they provide. This method of reimbursement is not used by the Department to reimburse the Contractor under the terms of this Contract.

Former Foster Care (FFC) or Former Foster Care Youth (FFCY) – For the purposes of this Contract, these individuals are enrolled in Aid Category 70. Depending on which group (Title IV-E or Non IV-E), their eligibility ranges from age eighteen (18) to twenty-six (26). These individuals were formerly covered under a FC designation. Refer to Section 3.6, *Foster Care and Adoption Assistance (AA) Enrollment and Health Plan Selection*.

Formulary – A list of drugs that the MCO has approved. Prescribing some of the drugs may require Service Authorization. The Department has developed a Preferred Drug List (PDL) that must be a subset of the Contractor’s Formulary that includes all the preferred drugs from the Department’s Preferred Drug List (PDL).

Foster Care (FC) – Pursuant to 45 CFR §1355.20, a twenty-four (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 FC. 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 the 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 FC. Pursuant to the Affordable Care Act, Virginia must provide Medicaid coverage to additional FC individuals (formerly Title IVE or non-Title IV-E) when the following conditions occur: the individual was under the responsibility of a Virginia-based FC agency and receiving Medicaid until discharged from FC upon turning twenty-one (21) years, the individual is not eligible for Medicaid in another mandatory Medicaid covered group, and the individual is under age twenty-six (26) years.

Foster Care Population – Includes Members under age twenty-one (21) who are in FC, (designation code 076); Members under age twenty-six (26) who were formerly in FC until their discharge from FC at age eighteen (18) or older, (designation code 070) or Members under age twenty-one (21) who receive AA (designation code 072).

Fostering Futures – Virginia’s program that implements provisions of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 that permit states to utilize federal title IV-E funding to provide FC maintenance payments and services and AA for youth ages eighteen (18) to twenty-one (21). The program offers services and support to youth transitioning to adulthood and self-sufficiency regardless of funding source.

Full Benefit Dual Eligible (FBDE) – A Medicare beneficiary who receives Medicare Part A, B, and/or D benefits and who also receives full Medicaid benefits (e.g., QMB Plus/Extended and SLMB Plus/Extended). **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)** – As defined in 42 CFR § 422.2, is a dual eligible special needs plan:

1. That provides eligible enrollees access to Medicare and Medicaid benefits under a single entity that holds both this Contract with CMS and the [CCMC Contract](#) for Medicaid managed care in Virginia,
2. That possesses the CCMC Contract with the Department that includes coverage of the following benefits to individuals eligible to enroll in this FIDE SNP in Virginia:
 - a. Primary care and acute care including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries;
 - b. LTSS, including coverage of nursing facility services for a period of at least 180 days during the plan year;
 - c. Behavioral health services;
 - d. Home health services as defined in § 440.70; and
 - e. Medical supplies, equipment, and appliances, as described in § 440.70(b)(3)
3. That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries (See Section 4.0, *Integrated Model of Care*, of this Contract);
4. That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, and quality improvement (See Sections 5.0, *Medicare-Medicaid Coordination Requirements*, Section 6.0, *Member*

Communications, Marketing and Education, and Section 7.1, Contract Oversight and Compliance, of this Contract);

5. That integrates appeals and grievances in accordance with 422.629 – 422.634, 438.210, 438.400, and 438.402;
6. That operates with exclusively aligned enrollment; and
7. Whose CCMC contract with the Department covers the entire service area as this D-SNP (The Contractor cannot operate in a locality where they do not meet Medicaid network standards).

Functional Family Therapy (FFT) – A short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including cooccurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT is a primarily home-based service that addresses both symptoms of Serious Emotional Disturbance in the identified youth as well as parenting/caregiving practices and/or Caregiver challenges that affect the youth and Caregiver’s ability to function as a family.

Grievance – In accordance with 42 CFR §438.400, a Grievance means an expression of dissatisfaction about any matter other than an Adverse Action or Adverse Benefit Determination. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member’s rights.

Guardian – An adult who is legally responsible for the care and management of a minor child or another adult.

Habilitation Services and Devices – Services and devices that help an individual keep, learn, or improve skills and functioning for daily living.

Healthcare Effectiveness Data and Information Set (HEDIS®) – A tool developed and maintained by the National Committee for Quality Assurance (NCQA) that is used to measure performance on dimensions of care and service in order to maintain and/or improve quality.

Health Disparities – Fair and just opportunities to be as healthy as possible, requiring reducing and eliminating disparities in health and its determinants adversely affecting excluded or marginalized groups that have been excluded or marginalized, including poverty, discrimination, and their consequences, including powerlessness, lack of access to good jobs with fair pay, quality education and housing, and safe environments.

Health Insurance – Type of insurance coverage that pays for health, medical and surgical expenses incurred by the member.

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

Health Record – Any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health Record" also includes the substance of any communication made by an

individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual. (Code § 32.1-127.1:03).

Health Related Social Needs (HRSN) – Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and Outcomes.

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 supports (LTSS), and social needs. The HRA is used as a tool in Care Management to assist in the development of the Member’s comprehensive person-centered Individualized Care Plan (ICP).

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP) – As defined in 42 CFR § 422.2, is a dual eligible special needs plan offered by an MA organization that provides coverage, consistent with State policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements: (1) The capitated contract is between the MA organization and the Medicaid agency; or (2) The capitated contract is between the MA organization’s parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency.

Home- and Community-Based Services (HCBS) Waivers – A variety of home- and community-based services authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be authorized to receive one (1) or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutional (Nursing Facility) placement. The 1915(c) waivers are one (1) of many options available to states to allow the provision of long-term care services in home- and community-based settings under the Medicaid program. States can offer a variety of services under a HCBS waiver. Waivers can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Home Health Care – Health care services a person receives in the home including nursing care, home health aide services and other services.

Homeless – In accordance with 42 U.S.C., 254b, an individual experiencing homelessness is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Hospice – As defined in § 32.1-162.1 of the Code of Virginia, a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable Hospice administration providing palliative and supportive medical and other health services to terminally ill

patients and their families. Children under twenty-one (21) years of age are permitted to continue to receive curative medical services even if they also elect to receive Hospice services. A Hospice utilizes a medically directed interdisciplinary team. A Hospice program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. Hospice care must be available twenty-four (24) hours a day, seven (7) calendar days a week.

Hospital or Health System – A facility that meets the requirements of 42 CFR §482, as amended.

Indian Health Care Provider (IHCP) – Per 42 CFR § 438.14, a health care program, including tribal clinic Providers and Providers of contract health services (CHS), operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603). Also refer to definition of AI/AN.

Individualized (Person-Centered) Care Plan (ICP) – The Contractor’s comprehensive written document developed with a Member that specifies the Member’s services and supports (both formal and informal). The ICP is developed through a person-centered planning process that incorporates the Member’s strengths, skills, needs, preferences, and goals. 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.

Individuals with Disabilities Education Act – Early Intervention Services or “IDEA” or “IDEA-EIS” – A program (as described in 20 U.S.C. § 1471 and 34 CFR §303.12) administered by the Virginia Department of Behavioral Health and Developmental Services. EI Services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one (1) or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development.

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.

Institution for Mental Disease (IMD) – In accordance with 42 CFR §435.1010, an IMD is a Hospital, Nursing Facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An Institution for Mental Disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, and whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an Institution for Mental Disease. An IMD may be private or state-run. A State Institution for Mental Disease or State Mental Hospital is a Hospital, psychiatric institute, or other institution operated by the DBHDS that provides care and treatment for persons with mental illness. See also the definition for “State Institution for Mental Disease or State-run IMD or State Mental Hospital”.

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. Also see Activities of Daily Living (ADLs).

Integrated Reconsideration - A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under 422.580 and appeal under 438.400 of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in 422.629 and 422.632 through 422.634.

Intensive In-Home Services (IIH) for Children/Adolescents Under Age Twenty-One (21) – Time-limited interventions provided in the Member'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 a Member 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 Member.

Intensive Outpatient Services (ASAM Level 2.1) – A structured program of skilled treatment services for adults, children, and adolescents delivering a minimum of three (3) service hours per service day for adults to achieve an average of nine (9) to nineteen (19) hours of services per week and a minimum of two (2) service hours per service day for children and adolescents to achieve an average of six (6) to nineteen (19) hours of services per week. Withdrawal management services may be provided as necessary. 12VAC30-130-5090.

Interdisciplinary Care Team (ICT) – A team of professionals that collaborate, either in-person or through other means, to develop and implement a person-centered Individualized Care Plan (ICP) built on the individual's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity and meets the medical, behavioral, LTSS, early intervention, and social needs of Members. ICTs include the MCO Care Manager and may include physicians, physician assistants, LTSS providers, nurses, specialists, pharmacists, behavior health specialists, early intervention Care Manager/providers, social workers and other appropriate entities 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 (ICF/IID) – A facility licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to individuals with intellectual/developmental disabilities 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 Members toward the achievement of a more independent level of functioning.

Investigation – As used in this Contract 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. The Department 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 CFR §493.3, as amended.

Legal Holiday – Twelve (12) specific days of any calendar year that State offices are closed. Contractors may elect to be closed for Legal Holidays; however, it is not required. Legal Holidays do not include any additional time off that may be appropriated to State employees by the Governor or legislature.

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 or to receive CCC Plus Waiver services.

Level of Care Review – The periodic, but at least annual, review of a Member’s condition and service needs to determine whether the Member continues to need a level of care specified by a waiver. Also referred to as Level of Care Review Instrument (LOCERI). Also see the definition for nursing facility annual reassessment. For more information about LOCERI, including the Level of Care User Guide and Tutorial, is available on the Virginia Medicaid Web Portal, Provider Resources tab.

Limited English Proficient (LEP) – In accordance with 42 CFR §438.10, potential Enrollees and Enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or Encounter.

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 – A local public 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 that has enrolled with the Department as a Provider of Local Education Agency-Based Services.

Local Education Agency-Based Services – State Plan-approved health care services rendered to Member students in a school setting by qualified Providers employed or contracted by a Department-enrolled Local Education Agency Provider. Claims for these services are processed as FFS and the Local Education Agency is reimbursed using a reconciled cost-based methodology. These services are carved out of the Managed Care contracts.

Local Lead Agency (LLA) – An agency under contract with the Department of Behavioral Health and Developmental Services to facilitate implementation of a local EI system, as described in Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia.

Long-Stay Hospital (LSH) – Hospitals that provide a slightly higher Level of Care than Nursing Facilities. The Department recognizes two (2) facilities that qualify the individual for exemption as Long-Stay

Hospitals: Lake Taylor Transitional Care Hospital (Norfolk) and Hospital for Sick Children Pediatric Center (Washington, DC).

Long-Term Services and Supports (LTSS) - Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

MAGI Adults (also known as the Medicaid expansion group) – This population includes adults who are aged nineteen (19) through sixty-four (64) years of age, with incomes up to one hundred thirty eight percent (138%) of the federal poverty level (one hundred thirty three percent (133%) plus a five percent (5%) income disregard), who do not have Medicare, and who are not otherwise eligible for a Medicaid mandatory coverage group. Low-income families, qualified pregnant women and children, individuals eligible under the aged, blind, and disabled (ABD) groups are examples of mandatory eligibility groups, as described in 12 VAC 30-30-10.

Managed Care Plan or Managed Care Organization (MCO), or Health Plan – An organization which offers Managed Care Health Insurance plans (MCHIP), as defined by Code of Virginia § 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:

1. Contains one (1) 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 (1) or more Providers with respect to the delivery of health care services and
2. 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 must be deemed to be offering one (1) or more MCHIPs. For the purposes of this definition, the prohibition of Balance Billing by a Provider must 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 must encompass only one (1) Provider Network or set of Provider Networks. Additionally, for the purposes of this Contract, and in accordance with 42 CFR §438.2, an entity that has qualified to provide the services covered under this Contract 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 CFR §438.116.

Managed Care Program – As defined in 42 CFR §438.2, a Managed Care delivery system operated by a State as authorized under Sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

Mandatory High Priority Population – Members, as defined in Section 8.4.2 of the CCMC Contract, *Priority Populations*, whom the Contractor must assign to receive High Intensity Care Management.

Mandatory Priority Population – Members, as defined in Section 8.4.2 of the CCMC Contract, *Priority Populations*, whom the Contractor must assign to receive Care Management.

Marketing – In accordance with 42 CFR §438.104 means any communication, from an MCO to a Medicaid Member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the Member to enroll in that particular MCO's Medicaid product, or either to not enroll in or to disenroll from another MCO's Medicaid product.

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.

Master's-Level Social Worker (MSW) – Person who holds a Master's degree from an accredited school of social work. Individual is not currently licensed and may or may not be working toward meeting licensure requirements.

MCO-Determined Priority Population – Members, as defined in Section 8.4.2, *Priority Populations*, whom the Contractor must assign to receive either Care Management or Care Coordination, at the Contractor's discretion.

MCO Member Health Screening (MMHS) – A two-part questionnaire developed by the Department that all newly enrolled Cardinal Care Members must receive. Results from completed questionnaires provide initial insight on Members entering the program and the associated population, and identifies opportunities for supports, offering potential clinical pathways to improved health Outcomes.

Medicaid Enterprise System (MES) – The Department's modernized technology system which will replace the current Medicaid Management Information System (MMIS).

Medicaid Management Information System (MMIS) – The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.

Medicaid Member or "Member" – Any individual enrolled in the Virginia Medicaid program.

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

Medically Complex MAGI Adult – Individuals eligible in a MAGI adult aid category, i.e., 100, 101, 102, or 103, who receive LTSS, or are a former Governor's Access Plan (GAP) participant, or have a complex medical or behavioral health condition and a functional impairment, or who have an intellectual or DD.

Medically Needy – Individuals who meet Medicaid covered group requirements, but have excess income. A Medically Needy determination requires a resource test and includes pregnant women, children under the age of eighteen (18), FC and AA, and those in ICF/IIDs up to age twenty-one (21), ABD up to age twenty-one (21). Parents and caretaker relatives do not qualify under Medically Needy.

Medically Necessary or Medical Necessity – 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 twenty-one (21)), and federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

Medication Monitoring – An electronic device 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 Title XVIII of the Social Security Act – The Federal health insurance program for people age sixty-five (65) or older, people under sixty-five (65) with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A provides coverage of inpatient Hospital services and services of other institutional Providers, such as skilled Nursing Facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers Physician Services, outpatient services, some Home Health Care, Durable Medical Equipment (DME), and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare Member with the option of receiving Part A and Part B services through a private Health Plan. Medicare Part D provides outpatient prescription drug benefits.

Medicare Advantage – Sometimes referred to as “MA Plans,” includes 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 Advantage (MA) Contract – The Medicare Advantage Plan Contract between the MA Health Plan and CMS to provide MA Dual-Eligible Special Needs Plan.

Medicare Advantage Dual Eligible Special Needs Plan or “MA Special Needs Plan” (MA D-SNP) – A Medicare Advantage Health Plan contracted with CMS to provide Medicare Part A, B and D benefits to beneficiaries who are dually eligible for Medicare and Medicaid as defined and pursuant to this Contract. (See definition for Contractor.)

Medicare Advantage Organization - A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

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 – Enrollee or Beneficiary of the Medicaid and/or Medicare programs.

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-Intensive Outpatient (MH-IOP) – Intensive Outpatient Services (IOP) are structured programs of skilled treatment services for adults and youth focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. (State Plan Amendment and Appendix E of Mental Health Services Manual).

Mental Health Parity Addiction Equality Act (MHPAEA) – Requires that the financial requirements (such as Coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

Mental Health-Partial Hospitalization Program (MH-PHP) – Mental Health Partial Hospitalization Programs are standard, short-term, non-residential, medically-directed services for adult and youth Members who require intensive, highly coordinated, structured and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than Intensive Outpatient, Mental Health Skill Building, or Psychosocial Rehabilitation.

Mental Health Professional – In accordance with the Virginia Department of Health Professions (DHP), a Mental Health Professional is a person who by education and experience is professionally qualified and licensed by the Commonwealth to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development. See Virginia Administrative Code for more information.

Mental Health Skill-Building Assessment and Services (MHSS) – Goal directed training to enable Members to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services must include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the Member's health and safety; Activities of Daily Living (ADLs), 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 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. All Medicare and Medicaid certified Nursing Facilities were required to use the MDS 3.0.

Mobile Crisis Response – Provides rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. This service is provided twenty-four (24) hours a day, seven (7) calendar days a week.

Model of Care (MOC) – 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 Management 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 Contractor provides services that meet the needs of Members.

Monitoring – The ongoing oversight 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 Member and/or the Member’s family, as appropriate, in-person or by telephone; and/or interviewing service Providers.

Multisystemic Therapy (MST) – An intensive, evidence-based treatment program provided in home- and community settings for youth who have received referral for the treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. MST is appropriate for youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST includes engagement with the youth’s family, Caregivers and natural supports and professionals delivering interventions in the recovery environment.

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) – A national health identifier for all health care Providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of nine (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 this Contract will be required to have and use an NPI.

Network Provider – Any Provider, group of Providers, or entity that has a Network Provider agreement with a MCO or a Subcontractor and receives Medicaid or CHIP/FAMIS funding directly or indirectly to order, refer or render Covered Services as a result of the state’s Contract with an MCO, PIHP, or PAHP. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement.

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

Non-Participating Provider – A health care entity or health care professional not in the Contractor’s Participating Provider Network.

Nursing Facility (NF) – Any licensed skilled Nursing Facility, skilled care facility, Intermediate Care Facility, nursing care facility, or Nursing Facility, whether free-standing or a portion of a free-standing medical care facility. This includes, but is not limited to, a 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.

Office Based Addiction Treatment Providers or “Preferred OBATs” – Deliver addiction treatment services to Members with a primary diagnosis from the Diagnostic and Statistical Manual of Mental

Disorders (DSM-5) for substance-related and addictive disorders, with the exception of tobacco-related disorders and non-substance-related addictive disorders, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems. Services are provided by buprenorphine-waivered practitioners working in collaboration and co-located with licensed Credentialed Addiction Treatment Practitioners providing psychosocial treatment in public and private practice settings (12VAC30-130-5020).

Ombudsman – The independent State entity that will provide advocacy and problem-resolution support for CCMC participants and serve as an early and consistent means of identifying systemic problems.

Ongoing Care Management – Providing regular, ongoing support to address a Member’s health care needs, functional needs, accessibility needs, Social Needs, strengths and supports, goals and other characteristics in alignment with the Member’s ICP and regular courses of treatment.

Open Enrollment – The timeframe in which Members are allowed to change from one (1) MCO to another, without cause, at least once every twelve (12) months per 42 CFR §438.56(c)(2) and (f)(1), as described in this Contract.

Other Full Benefit Dual Eligible (FBDE) - An individual who is entitled to Medicare, does not meet the income or resource criteria for QMB+ or SLMB+, but is eligible for full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers.

Out-of-Network – Coverage provided outside of the established MCO network; medical care rendered to a Member by a Provider not affiliated with the Contractor or contracted with the Contractor or its Subcontractors.

Outcomes – As defined in 42 CFR §438.320, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

Overpayment – As defined in 42 CFR §438.2, any payment made to a Network Provider by a MCO to which the Network Provider is not entitled to under Title XIX of the Act or any payment to a MCO by a State to which the MCO is not entitled to under Title XIX of the Act.

Partial Benefit Dual Eligible - Individuals who receive both Medicare and Medicaid coverage but who are NOT eligible for full Medicaid benefits but are eligible for Medicaid cost sharing (e.g., individuals who qualify as Specified Low-Income Medicare Member (SLMBs), Qualified Medicare Member (QMBs), Qualified Disabled and Working Individuals (QDWIs), or Qualifying Individuals (QIs)). **Partial**

Hospitalization Services (ASAM Level 2.5) – Are a minimum of twenty (20) hours per week and at least five (5) service hours per service day of skilled treatment services with a planned format, including individual and group psychotherapy, substance use disorder counseling, medication management, education groups, occupational and recreational therapy, and other therapies. Withdrawal management services may be provided as necessary. (12VAC30-130-5100). Also called “intensive outpatient services.”

Participating Provider – Providers, Hospitals, home health agencies, clinics, and other places that provide health care services, medical equipment, and LTSS that are contracted with the Contractor’s health plan. Participating Providers are also “in-Network Providers” or “plan Providers.”

Passthrough Payment – Any amount required by the State to be added to the contracted payment rates, and considered in calculating the Actuarially Sound Capitation Rate, between the MCO, PIHP, or PAHP and Hospitals, physicians, or Nursing Facilities that is not for the following purposes: A specific service or benefit provided to a specific Enrollee covered under the Contract; a Provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 CFR §438.6(a) for services and Enrollees covered under the Contract; a subcapitated payment arrangement for a specific set of services and Enrollees covered under the Contract; GME payments; or FQHC or RHC wrap around payments.

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 who are not covered through MAGI adult (Medicaid expansion) and who reside in a NF (skilled or custodial) or are enrolled in a HCBS waiver. Patient pay is required to be calculated for every individual (including AI/AN) although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be the responsibility of the Contractor and must be outlined in the Contractor’s Provider agreement.

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 Care Services (EPSDT) – EPSDT Personal Care Services are designed to assist children under the age of twenty-one (21) who meet the criteria for EPSDT Personal Care as defined in the EPSDT Personal Care Services Supplement with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), Medically Necessary supervision and monitoring of self-administered medications. The child’s need for assistance with ADLs due to a health condition must be documented by the child’s Primary Care Provider on the EPSDT Functional Status Assessment Form (DMAS-7). The form must be completed and signed by a physician, physician’s assistant or nurse practitioner and updated every year. EPSDT Personal Care criteria is utilized for children not enrolled in CCC Plus HCBS waiver. For Members enrolled in CCC Plus HCBS waiver, including those Members under twenty-one (21) years old, personal care will be provided under the waiver. As such CCC Plus HCBS waiver criteria and forms are used to determine personal care hours for these Members. See Section 5.12.2, *Commonwealth Coordinated Care Plus Waiver*.

Personal Care Services (Non-EPSDT) – A range of support services that includes assistance with ADLs/IADLs, access to the community, and self-administration of medication or other medical needs, and the monitoring of health status and physical condition provided through the AD or consumer-directed model of service. Personal Care Services must be provided by PCAs or attendants within the scope of their licenses or certifications, as appropriate.

Physician Incentive Plan – Any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan Member.

Physician Services – Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.

Plan First – The Medicaid FFS Family Planning Program. The purpose of this program is to reduce unplanned pregnancies, increase spacing between births, reduce infant mortality rates, and reduce the rates of abortions due to unintended pregnancies. Individuals not eligible for full benefit Medicaid or FAMIS/FAMIS MOMS who have income between one hundred thirty-eight percent (138%) and less than or equal to two hundred percent (200%) of the federal poverty level (plus a five percent (5%) disregard) and meet citizenship and identity requirements may be eligible for Plan First.

Plan of Safe Care – A guide developed by the Contractor with their Members to ensure mothers and others have the necessary resources to safely care for the unique challenges of an infant who is exposed to substances during pregnancy. Each mother and infant's needs vary.

Population Health – The health of a population as measured by health status indicators and as influenced by social, economic, and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services, as well as the equitable distribution of such Outcomes within the population.

Post-Adoption Case Management (PACM) Services – PACM will provide families for Members in AA with twelve (12) months of Case Management services after the finalization of an adoption from FC. Families will automatically be referred to PACM by the VDSS Adoption Negotiator and families may start services right away or they can enroll at a later date when needed.

Post-Stabilization Care Services – As defined at 42 CFR §438.114(a), Covered Services related to an emergency medical condition that are provided after a Member is Stabilized in order to maintain the Stabilized condition or to improve or resolve the Member's condition.

Prescription Drug Coverage – Prescription Drugs or medications covered (paid) by the Health Plan. Some over-the-counter medications are covered.

Prescription Drugs – A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary Care – As defined in 42 CFR §438.2, all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the Department, to the extent the furnishing of those services is legally authorized in the State.

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

Primary Care Provider (PCP) – A practitioner who provides preventive and primary medical care for eligible Members 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, clinics including, but not limited to health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Priority Population – Members, as defined in Section 8.4.2 of the CCMC Contract, *Priority Populations*, as requiring Care Management under Cardinal Care based on the Member's need and risk level.

Privacy – Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing Medicaid regulations, including 42 CFR §§431.300 through 431.307, as well as relevant Virginia privacy laws.

Private Duty Nursing (PDN) – Nursing care services available for children under age twenty-one (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.

Program Integrity – The process of identifying and referring any suspected Fraud or Abuse activities or program vulnerabilities.

Program of All-inclusive Care for the Elderly (PACE) – PACE provides the entire spectrum of medical (preventive, primary, acute) and LTSS to their Enrollees without limit as to duration or dollars. PACE participants are excluded from the CCMC program.

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. See 45 CFR 160.103.

Provider – As defined in 42 CFR §438.2, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.

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 the Department.

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 Providers, community and institutional long-term care Providers, pharmacy Providers, and acute Providers employed by or under Subcontract with the Contractor. Also see Network Provider.

Psychosocial Rehabilitation Services – A treatment program of two (2) or more consecutive hours per day provided to groups of adults in a non-residential setting. Members 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 Member about mental illness, substance use disorders (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.

Psychiatric Residential Treatment Facilities (PRTF) – Means the same as defined in 42 CFR §483.352 and are a twenty-four (24)-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral,

substance abuse, cognitive, and training needs of an individual younger than twenty-one (21) years of age in order to prevent or minimize the need for more intensive treatment.

Qualified Disabled Working Individual (QDWI) – An individual who has income that does not exceed two hundred percent (200%) of the Federal Poverty Level (FPL) and whose resources do not exceed \$2,000. The Medicaid agency pays Medicare Part A premiums. No other cost sharing is covered for these individuals. The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement for individuals in the QDWI group defined in subsection 26 of [12VAC30-30-10](#).

Qualified Individuals (QI) – An individual who has income that does not exceed one hundred thirty five percent (135%) of the Federal Poverty Level (FPL) and whose resources do not exceed the limit set for the Medicare Part D Low-Income Subsidy (LIS) program. The Medicaid agency pays their Part B premiums.

Qualified Medicare Beneficiary (QMB) – An individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed the limit set for the Medicare Part D Low-Income Subsidy (LIS) program. A QMB is eligible for Medicaid Payment of Medicare premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D). These individuals are not eligible for additional benefits available under the State Plan for fully eligible Medicaid recipients.

Qualified Medicare Beneficiary Plus (QMB+) – An individual who is entitled to Medicare and meets the Federal income standard of income equal to or less than 100 percent of the Federal Poverty Level (FPL) and is determined eligible for full Medicaid coverage. Some QMB Plus individuals may achieve eligibility through a spend-down. A QMB Plus is eligible for Medicaid Payment of Medicare Part A premiums, Medicare Part B premiums and Medicare coinsurance and Medicare deductibles for Medicare covered services (except for Medicare Part D). Also referred to as QMB Plus or QMB Extended.

Qualifying CCC Plus HCBS Waiver Services – Qualifying Services can be authorized as stand-alone services. Qualifying services include: ADHC, personal care, respite, and Private Duty Nursing services. The following CCC Plus HCBS waiver services are not qualifying waiver services: AT, EM, and PERS, and must be authorized in conjunction with at least one (1) Qualifying CCC Plus HCBS Waiver Service.

Quality – As defined in 42 CFR §438.320, as it pertains to EQR, the degree to which an MCO increases the likelihood of desired Outcomes of its Enrollees through:

1. Its structural and operational characteristics;
2. The provision of services that are consistent with current professional, evidenced-based-knowledge;
3. Interventions for performance improvement.

Quarters – Calendar quarters starting on January 1st, April 1st, July 1st, and October 1st.

Reassessment – For Members enrolled in a waiver or a Nursing Facility, the periodic (in accordance with waiver requirements), face-to-face review of a Member’s condition and service needs.

Registered Nurse (RN) – Person who is licensed or certified in Virginia as an RN or holds a RN/LPN license with multi-state privilege recognized by Virginia in accordance with §54.1-3040.1 et. seq., of the Code of Virginia.

Rehabilitation Services and Devices – Treatment the Member receives to help the Member recover from an illness, accident, or major operation.

Residential Crisis Stabilization Unit (RCSU) – Serve as diversion facilities from inpatient hospitalization. Residential Crisis Stabilization Units provide short-term, twenty-four (24) hours a day, seven (7) calendar days a week, facility-based psychiatric/substance-related crisis evaluation and brief intervention services. The service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning.

Respite Services or Respite Care 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.

Rural Health Clinic (RHC) – A facility as defined in 42 CFR §491.2, as amended.

Safety Net Providers – Providers that organize and deliver a significant level of health care and other related services to Medicaid, FAMIS, uninsured, and other vulnerable populations.

Screening – The process to:

1. Evaluate the functional, nursing, and social supports of individuals referred for screening for certain long-term services requiring Nursing Facility eligibility;
2. Assist individuals in determining what specific services the individual needs;
3. Evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and
4. Provide a list to individuals of appropriate Providers for Medicaid-funded Nursing Facility or HCBS care for those individuals who meet Nursing Facility Level of Care.

Screening Team – The Medicaid MLTSS Screening Team contracted with the Department that is responsible for performing screenings for Nursing Facilities or, if qualified, waiver services pursuant to the Code of Virginia § 32.1-330. Screening teams include:

1. "Community-Based Team" (CBT) means a nurse, social worker or other assessors designated by the Department and a physician who are employees of, or contracted with, the Virginia Department of Health or the local Department of Social Services;
2. "Hospital Team" means persons designated by the Hospital who are responsible for conducting and submitting the screenings for inpatients to the Department's automated system; and
3. "Department or DMAS designee" means the public or private entity with an agreement with the Department to complete screenings.

Serious Emotional Disturbance – Used to refer to children from birth through age seventeen (17) who have had a serious mental health problem diagnosed under the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or who exhibit all of the following: problems in personality development and social functioning that have been exhibited over at least one (1) years' 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 (1) or more agency. See the [DBHDS website](#) for more information.

Serious Mental Illness (SMI) – Used to refer to individuals ages eighteen (18) and older who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or DD are included. The population is defined along three (3) dimensions: diagnosis, level of disability, and duration of illness. All three (3) dimensions must be met to meet the criteria for Serious Mental Illness. (Mental Health Services Manual, Chapter IV).

Service Authorization (SA) – 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.

Service Code – Refers to the taxonomy of identification codes used by healthcare Providers to report medical services provided to patients to state Medicaid agencies or fiscal agents. Service Codes discussed in this Contract include Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), and International Classification of Diseases, Tenth Revision (ICD-10) codes.

Service Authorization Contractor – An entity that is contracted to manage authorization of health and other Covered Services. The Department's Service Authorization Contractor is currently responsible for authorization of the Department's medical and behavioral health benefits for Medicaid and FAMIS Members enrolled in FFS, including for Residential Treatment Services, and for carved out behavioral health benefits including Therapeutic Group Home (TGH) and TFC Case Management services. The Department also contracts with a separate vendor to manage authorization and administration of carved out dental services.

Service Authorization Request – A Managed Care Member's request for the provision of a service.
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 person-centered Individualized Care Plan (ICP) that are:

1. Not otherwise covered under the State Plan for Medical Assistance Services home health benefit;
2. Required to prevent institutionalization;
3. 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

4. Provided by a licensed RN, or by an LPN under the supervision of an RN, to CCC Plus HCBS 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.

Social Needs – Needs related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and informational supports, and personal goals (e.g., attend school, have a job).

Special Low Income Medicare Beneficiary (SLMB) - An individual who has income that does not exceed 120% of the Federal Poverty Level (FPL) and whose resources do not exceed the limit set for the Medicare Part D Low-Income Subsidy (LIS) program. The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in subsection 27 of [12VAC30-30-10](#).

Special Low Income Medicare Beneficiary Plus (SLMB+) - An individual who is entitled to Medicare and meets the Federal income standard of income greater than 100 percent but less than one hundred twenty percent (120%) of the FPL and who also meets the financial criteria for full Medicaid coverage. Some SLMB Plus individuals may achieve eligibility through a spend-down. The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals determined eligible as a SLMB+. Also referred to as SLMB Plus or SLMB Extended.

Specialist – A doctor who specializes in treating certain diseases, health problems, or conditions. For the purposes of this Contract, not a Primary Care or pediatric doctor.

Stabilized – As defined in 42 CFR §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 individual who is having contractions, that the individual has delivered the child and the placenta.**State Plan for Medical Assistance (State Plan)** – The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures, and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.

Subcontract – A written contract between the Contractor and a third party, under which the third party performs any one (1) or more of the Contractor’s obligations or functional responsibilities under this Contract.

Subcontractor – An individual or entity that has a contract with the Contractor to perform part of the responsibilities under this Contract that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the State. For Subcontracts which require that the Subcontractor be responsible for the provision of Covered Services, the Subcontractor must be considered both a Subcontractor and a Network Provider for the purposes of this Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with the Contractor.

Substance-Exposed Infants (SEIs) – Infants who experienced prenatal exposure to alcohol, tobacco, or other controlled substances. SEIs must include children born with Neonatal Abstinence Syndrome (NAS). SEIs/NAS infants require unique medical, behavioral health and Care Coordination services in order to reach optimum health Outcomes.

Substance Use Disorder (SUD) – Per 12VAC30-130-5020, means a substance-related addictive disorder, as defined in the DSM-5 with the exception of tobacco-related disorders and non-substance-related disorders, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems.

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 social, educational, vocational, housing, and other services. TCM services include: ARTS, brain injury, mental health, developmental disabilities, EI, TFC, and high-risk prenatal and infant Case Management services. Refer to Attachment E, *Cardinal Care Summary of Covered Services Chart*. Also see Post-Adoption Case Management (PACM) Services. In the instance of EI, this is also referred to as “EI service coordination.”

Telehealth – The use of telecommunications and information technology to support remote or long-distance physical and behavioral health care services. Telehealth is different from Telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision, and information across distance, and it is not restricted to modalities that involve real time, two (2)-way interaction (see “Telemedicine” below). Telehealth incorporates technologies such as telephone, facsimile machines, electronic, email systems, remote patient monitoring devices and Store-and-Forward applications, which are used to collect and Transmit patient data for monitoring and interpretation.

Telemedicine – A service delivery model that uses real time two (2)-way telecommunications to deliver covered physical and Behavioral Health Services for the purposes of diagnosis and treatment of a covered Member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment to link the Member at an originating site to an enrolled Provider approved to provide Telemedicine services at a distant (remote) site.

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 CFR §441.150 and Code of Virginia § 16.1-336 et seq and § 37.2-809 et seq. Different temporary detention statutes apply for adults than for juveniles.

Therapeutic Group Home (TGH) – Means a congregate residential service providing twenty-four (24)-hour supervision in a community-based home having eight (8) or fewer residents.

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 treatment programs of two (2) or more hours per day.

Threshold – A pre-established level of performance that, when it is not attained, results in initiating further in-depth review to determine if a problem or opportunity for improvement exists. Contractor failure to meet any Threshold in the Contract may result in compliance action or loss of Performance Incentive Awards.

Transmit – Send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

Transition Services – Services that are “set-up” expenses for individuals who are transitioning from an institution or licensed or certified Provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and Provider requirements for this service. For the purposes of Transition Services, an institution means a NF, or a specialized care facility/Hospital as defined at 42 CFR §435.1009. Transition Services do not apply to an Acute Care admission to a Hospital.

Transitional Care Management – Management of Member needs during transitions between clinical settings (e.g., between a Hospital and a rehabilitation facility) or between a clinical setting and home (e.g., from Hospital to home) to prevent unplanned or unnecessary readmissions, ER visits or adverse outcomes.

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 and adverse childhood experiences (ACEs) have played in their lives. This approach also builds on Member resiliency and strengths to address both the overall physical and emotional wellbeing of the individual.

Triggering Events – Any occurrence that suggests a change in a member’s condition or status that places the member at a higher risk of harm or jeopardizes their health, safety and welfare.

Treatment Foster Care (TFC) Case Management – Serves children under age twenty-one (21) in TFC who have certain complex behavioral health needs 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.

Twenty-three (23) Hour Crisis Stabilization – Provides a period of up to twenty-three (23) hours in a community-based facility that provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis. This service should be accessible twenty-four (24) hours a day, seven (7) calendar days a week and is indicated for those situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or Residential Crisis Stabilization Unit setting is necessary.

Unable to Contact (UTC) for Initial HRA – The Contractor’s reasonable efforts to contact the non-LTSS Member in-person, by telephone, or by mail immediately upon completion of the MCO Member Health Screening without success places the Member in the “UTC” category for the Initial HRA. “Reasonable efforts” are defined as at least three (3) documented attempts with more than one (1) method of contact being employed over more than one day, including a home visit. The Contractor is encouraged to reach out to the Member’s PCP and other treating providers, supports or DSS Medicaid workers to establish contact with a Member for status updates. See Section 4.5.4 of the CCMC Contract, *Unable to Contact for HRA*.

Unable to Contact (UTC) for MMHS – The Contractor’s reasonable efforts to contact the Member in-person, by telephone, or by mail in order to conduct the MMHS without success places the Member in the “UTC” category for the MMHS. “Reasonable efforts” are defined as at least three (3) attempts across more than one day, with more than one method of contact being employed. The Contractor must document each attempt, including what method was used on what date. If the Contractor is unable to reach the Member after reasonable efforts, the Contractor must place the Member in the Unable to Contact (“UTC”) category for the MMHS. See Section 4.3.2.3 of the CCMC Contract, *Unable to Contact for MMHS*.

Utilization Management (UM) – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

Validation – As defined in 42 CFR §438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Virginia Administrative Code (VAC) – Contains regulations of all the Virginia State Agencies. **Warm-Transfer** – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

8.2 Acronyms

AA – Adoption Assistance

ABA – Applied Behavior Analysis

ACT – Assertive Community Treatment

AD – Agency-Directed Services

ADHC – Adult Day Health Care Services

ADL – Activities of Daily Living

AIP – Applicable Integrated Plan

ARTS – Addiction and Recovery Treatment Services

AT – Assistive Technology

BHSA – Behavioral Health Services Administrator

BHH – Behavioral Health Home BI Waiver – Building Independence Waiver

BOI – Bureau of Insurance

BSW – Bachelor’s Level Social Worker

CAHPS® – Consumer Assessment of Healthcare Providers and Systems

CBO – Community-Based Organization

CCMC – Cardinal Care Managed Care Program or Contract

CCR – Comprehensive Care Review

CDL – Coverage Decision Letter

CFR – Code of Federal Regulations

CHIP – Children’s Health Insurance Program

CL Waiver – Community Living Waiver

CLIA – Clinical Laboratory Improvement Amendments

CMS – Centers for Medicare and Medicaid Services

CSB – Community Service Board

CYSHCN – Children and Youth with Special Healthcare Needs

DBHDS – Department of Behavioral Health and Developmental Services

DMAS – Department of Medical Assistance Services

DD – Developmental Disability

DHP – Department of Health Professions

DIP – D-SNP Improvement Plan

DME – Durable Medical Equipment

D-SNP – Dual Eligible Special Needs Plan

ECO – Emergency Custody Order

EI – Early Intervention Services

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ESRD – End Stage Renal DiseaseFBDE – Full Benefit Dual Eligible

FFS – Fee-For-Service

FFT – Functional Family Therapy

FIDE SNP – Fully Integrated Dual Eligible Special Needs Plan

FIS Waiver – Family and Individual Supports Waiver HCBS – Home- and Community-Based Care Services

HEDIS – Healthcare Effectiveness Data and Information Set

HIDE SNP – Highly Integrated Dual Eligible Special Needs Plan

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIPP – Health Insurance Premium Payment

HOS – Health Outcome Survey

HPMS – Health Plan Management System

HRA – Health Risk Assessment

HRSN – Health Related Social Needs

IADL – Instrumental Activities of Daily Living

IAH – Independence at Home Demonstration

ICF/IID – Intermediate Care Facility/Individuals with Intellectual Disabilities

ICP – Individualized Care Plan

ICT – Interdisciplinary Care Team

IFSP – Early Intervention Individualized Family Service Plan

IHCP – Indian Health Care Provider

IIH – Intensive In-Home Services

IMD – Institution for Mental Disease

LBSW – Licensed Bachelor’s Level Social Worker

LEIE – List of Excluded Individuals and Entities

LLA – Local Lead Agency

LMHP – Licensed Mental Health Professional

LMSW – Licensed Master’s Social Worker

LOC – Level of Care

LSH – Long-stay Hospital LTSS – Long Term Services & Supports

MA – Medicare Advantage

MCHIP – Managed Care Health Insurance Plan

MCO – Managed Care Organization

MDS – Minimum Data Set

MES – Medicaid Enterprise System

MH-IOP – Mental Health-Intensive Outpatient

MHPAEA – Mental Health Parity Addiction Equality Act

MH-PHP – Mental Health-Partial Hospitalization Program

MHSS – Mental Health Skill-Building Assessment and Services

MLTSS – Managed Long Term Services and Supports

MMHS – MCO Member Health Screening

MMIS – Medicaid Management Information System

MOC – Model of Care

MST – Multisystemic Therapy

MSW – Master’s Level Social Worker

NCQA – National Committee for Quality Assurance

NF – Nursing Facility

NPI – National Provider Identifier

PACE – Program of All-inclusive Care for the Elderly

PCP – Primary Care Provider

PDN – Private Duty Nursing

PHI – Protected Health Information

PRTF – Psychiatric Residential Treatment Facilities

QDWI – Qualified Disabled Working Individual

QI – Qualified Individual

QMB – Qualified Medicare Beneficiary

QMB+ – Qualified Medicare Beneficiary Plus

QMHP – Qualified Mental Health Professional

RCSU – Residential Crisis Stabilization Unit

RN – Registered Nurse

RTC – Residential Treatment Level C

SLMB – Special Low Income Medicare Beneficiary

SLMB+ – Special Low Income Medicare Beneficiary Plus

SMI – Serious Mental Illness

SUD – Substance Use Disorder

TCM – Targeted Case Management

TDO – Temporary Detention Order

TDT – Therapeutic Day Treatment

TGH – Therapeutic Group Home

USC – United States Code

UTC – Unable To Contact

VAC – Virginia Administrative Code

9 Signature Page

Effective Dates: January 1, 2026 through December 31, 2026

Contract Name: Dual Special Needs Plan (D-SNP)

Issued By: Commonwealth of Virginia, Department of Medical Assistance Services

Contractor: <Health Plan>

This contract is governed by the laws of the Commonwealth of Virginia and interpreted in accordance with Virginia law, except to the extent preempted by Federal law. The parties of this Contract will carry out their obligations under this Contract in the manner prescribed by all applicable laws, regulations and policies, including Federal and State law governing the Medicare and Medicaid programs.

This Contract is effective January 1, 2026 and shall continue through December 31, 2026.

1. By signature of this Contract, the Contractor agrees to adhere to all D-SNP Contract provisions. As part of this signature document, the Contractor shall operate in all localities noted on the following Locality Listing.
2. This contract is contingent upon receipt of final approval from the Centers for Medicare and Medicaid Services (CMS). Any revisions needed shall be completed through a subsequent contract Amendment.
3. By signature of this Contract, the Contractor agrees to adhere to all D-SNP program 2026 Contract provisions, including compliance with Federal conflict of interest provisions and compliance with requirements in 42 CFR § 438.610 prohibiting Contractor affiliations with individuals debarred by Federal agencies.

In accordance with Chapter 16-B of the Medicare Managed Care Manual, each dual eligible special needs plan (D-SNP) must submit a State Medicaid Agency Contract (SMAC or D-SNP Contract) to CMS for review by the first Monday in July every year for each state in which it seeks to operate for the upcoming contract year. In addition, the Social Security Act and federal regulations require D-SNPs to have a contract with state Medicaid agencies to provide benefits individuals are entitled to receive as medical assistance under Title XIX of the Act (DMAS Cardinal Care Managed Care (CCMC) contract).

Due to ongoing litigation related to CCMC Contract Request for Proposals 13330 all Contractors may execute this Contract; however, if a Contractor does not have an executed CCMC Contract with the Department that is operational at the time this Contract is signed, then any such Contractor will not be permitted to operate its D-SNP, including marketing, enrolling, and providing services under this Contract, unless and until the Contractor has entered into a CCMC Contract with the Department and the CCMC program begins operating under that Contract. IN WITNESS HEREOF, the parties have caused this Contract Amendment to be duly executed intending to be bound thereby.

CONTRACTOR:

<Health Plan Name>

COMMONWEALTH OF VIRGINIA:

Department of Medical Assistance Services

BY: _____

BY: _____

NAME and DATE: _____

NAME and DATE: _____

TITLE: _____

TITLE: Director

9.1 Verifying Plan Design

The Contractor must complete one table below for each contract (Health Plan Number) and each PBP offered in Virginia. For example, if a Contractor has one contract with two PBPs they'd need to complete two tables, one for each PBP.

1. The italicized language and the checked boxes are provided as examples. Please remove the examples and checked boxes prior to submission.
2. Completion of the Description column is optional. It is intended to provide the Contractor with an opportunity to describe some nuance that the Department may not otherwise know. For example, some D-SNPs elect to segregate populations enrolled by PBP – Duals also in a Medicaid Waiver in one PBP, Duals not in a Waiver in another PBP, Duals with ESRD in yet another PBP, etc. The Department wouldn't necessarily know that so the Contractor could include that information here. The description should be no more than two brief sentences.
3. The Contractor can add more additional tables if needed.

Integration by Contract and PBP			
Health Plan Name	Health Plan Number Including PBP	D-SNP Type	Description
<i>Acme Health Care</i>	<i>H-1111-001</i>	<input checked="" type="checkbox"/> FIDE AIP	Contract To Describe Populations enrolled in this PBP:

Integration by Contract and PBP			
Health Plan Name	Health Plan Number Including PBP	D-SNP Type	Description
<i>Acme Health Care</i>	<i>H-1111-002</i>	<input checked="" type="checkbox"/> FIDE AIP	Contract To Describe Populations enrolled in this PBP:

Integration by Contract and PBP			
Health Plan Name	Health Plan Number Including PBP	D-SNP Type	Description

<i>Acme Health Care</i>	<i>H-1111-003</i>	<input type="checkbox"/> FIDE AIP	Contract To Describe Populations enrolled in this PBP:
-------------------------	-------------------	-----------------------------------	--

9.2 Verifying Service Area

The Contractor is required to identify which localities it has been approved to operating within. The Contractor must complete one table for each PBP.

D-SNP CONTRACT LOCALITY LISTING					
(Place X Beside Participating Locality)					
Accomack County			Franklin County		Norton City
Albemarle County			Frederick County		Nottoway County
Alexandria City			Fredericksburg City		Orange County
Alleghany County			Galax City		Page County
Amelia County			Giles County		Patrick County
Amherst County			Gloucester County		Petersburg City
Appomattox County			Goochland County		Pittsylvania County
Arlington County			Grayson County		Poquoson City
Augusta County			Greene County		Portsmouth City
Bath County			Greensville County		Powhatan County
Bedford County			Halifax County		Prince Edward County
Bland County			Hampton City		Prince George County
Botetourt County			Hanover County		Prince William County
Bristol City			Harrisonburg City		Pulaski County
Brunswick County			Henrico County		Radford City
Buchanan County			Henry County		Rappahannock County
Buckingham County			Highland County		Richmond City
Buena Vista City			Hopewell City		Richmond County
Campbell County			Isle of Wight County		Roanoke City
Caroline County			James City County		Roanoke County
Carroll County			King and Queen County		Rockbridge County
Charles City County			King George County		Rockingham County
Charlotte County			King William County		Russell County
Charlottesville City			Lancaster County		Salem City
Chesapeake City			Lee County		Scott County
Chesterfield County			Lexington City		Shenandoah County
Clarke County			Loudoun County		Smyth County
Colonial Heights City			Louisa County		Southampton County
Covington City			Lunenburg County		Spotsylvania County
Craig County			Lynchburg City		Stafford County
Culpeper County			Madison County		Staunton City
Cumberland County			Manassas City		Suffolk City

Danville City			Manassas Park City			Surry County	
Dickenson County			Martinsville City			Sussex	
Dinwiddie County			Mathews County			Tazewell County	
Emporia City			Mecklenburg County			Virginia Beach City	
Essex County			Middlesex County			Warren County	
Fairfax City			Montgomery County			Washington County	
Fairfax County			Nelson County			Waynesboro City	
Falls Church City			New Kent County			Westmoreland County	
Fauquier County			Newport News City			Williamsburg City	
Floyd County			Norfolk City			Winchester City	
Fluvanna County			Northampton County			Wise County	
Franklin City			Northumberland County			Wythe County	
						York County	
TOTAL LOCALITIES = <u> </u> OF 133							

10 Covered Services Chart

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Abortions, induced	42 CFR §§441.202, 441.203 and 441.206 12 VAC 30-50-100, 12 VAC 30-50-105, 12 VAC 30-50-110, 12 VAC 30-50-140, and 12 VAC 30-50-180. Also, See Hospital Manual Chapters IV and VI, and Exhibits for required forms.	Yes, limited	Yes, limited	The Contractor must provide coverage for induced abortions only in limited cases where a physician has found, and certified in writing, that on the basis of their professional judgment, the life of the mother would be substantially endangered if the fetus were carried to term. The certification must contain the name and address of the member. The Contractor is responsible for ensuring that payment and documentation of abortion services complies with State and Federal requirements.
Assisted Suicide	Assisted Suicide Funding Restriction Act of 1997 (42 USC § 14401, et. seq.)	No	No	The Contractor must not cover services related to assisted suicide, euthanasia, or mercy killings, or any action that may secure, fund, cause, compel, or assert/advocate a legal right to such services.
Behavioral Health Services - 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.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Christian Science Sanatoria Facilities and Nurses	12 VAC 30-50-300	Yes	No	The Contractor is not required to cover this service. Individuals will be excluded from Managed Care participation when admitted to a Christian Science Sanatoria and services will be covered under the fee-for-service program per Department established criteria and guidelines. Christian Science Nursing Services are not covered.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor must cover all clinic services, which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Clinical Trials	SMD # 21-005	Yes	Yes	The Contractor must cover routine patient services furnished in connection with a Member's participation in a qualifying clinical trial, as defined in Section 22, <i>Definitions</i> of the CCMC Contract, SMDL #21-005, and the Virginia Medicaid State Plan. Routine patient services include any item or service provided to the Member under the qualifying clinical trial that are needed to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that such items or services are otherwise covered outside the course of participation in the qualifying clinical trial. The Contractor is not required to provide coverage for any investigational item or service that is the subject of the qualifying clinical trial or for any service that is not otherwise covered under this Contract. The Contractor is not required to cover any items or service needed solely to satisfy data collection and analysis for the qualifying clinical trial, or for any services that are not used in the direct clinical management of the Member.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor must cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				Society, for the ages, family histories and frequencies referenced in such recommendations.
Community Intellectual Disability Case Management (T1017)	12 VAC 30-50-440	Yes	No	The Contractor must provide information and referrals as appropriate to assist Members in accessing these services through the individual’s local community services board. Also Part 4.C.
Court-Ordered Services	Code of Virginia Section 37.1-67.4	Yes	Yes	The Contractor must cover all medically necessary court-ordered services. In the absence of a contract otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.
Dental	12 VAC 30-50-190 See Dental Manual	Yes	Limited coverage	<p>The Department’s contracted dental benefits administrator (DBA) will cover routine dental services; therefore, these services are carved out of the Managed Care program. However, the Contractor is responsible for transportation and medications related to covered dental services. The Contractor must also cover medically necessary anesthesia and hospitalization services for its Members when determined to be medically necessary by the Department’s Dental Benefits Administrator.</p> <p>Effective July 1, 2022 in accordance with Virginia Appropriations Act, Item 304 PPPP the Contractor must provide coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a Medicaid enrollee who is determined by a licensed dentist in consultation with the enrollee's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care to an enrollee age ten or younger. Additionally, in accordance with the Code of Virginia,</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				<p>§ 38.2-3418.12, coverage for anesthesia is required for persons who are severely disabled, or persons who have a medical condition that require admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the covered person’s treating physician that such services are required to effectively and safely provide dental care. The Contractor’s determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the covered person requires the utilization of general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide the underlying dental care.</p> <p>The Contractor must 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 must cover dental screenings and dental varnish under EPSDT. See Section 5.2.1 of the CCMC Contract for additional requirements.</p>
Developmental Disability Support Coordination (T2023)	12 VAC 30-50-490	Yes	No	These services will be covered through Medicaid fee-for-service. The Contractor must provide information and referrals as appropriate to assist Members in accessing these services through the individual’s local community services board. Also see Part 4.C.
Dietary Counseling	12VAC30-60-200 https://www.uspreventiveservicestaskforce.org/uspstf/	Yes	Limited Coverage	The Contractor must cover medically necessary dietary counseling services. Coverage must be provided in accordance with U.S. Preventive Task Force recommendations, as described at: https://www.uspreventiveservicestaskforce.org/

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Doula Services		Yes	Yes	<p>In accordance with the 2021 Virginia Acts of Assembly, Chapter 552, the Contractor must cover certain services covered by certified Doulas. Services must include up to eight (8) prenatal/postpartum visits, and support during labor and delivery. The Contractor must also implement up to two (2) linkage-to-care incentive payments for postpartum and newborn care.</p> <p>Covered Services Include:</p> <ol style="list-style-type: none"> 1. 99600-HD Initial Prenatal Visit; Maximum six (6) units of fifteen (15) minutes each (total max of 90 minutes). One (1) date of service only. 2. 59425-HD Standard care, prenatal visit; Maximum three (3) visits (initial prenatal (see above) and three prenatal visits). Bill in fifteen (15) minute increments for a total of sixty (60) minutes per visit. 3. 59409-HD Labor support, Vaginal birth; one (1) unit. 4. 59514-HD Labor Support, C-section; one (1) unit. 5. 59430-HD Postpartum Care, Postpartum Visit; Maximum four (4) visits. Bill in fifteen (15) minute increments for a total of sixty (60) minutes per visit. 6. 99199-HD Incentive Mother Postpartum; one (1) unit. 7. 99199-HD Incentive Newborn Postpartum; one(1) unit. Must be billed under the newborns Medicaid ID. <p>All claims for Doula services must include diagnosis code Z32.2 (encounter for childbirth instruction).</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services - See Part 3A of this Attachment				
Early Intervention Services - See Part 3B of this Attachment				
Emergency Services	42 CFR § 438.114 12 VAC 30-50-110 12 VAC 30-50-300	Yes	Yes	The Contractor must cover all emergency services without service authorization. The Contractor must also cover services needed to ascertain whether an emergency exists. The Contractor must not restrict a Member’s choice of provider for emergency services.
Emergency Services – Post-Stabilization Care	42 CFR § 422.100(b)(1)(iv)	Yes	Yes	The Contractor must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary until AFTER an emergency condition has been stabilized.
Enhanced Services	Cardinal Care MCO Contract	No	Yes	Enhanced benefits are services offered by the Contractor to Members in excess of the Cardinal Care program covered services. Enhanced benefits do not have to be offered to individuals in every category of eligibility; however, must be available to all individuals if placed on the Cardinal Care health plan comparison chart. See Section 5.4 of the CCMC Contract, <i>Enhanced Benefits</i> for more information.
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. For those Members < twenty-one (21), clinical trials are not always considered to be experimental or investigational and must be evaluated on a case-by-case basis, including using EPSDT criteria as appropriate. Also see Clinical Trials and EPSDT Services in Section 3B.
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover family planning services, which are defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions. In

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				accordance with 42 CFR §§438.10, 438.210, and 441.20, the Contractor is prohibited from restricting a Member’s choice of provider (network or out-of-network) or method for family planning services or supplies. The Contractor cannot require an enrollee to obtain a referral before choosing a family planning provider.
Gender Dysphoria Treatment Services	Pending Manual Citation	Yes	Yes	In accordance with the 2021 Virginia Acts of Assembly, Chapter 552, Item 313 (ZZZZZ),the Contractor must cover all Gender Dysphoria treatment services as outlined in the Department’s coverage manuals and guidelines, including pharmacological, behavioral health, medical (hormonal), surgical, and procedural & therapeutic services. The Contractor is prohibited from imposing additional authorization criteria to access Gender Dysphoria treatment services and prohibited from imposing additional authorization criteria to access
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01. 12 VAC 30-50-510 Chapter IV of the Physician Manual	Yes	Yes	The Contractor must comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The Contractor must ensure that, as a routine component of prenatal care, every pregnant Member must be advised of the value of testing for HIV infection. Any pregnant Member must have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal must be maintained in the Member’s Medical Record.
Home Health Services	12VAC30-10-220 12VAC30-50-160 12VAC30-50-200 12 VAC 30-60-70	Yes	Yes	The Contractor must cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits per year are allowed. Skilled home health visits are limited based upon medical necessity. The Contractor must manage conditions, where medically necessary and regardless of whether the need is long or short-term, including in

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
	<p>42 CFR § 440.70</p> <p>41 CFR § 441.15</p>			<p>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.</p> <p>Medicaid home health services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to all categorically and medically needy participants determined to be eligible for assistance. Home health services for Medicaid must not be of any less or greater duration, scope, or quality than that provided participants not receiving State and/or Federal assistance for those home health services. For the purpose of the Virginia Medical Assistance Program, a home health agency is an agency or distinct unit that is primarily engaged in providing licensed nursing services and other therapeutic services outside an institutional setting. Services covered under Home Health include:</p> <p>0550 Skilled Nursing Assessment 0551 Skilled Nursing Care, Follow-Up Care 0559 Skilled Nursing Care, Comprehensive Visit 0571 Home Health Aide Visit 0424 Physical Therapy, Home Health Assessment 0421 Physical Therapy, Home Health Follow-Up Visit 0434 Occupational Therapy, Home Health Assessment 0431 Occupational Therapy, Home Health Follow-Up Visit</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				0444 Speech-Language Services, Home Health Assessment 0441 Speech Language Services, Home Health Follow-Up Visit 0542 Non-Emergency Transportation, Per Mile Additional information can be found in the Home Health provider manual available on the Department’s web portal at: www.virginiamedicaid.dmas.virginia.gov
Hospice Services - See Part 4 (LTSS) of this Attachment.				
Hysterectomies	42 CFR Part 441 Subpart F as amended. See Hospital Manual Chapter IV, Exhibits For required forms.	Yes, limited.	Yes, limited.	The Contractor may not impose a thirty (30)-day waiting period for hysterectomies that are not performed for rendering sterility. The Contractor must inform the patient that the hysterectomy will result in sterility and must have the patient acknowledge her understanding. Patients undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization form (DMAS-3004) or adhere to the waiting period. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. The Contractor must comply with State and Federal reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or upon request.
ID/DD/DS Waivers (known Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waiver) See Part 4C of this Attachment.				

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Immunizations	12 VAC 30-50-130 Physician Manual, Chapter IV. Provider Manual Supplement B -EPSDT Supplement	Yes	Yes	The Contractor must cover immunizations within the most current Advisory Committee on Immunization Practices (ACIP) guidelines, without cost sharing for children under age twenty-one (21) (through the EPSDT benefit), Medicaid adults (including Expansion), and Medicaid Works, who are required to receive all essential health benefits (EHB). The Contractor is also required to provide coverage for the COVID-19 vaccine for all populations and for the flu and pneumonia immunizations for “at-risk” populations within the Center for Disease Control (CDC) guidelines. The Contractor must educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates. See EPSDT in part 3B for immunizations for children, and Section 5.11 of the CCMC Contract, <i>Covered Services for MAGI Adult Medicaid Expansion Population</i> .
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 must cover inpatient stays in general acute care and rehabilitation hospitals for all Members within at least equal amount, duration and scope as available under the Medicaid State Plan for all individuals and the EPSDT benefit for children under age twenty-one (21). Contractor coverage must include, but not be limited to, all of the following: maternity length of stay requirements; radical or modified radical mastectomy, total or partial mastectomy length of stay requirements; and an early discharge follow-up visit in maternity cases where the Member is discharged earlier than forty-eight (48) hours after the day of delivery. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 631 of 1998 Virginia Acts of Assembly, § 32.1-325(a)(1) through § 32.1-325(a)25 of the Code of Virginia.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID); state or private. - See Part 4 of this Attachment.				
Laboratory, Radiology and Anesthesia Services	12 VAC 30-50-120	Yes	Yes	The Contractor must cover all medically necessary laboratory, radiology and anesthesia services directed and performed within the scope of the license of the practitioner. In accordance with 42 CFR §§ 493.1 and 493.3, all laboratory testing sites providing services under this Contract are required to have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)	12VAC30-50-220	Yes	Yes	Screenings will be covered for Members who meet all of the following criteria: fifty-five through eighty (55-80) years of age; asymptomatic (no signs or symptoms of lung cancer); tobacco smoking history of at least one (1) pack per day for thirty (30) or more years; current smoker or former smoker who has quit smoking within the last fifteen (15) years; and, receive a written order furnished by a licensed provider or a qualified non-physician practitioner for lung cancer screening with LDCT that meets the requirements described above. Prior authorization may be required.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor must cover low-dose screening mammograms for determining presence of occult breast cancer. Screening mammograms for age forty (40) and over must be covered consistent with the guidelines published by the American Cancer Society.
Medical Supplies and Equipment	12 VAC 30-50-165 12 VAC 30-60-75 12 VAC 30-80-30	Yes	Yes	The Contractor must cover medical supplies and equipment at least to the extent covered by the Department. The Contractor’s DME benefits must be limited based upon medical necessity. There are no maximum benefit limits on DME. The Contractor must cover nutritional supplements and supplies (enteral nutrition) for children and adults. The Contractor must cover specially manufactured DME

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				<p>equipment that was prior authorized by the Contractor per requirements specified in the DME supplies manual. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the plan, even if the Member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the Member is retro-disenrolled for any reason by the Department and the effective date of the retro-disenrollment precedes the date the equipment was authorized by the plan. The Contractor must use the valid preauthorization begin date as the invoice date.</p> <p>The MCOs must work with the Member to receive/replace DME supplies that have been lost or destroyed, or the current DME provider is not available, as a result of a disaster or emergency in accordance with Code of Virginia § 44.146.16.</p> <p>Additional information can be found in the Durable Medical Equipment & Supplies provider manual available on the Department’s web portal at: www.virginiamedicaid.dmas.virginia.gov</p>
Mental Health Services - See Part 2 of this Attachment				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor must cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.
Organ Transplantation	12 VAC 30-50-540 12 VAC 30-50-550 12-VAC 30-50-560 12 VAC 30-50-580, 12 VAC 30-10-280	Yes	Yes	The Contractor must cover organ transplants for children and adults in accordance with 12 VAC 30-10-280, 12 VAC 30-50-540, VAC 30-50-550, VAC 30-50-560, 12 VAC 30-50-580, and Section 1903(i) of the Social Security Act within at least equal amount, duration, and scope as Medicaid fee-for-service. The Contractor must provide for similarly situated individuals to be treated alike and

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
	12 VAC 30-50-100G 12 VAC 30-50-105K			for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees. Transplant services for kidneys, corneas, hearts, lungs, livers (from living or cadaver donors), and bone marrow/stem cell must be covered for all eligible persons as medically necessary and based on evidenced-based clinical standards of care. Experimental or investigational transplants are not covered. Contractor must cover necessary procurement/donor related services. Transplant services must be covered for children (under twenty-one (21) years of age) per EPSDT guidelines.
Outpatient Hospital Services	12 VAC 30-50-110	Yes	Yes	The Contractor must cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services must be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor must cover annual pap smears consistent with the guidelines published by the American Cancer Society.
Personal Care; EPSDT	https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library 42 CFR § 441.50	Yes	Yes	The Contractor must cover medically necessary personal care services for children under age twenty-one (21) consistent with the Department’s criteria described in the EPSDT Supplement, available on the Department’s website at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
	1905(a) of Social Security Act			<p>Individuals have the choice to receive personal care through an agency-directed or consumer-directed delivery model. The delivery model is to be chosen by the adult individual or the caregiver if the individual is under age eighteen (18) or is not able to make a choice.</p> <p>This is not a State Plan covered benefit for Adults. Coverage is available for children under age twenty-one (21) under EPSDT. Personal care coverage is also available for Members through HCBS waiver programs. See Part 4 of this coverage chart.</p>
<p>Personal Care Medicaid Works</p> <p>See CCC Plus Waiver services in Part 4b.</p>	<p>12VAC30-60-200 12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the CCC Plus Waiver Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>The Contractor must provide coverage for personal care services for Medicaid works individuals using the same coverage criteria as the personal care coverage criteria under the CCC Plus HCBS Waiver, however, Medicaid Works individuals are not required to have a Medicaid LTSS screening. In order to receive personal care services, Medicaid Works individuals who meet coverage criteria must be enrolled with the Medicaid Works (MW) exception indicator. Medicaid Works individuals also have no patient pay responsibility for the personal care services. Criteria information regarding personal care can be found in the Commonwealth Coordinated Care Plus Waiver Provider Manual, Chapter IV, beginning on page 10. The manual is available on the web portal at www.virginiamedicaid.dmas.virginia.gov under the Provider Resources; Provider Manuals link.</p>
<p>Physical Therapy (PT), Occupational</p>	<p>12 VAC 30-50-200 12 VAC 30-50-225</p>	Yes	Yes	<p>The Contractor must cover physical therapy, occupational therapy, speech pathology, and audiology services that are provided as an inpatient, outpatient</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Therapy (OT), Speech Pathology and Audiology Services	12 VAC 30-60-150			hospital service, outpatient rehabilitation agencies, or home health service. The Contractor’s benefits must include coverage for acute and non-acute conditions and maybe limited based upon medical necessity. There are no maximum benefit limits on PT, OT, SLP, and audiology services. These services are covered regardless of where they are provided, The plan must also cover all Medically Necessary, intensive physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130 42 CFR § 438.206	Yes	Yes	<p>The Contractor must cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one (21) under EPSDT. The Contractor must permit any female Member of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the Code of Virginia, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without service authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists.</p> <p>The Contractor must provide for a second opinion from a network provider, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member.</p>
Podiatry	12 VAC 30-50-150	Yes	Yes	The Contractor must cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot. The Contractor is not required to cover preventive health care, including routine foot

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture.
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410 12 VAC 30-50-280 12 VAC 30-50-290	Yes	Yes	The Contractor must cover prenatal and postpartum services to pregnant enrollees. The Contractor must cover case management services for its high-risk pregnant women. The Contractor must provide to qualified Members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. The Contractor must cover pregnancy-related and postpartum services for sixty (60) days after pregnancy ends for the Contractor’s enrolled Members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan must cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit must be provided to all mothers who meet the Department’s criteria and the follow-up visit must be provided within forty-eight (48) hours of discharge and meet minimum requirements.
Prescription Drugs	12 VAC 30-50-210 Chapter IV of the Pharmacy Manual	Yes	Yes	The Contractor must cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Behavioral Health visits. Refer to Section 5.15, <i>Pharmacy Services</i> .
Private Duty Nursing (PDN) under EPSDT	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 CFR § 441.50	Yes	Yes	The Contractor must cover medically necessary private duty nursing services for children under age twenty-one (21) consistent with the Department’s criteria described in the EPSDT Nursing Supplement, available on the Department’s

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
	1905(a) of Social Security Act			<p>website at: https://www.viriniamedicaid.dmas.virginia.gov/wps/portal (Also see Technology Assisted Program in Part 4 of this Attachment)</p> <p>Not a State Plan covered benefit for Adults. Coverage is available for children under age twenty-one (21) under EPSDT. PDN Coverage is also available for Members in the Technology Assisted Program.</p>
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor must 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 Chapter IV of the Prosthetic Devices Manual	Yes	Yes	The Contractor must 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 twenty-one (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 must 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 must cover reconstructive breast surgery.
Local Education Agency-Based Services	12 VAC 30-50-130	Yes	No	State plan-approved Local Education Agency-Based Services (see Section 22, <i>Definitions</i> and Section 23, <i>Acronyms</i> of the CCMC Contract) rendered to member students in the school setting by qualified providers that are employed or contracted by a Department-enrolled Local Education Agency Provider are billed using FFS and reimbursed using a reconciled cost-based methodology. These services are carved-out of the Managed Care contracts. Services rendered in a

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				<p>school setting that are not part of Local Education Agency-Based Services must be covered by the Contractor in accordance with the Department’s established criteria and guidelines. The Contractor may not deny medically necessary covered services rendered in a non-school setting based on the fact that the child is receiving the same covered services as part of a local education agency school-based services program. Private duty nursing and personal care services provided through EPSDT, Technology Assisted Program, Community Living Waiver, or Family and Individual Supports Waiver are not considered Local Education Agency-based services, including when provided in the school setting or provided before or after school by personnel not employed by or contracted by the Local Education Agency.</p>
<p>Skilled Nursing Facility Care - See Part 4A (LTC Facility Services) of this Attachment.</p>				
Sterilizations	<p>42 CFR § 441, Subpart F, as amended</p> <p>Code of Virginia § 54.1-2974</p>	Yes, limited.	Yes, limited.	<p>The Contractor must not perform sterilization for a Member under age twenty-one (21). The Contractor must comply with State and Federal requirements and must comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia § 54.1-2976. The Contractor must ensure that the consent form DMAS-3004 of 42 CFR § 441.258 is both obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the Member being informed, the Member giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. The Contractor must comply with State and Federal reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				to the Department prior to signing the initial contract, upon revision or upon request.
Substance Use Disorder Treatment - See Part 2C of this Attachment.				
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The Contractor must provide coverage for telemedicine services. Telemedicine is defined as the real time or near real time two(2)-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, certified nurse-midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one (1) 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 must be compliant with HIPAA requirements.
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 42 CFR § 440.170(a) Chapter IV of the Transportation Manual	Yes	Yes	The Contractor must 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 as described here and as further detailed in Section 5.14 of the CCMC Contract, <i>Non-Emergency Medical Transportation Services (NEMT)</i> . These modes must include, but must 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 must cover air travel for critical needs. The Contractor must cover travel expenses determined to be

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				<p>necessary to secure medical examinations and treatment as set forth in CFR § 440.170(a). The Contractor must 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 must cover transportation to and from Medicaid covered behavioral health services. Community Living, Family and Individual Supports, and Building Independence Waiver Members must receive acute and primary medical services via the Contractor and must receive waiver services and related medical transportation to waiver services via the fee-for-service program.</p>
Tobacco Cessation	<p>State Medicaid Director Letter, June 24, 2011 – page 4</p> <p>2021 Virginia Acts of Assembly, Chapter 552.</p>	Yes	Yes	<p>The Contractor must cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy for all Medicaid Members. The EPSDT benefit includes the provision of anticipatory guidance and risk reduction counseling with regard to vaping or tobacco use during routine well-child visits. In addition to routine visits, additional counseling and Nicotine Replacement Therapy must be provided when medically necessary for individuals under age twenty-one (21).</p>
Vision Services	<p>12 VAC 30-50-210</p> <p>Chapter IV of the Vision Services Manual</p>	Yes	Yes	<p>The Contractor must cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. The Contractor must also cover eyeglasses for children under age twenty-one (21). The Contractor’s benefit limit for routine refractions must not be less than once every twenty-four (24) months.</p>
Brain Injury Services Case Management	*New Service-Regulations Pending	Yes	Yes	<p>The Contractor must cover medically necessary Brain Injury Services Case Management. Brain Injury Services Case Management is defined as a service to assist individuals, eligible under the State Plan who reside in a community or</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
	Brain Injury Services Manual (Pending)			institutional setting, in gaining access to needed medical, social, educational, and other services as planned upon discharge from a facility setting or while residing in the community. Case management does not include the provision of direct clinical or treatment services. Service Code: Pending

Waiver Services (Home- and Community-Based) - See Part 4 B (LTSS) of this Attachment.

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES*

*Coverage must comply with Federal Mental Health Parity law. (See Section 5.6 in the CCMC Contract, Mental Health Parity and Addiction Equity Requirements (MHPAEA))

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
---------	--	-------------------	-------------	-----------------------------

INPATIENT BEHAVIORAL HEALTH TREATMENT SERVICES

Inpatient Psychiatric Hospitalization in Free-standing Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 12VAC30-50-130 12VAC30-50-100	Yes	Yes	The Contractor must 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).
---	---	-----	-----	--

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES*

*Coverage must comply with Federal Mental Health Parity law. (See Section 5.6 in the CCMC Contract, Mental Health Parity and Addiction Equity Requirements (MHPAEA))

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	<p>12VAC30-50-105 Manual-Psychiatric Services Chapter 4</p> <p>Final Rule: 42 CFR Part 438.6 page 27861 and pages 27557 and 27558</p> <p>Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)</p>			<p>The Contractor may authorize admission to a free-standing psychiatric hospital “in lieu of” inpatient psychiatric hospitalization in a general hospital (per below) for Medicaid Members between the ages of twenty-one (21) and sixty-four (64). Coverage must comply with Federal Mental Health Parity law and Federal provisions for IMDs. Where the length of stay exceeds fifteen (15) days in a calendar month, the Contractor is required to refund the capitation payment, consistent with the Federal regulations described in 42 CFR § 438.6, 42 CFR § 438.3(e)(2) and in the CCMC Contract, Section 5.5.1.2, <i>IMD Enhanced and State Plan Substituted (“In Lieu Of”) Services of for Certain Medicaid Members.</i></p> <p>Exception: FAMIS MOMS and FAMIS PC are not eligible for services furnished in a state or private free-standing psychiatric mental hospital/IMD setting; however, managed care plans may elect to cover as an additional benefit for their FAMIS MOMS and FAMIS PC enrolled members.</p>
<p>Inpatient Psychiatric Hospitalization in General Hospital</p>	<p>12 VAC 30-50-100 12VAC30-50-130 12VAC30-50-105 12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25</p>	<p>Yes</p>	<p>Yes</p>	<p>The Contractor must 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.</p>

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES*

*Coverage must comply with Federal Mental Health Parity law. (See Section 5.6 in the CCMC Contract, Mental Health Parity and Addiction Equity Requirements (MHPAEA))

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	Manual-Psychiatric Services, Chapter 4			
State Geriatric Hospital Placements (Piedmont, Hiram Davis, and Hancock)		Yes	No	Individuals in Piedmont, Hiram Davis, and Hancock state geriatric facilities are excluded from Managed Care program participation.
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO) (Revenue Codes for TDOs and Service Code 0450 for ECOS)	Code of Virginia § 16.1-340 and 340.1 and §§ 37.2-808 through 810 Appendix B of the Hospital Manual	Yes	Yes	Pursuant to 42 CFR § 441.150 and the Code of Virginia, § 16.1-335 et seq., § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor must provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services, except if the Member is twenty-one (21) through sixty-four (64) and admitted to a free-standing facility. The Contractor is responsible for all TDO admissions to an acute care facility regardless of age. The medical necessity of the TDO services is assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the Member is under TDO for Mental Health Services. The duration of temporary detention must be in accordance with §16.1-335 et seq. of the Code of Virginia for individuals under age eighteen (18) and §37.2-800 et. seq. for adults age eighteen (18) and over. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES*

*Coverage must comply with Federal Mental Health Parity law. (See Section 5.6 in the CCMC Contract, Mental Health Parity and Addiction Equity Requirements (MHPAEA))

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				<p>appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services.</p> <p>Exception: FAMIS MOMS and FAMIS PC coverage does not include TDO treatment in a state or private free-standing psychiatric hospital/IMD setting. Managed care plans may elect to cover as an additional benefit for their FAMIS MOMS and FAMIS PC enrolled members. Coverage is also available through the State TDO fund.</p>
OUTPATIENT BEHAVIORAL HEALTH SERVICES – Psychiatric Services Manual for All				
Electroconvulsive Therapy	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	The Contractor must cover medically necessary electroconvulsive therapy services. Coverage must comply with Federal Mental Health Parity law.
Pharmacological Management, including prescription and review of medication, when performed with psychotherapy services	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary pharmacological management services. (CPT 90863)

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES*

*Coverage must comply with Federal Mental Health Parity law. (See Section 5.6 in the CCMC Contract, Mental Health Parity and Addiction Equity Requirements (MHPAEA))

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Psychiatric Diagnostic Evaluation	12 VAC 30-50-180 12 VAC 30-50-140 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Psychiatric Diagnostic Evaluation ; with Medical Service (CPT 90792 alone or GT)
Psychological/ Neuropsychological Testing	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary psychological and neuropsychological testing services. Coverage must comply with Federal Mental Health Parity law. The former psychological testing CPT codes (96101-96103) and neuropsychological testing CPT codes (96118-96120) are retired, and have been replaced with the following codes, effective Jan. 1, 2019: Psychological Testing administered by Computer (CPT: computer:96146) Neurobehavioral Status Exam (CPT: 96116 and 96121 for Each additional Hour) Neuropsychological Testing Administered by Psychologist/Physician (CPT: 96132 and 96133 for Each additional Hour; 96136 and 96137 for Each additional thirty (30) minutes)

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES*

*Coverage must comply with Federal Mental Health Parity law. (See Section 5.6 in the CCMC Contract, Mental Health Parity and Addiction Equity Requirements (MHPAEA))

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				Neuropsychological Testing Administered by Technician (CPT: 96138 and 96139 for Each additional thirty (30) minutes) Neuropsychological Testing Administered by Computer(CPT: 96146)
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4	Yes	Yes	The Contractor must cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy. 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 twenty-one (21).
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Use the most up-to-date version of the CPT codes.

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Applied Behavior Analysis (ABA)	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 [excluding C.4, D.2(d) and E(i)] Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	The Contractor is required to provide coverage for Applied Behavior Analysis (ABA). ABA means the practice of behavioral analysis by the Virginia Board of Medicine in §54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. See the DMAS Mental Health Services Provider Manual, Intensive Community Based Support – Youth Appendix D, for service codes, available at: https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal
Assertive Community Treatment (ACT)	Mental Health Services Manual (formerly CMHRS)	Yes	Yes	Assertive Community Treatment (ACT) is a highly coordinated set of services offered by a group of medical, behavioral health, and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities						
	Chapters 2, 4 & 6 and Appendix E			<p>ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of individuals’ needs, and oriented around individuals’ personal goals. A fundamental charge of ACT is for the team to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time.</p> <p>Assessment Service Code: See Mental Health Services Provider Manual, Intensive Community Based Support Appendix E for assessment requirements, including billing codes.</p> <p>Treatment Service Code: H0040</p> <table border="1" data-bbox="974 1289 1871 1416"> <tr> <td data-bbox="974 1289 1079 1333">U2</td> <td data-bbox="1079 1289 1871 1333">Contracted as Base Small Team</td> </tr> <tr> <td data-bbox="974 1333 1079 1377">U1</td> <td data-bbox="1079 1333 1871 1377">Contracted as Base Medium Team</td> </tr> <tr> <td data-bbox="974 1377 1079 1416">none</td> <td data-bbox="1079 1377 1871 1416">Contracted as Base Large Team</td> </tr> </table>	U2	Contracted as Base Small Team	U1	Contracted as Base Medium Team	none	Contracted as Base Large Team
U2	Contracted as Base Small Team									
U1	Contracted as Base Medium Team									
none	Contracted as Base Large Team									

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities	
				U5	Contracted as High Fidelity Small Team
				U4	Contracted as High Fidelity Medium Team
				U3	Contracted as High Fidelity Large Team
Community Stabilization	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	<p>The Contractor shall provide Community Stabilization services which are short-term and designed to support an individual and their natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community stabilization services in an individual’s natural environment and provide referral and linkage to other community-based services at the appropriate level of care. Interventions may include: brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring intellectual/developmental disabilities and substance use are also available through this service.</p> <p>The goal of Community Stabilization services is to continue to stabilize the individual within their community and support the individual and/or support system during the period between either 1) an initial Mobile Crisis Response and entry in to an established follow-up service at the appropriate level of care or 2) transitional step-</p>	

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities										
				<p>down from a higher level of care if the next level of care service is identified but not immediately available for access.</p> <p>Treatment Service Code: S9482</p> <table border="1" data-bbox="970 797 2007 1118"> <thead> <tr> <th data-bbox="970 797 1142 837">Modifier</th> <th data-bbox="1142 797 2007 837">Modifier Meaning</th> </tr> </thead> <tbody> <tr> <td data-bbox="970 837 1142 878">HN</td> <td data-bbox="1142 837 2007 878">1 QMHP-A or QMHP-C or 1 CSAC^x</td> </tr> <tr> <td data-bbox="970 878 1142 919">HO</td> <td data-bbox="1142 878 2007 919">1 Licensed^x</td> </tr> <tr> <td data-bbox="970 919 1142 1000">HT, HM</td> <td data-bbox="1142 919 2007 1000">1 Licensed^x and 1 Peer or 1 Licensed^x and 1 CSAC-A</td> </tr> <tr> <td data-bbox="970 1000 1142 1118">HT</td> <td data-bbox="1142 1000 2007 1118">1 Licensed^x and 1 QMHP-E or QMHP-C or QMHP-A or 1 Licensed^x and 1 CSAC^x</td> </tr> </tbody> </table> <p>^x= Includes supervisees and residents</p>	Modifier	Modifier Meaning	HN	1 QMHP-A or QMHP-C or 1 CSAC ^x	HO	1 Licensed ^x	HT, HM	1 Licensed ^x and 1 Peer or 1 Licensed ^x and 1 CSAC-A	HT	1 Licensed ^x and 1 QMHP-E or QMHP-C or QMHP-A or 1 Licensed ^x and 1 CSAC ^x
Modifier	Modifier Meaning													
HN	1 QMHP-A or QMHP-C or 1 CSAC ^x													
HO	1 Licensed ^x													
HT, HM	1 Licensed ^x and 1 Peer or 1 Licensed ^x and 1 CSAC-A													
HT	1 Licensed ^x and 1 QMHP-E or QMHP-C or QMHP-A or 1 Licensed ^x and 1 CSAC ^x													
Functional Family Therapy (FFT)	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	The Contractor shall cover Functional Family Therapy (FFT) which is a short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including co-occurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT is a primarily home-based service that addresses both symptoms of serious emotional disturbance in the identified youth as well as parenting/caregiving practices and/or caregiver challenges that affect the youth and caregiver’s ability to function as										

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities									
				<p>a family. The FFT model is a rehabilitative service that serves as a step-down and diversion from higher levels of care and seeks to understand and intervene with the youth within their network of systems including, family, peers, school and neighborhood/community.</p> <p>Treatment Service Code: H0036</p> <table border="1" data-bbox="970 873 1990 1373"> <tr> <td data-bbox="970 873 1108 1013">HN</td> <td data-bbox="1108 873 1350 1013">Bachelor's Established Team</td> <td data-bbox="1350 873 1990 1013">One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td> </tr> <tr> <td data-bbox="970 1013 1108 1230">HO</td> <td data-bbox="1108 1013 1350 1230">Master's/Licensed Established Team</td> <td data-bbox="1350 1013 1990 1230">One FFT Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.</td> </tr> <tr> <td data-bbox="970 1230 1108 1373">HK, HN</td> <td data-bbox="1108 1230 1350 1373">Bachelor's New Team</td> <td data-bbox="1350 1230 1990 1373">One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td> </tr> </table>	HN	Bachelor's Established Team	One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP	HO	Master's/Licensed Established Team	One FFT Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.	HK, HN	Bachelor's New Team	One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
HN	Bachelor's Established Team	One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP											
HO	Master's/Licensed Established Team	One FFT Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.											
HK, HN	Bachelor's New Team	One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP											

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities		
				HK, HO	Master's/Licensed New Team	One FFT Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP
Intensive In-Home (IIH) Assessment and Services	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-130-2000 12 VAC 30-60-5 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	Yes	Yes	The Contractor must cover medically necessary Intensive In-Home Assessment Services. Intensive in-home services (IIH) for youth under age 21 are intensive therapeutic interventions provided in the youth’s residence (or other community settings as medically necessary and documented in the Comprehensive Needs Assessment and ISP), to improve family functioning, and significant functional impairments in major life activities that have occurred due to the youth’s mental, behavioral or emotional illness in order to prevent an out of home placement, stabilize the youth, and gradually transition the youth to less restrictive levels of care and supports. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and include clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote benefits of psychoeducation in the home setting of a youth who is at risk of being moved into an out-of-home placement or who		

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				<p>is being transitioned to home from an out-of-home placement due to a documented medical need of the youth.</p> <p>Comprehensive Needs Assessment Service Code: H0031</p> <p>Treatment Service Code: H2012</p>
Mental Health Case Management	<p>12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-143 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)]</p> <p>12 VAC 30-60-5 Mental Health Services Manual (formerly CMHRS)</p>	Yes	Yes	<p>The Contractor must cover medically necessary Mental Health Case Management services. Mental health Case Management is defined as a service to assist individuals, eligible under the State Plan 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.</p> <p>Service Code: H0023</p>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	Manual Chapters 2, 4 & 6			
Mental Health Intensive Outpatient (MH-IOP)	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix F	Yes	Yes	The Contractor shall cover Mental Health Intensive Outpatient Services (MH-IOP) which are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time limited treatment programs that integrate evidence-based practices for youth (ages six (6) – seventeen (17) years) and adults (eighteen (18) years and older). MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention and reducing the need for a more acute level of care. MH-IOP services are appropriate when an individual requires at least six (6) hours of clinical services a week (for youth ages six (6) – seventeen (17)), or nine (9) hours of clinical services as week (for adults 18 years and older) over several days a

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				<p>week and totaling a maximum of nineteen (19) hours per week. A MH-IOP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-IOP tapers in intensity as an individual’s symptoms improve as evidenced by their ability to establish community supports, resume daily activities or participate in a lower level of care.</p> <p>Assessment Service Code: See Mental Health Services Provider Manual, Intensive Clinic Based Support Appendix for assessment billing requirements.</p> <p>Treatment Service Code: S9480/ S9480 GO (Occupational Therapy)</p>
Mental Health – Partial Hospitalization Program	Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	Yes	Yes	<p>Mental Health Partial Hospitalization Programs (MH-PHPs) are highly structured clinical programs designed to provide an intensive combination of interventions and services which are similar to an inpatient program, but available on a less than twenty-four (24)-hour basis. MH-PHP are active, focused and time-limited treatment programs intended to stabilize acute symptoms in youth six to seventeen (6-17 years old) and adults (eighteen (18) years +). The average length of stay may be four (4) to six (6) weeks, though length of stay should reflect individual symptom severity, needs, goals and medical necessity criteria. MH-PHP can serve as a transition program, such as a step-down option following an inpatient hospitalization. MH-PHP can serve as a diversion</p>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				<p>for an individual from inpatient care, by providing an alternative that allows for intensive clinical services without hospital admission. The target population consists of individuals that would likely require inpatient hospitalization in the absence of receiving this service. MH-PHPs services may occur in either a hospital- or community-based location.</p> <p>MH-PHP services are appropriate when an individual requires at least four (4) hours of clinical services a day, over several days a week and totaling a minimum of twenty (20) hours per week. A MH-PHP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-PHP tapers in intensity and frequency as an individual’s symptoms improve, they are able to establish/reestablish community supports, and they are able to resume daily activities or are appropriate to participate in a lower level of care.</p> <p>Assessment Service Code: See Mental Health Services Provider Manual, Intensive Clinic Based Support Appendix for assessment billing requirements.</p> <p>Treatment Service Code: H0035</p>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Mental Health Peer Recovery Support Services	Regulations: 12 VAC 30-50-226 12 VAC 30-50-130 12 VAC 30-130-5160 through 12 VAC 30-130-5210 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] Manual: Mental Health Services Manual – Peer Recovery Support Services Supplement	Yes	Yes	The Contractor must cover medically necessary MH Peer Support Services for adults and MH Family Support Partners for youth under 21. MH Peer Support Services and MH Family Support Partners are peer recovery support services as defined in 12VAC35-250-10. Collaborative, nonclinical, peer-to-peer services that engage, educate, and support a member’s self-help efforts to improve his health, recovery, resiliency, and wellness to assist members in achieving sustained recovery from the effects of mental illness, addiction or both. Service Code H0024 (Individual) H0025 (Group)
Mental Health Skill-building Assessment and Services (MHSS)	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130	Yes	Yes	The Contractor must cover medically necessary Mental Health Skill-building Assessment and Services. Mental Health Skill-building Services (MHSS) are defined as goal directed training and supports to enable restoration of an individual to the highest level of

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	<p>12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)]</p> <p>12 VAC 30-60-5 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6</p>			<p>baseline functioning and achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS services must provide face to face activities, instruction, interventions, and goal directed trainings that are designed to restore functioning and that are defined in the ISP in order to be reimbursed by Medicaid. MHSS must include goal directed training in the following areas: (i) functional skills and appropriate behavior related to the individual’s health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities.</p> <p>Comprehensive Needs Assessment Service Code: H0032-U8</p> <p>Treatment Service Code: H0046</p>
Mobile Crisis Response	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	The Contractor shall cover Mobile Crisis Response which provides rapid response, assessment and early intervention to individuals experiencing a behavioral health crisis. This service is provided twenty-four (24) hours a day, seven (7) days a week. The purpose of this service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety in order to prevent the need for a higher level of care. Mobile Crisis Response is also the

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities														
				<p>mechanism by which pre-admission screenings for hospitalization may be performed by DBHDS pre-admission screening clinicians, when clinically necessary.</p> <p>Treatment Service Code: H2011</p> <table border="1" data-bbox="970 797 2022 1351"> <thead> <tr> <th data-bbox="970 797 1146 837">Modifier</th> <th data-bbox="1146 797 2022 837">Modifier Meaning</th> </tr> </thead> <tbody> <tr> <td data-bbox="970 837 1146 878">HO</td> <td data-bbox="1146 837 2022 878">1 Licensed^x</td> </tr> <tr> <td data-bbox="970 878 1146 959">32</td> <td data-bbox="1146 878 2022 959">Emergency Custody Order 1 Licensed^x</td> </tr> <tr> <td data-bbox="970 959 1146 1040">HT, HM</td> <td data-bbox="1146 959 2022 1040">1 QMHP-A/QMHP-C/CSAC^x and 1 PRS or 1 QMHP-A/QMHP-C/CSAC^x and 1 CSAC-A</td> </tr> <tr> <td data-bbox="970 1040 1146 1122">HT, HO</td> <td data-bbox="1146 1040 2022 1122">1 Licensed^x and 1 PRS or 1 Licensed^x and 1 CSAC-A or</td> </tr> <tr> <td data-bbox="970 1122 1146 1203">HT, HN</td> <td data-bbox="1146 1122 2022 1203">2 QMHPs (QMHP-A, QMHP-C and/or QMHP-E) /CSACs^x or 1 QMHP-A/QMHP-C and 1 CSAC^x</td> </tr> <tr> <td data-bbox="970 1203 1146 1351">HT</td> <td data-bbox="1146 1203 2022 1351">1 Licensed^x and 1 QMHP(QMHP-A, QMHP-C or QMHP-E) or 1 Licensed^x and 1 CSAC^x</td> </tr> </tbody> </table> <p>^x = Includes supervisees and residents</p>	Modifier	Modifier Meaning	HO	1 Licensed ^x	32	Emergency Custody Order 1 Licensed ^x	HT, HM	1 QMHP-A/QMHP-C/CSAC ^x and 1 PRS or 1 QMHP-A/QMHP-C/CSAC ^x and 1 CSAC-A	HT, HO	1 Licensed ^x and 1 PRS or 1 Licensed ^x and 1 CSAC-A or	HT, HN	2 QMHPs (QMHP-A, QMHP-C and/or QMHP-E) /CSACs ^x or 1 QMHP-A/QMHP-C and 1 CSAC ^x	HT	1 Licensed ^x and 1 QMHP(QMHP-A, QMHP-C or QMHP-E) or 1 Licensed ^x and 1 CSAC ^x
Modifier	Modifier Meaning																	
HO	1 Licensed ^x																	
32	Emergency Custody Order 1 Licensed ^x																	
HT, HM	1 QMHP-A/QMHP-C/CSAC ^x and 1 PRS or 1 QMHP-A/QMHP-C/CSAC ^x and 1 CSAC-A																	
HT, HO	1 Licensed ^x and 1 PRS or 1 Licensed ^x and 1 CSAC-A or																	
HT, HN	2 QMHPs (QMHP-A, QMHP-C and/or QMHP-E) /CSACs ^x or 1 QMHP-A/QMHP-C and 1 CSAC ^x																	
HT	1 Licensed ^x and 1 QMHP(QMHP-A, QMHP-C or QMHP-E) or 1 Licensed ^x and 1 CSAC ^x																	

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities						
Multisystemic Therapy (MST)	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	<p>The Contractor shall cover Multi-systemic therapy (MST) which is an intensive, evidence-based treatment program provided in home and community settings for youth (eleven (11) – seventeen (17) years of age) who have received referral for the treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. MST is appropriate for youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST includes an emphasis on engagement with the youth’s family, caregivers and natural supports and professionals delivering interventions in the recovery environment. MST is a short-term and rehabilitative service that may serve as a step-down and diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and neighborhood/community.</p> <p>Treatment Service Code: H2033</p> <table border="1" data-bbox="970 1141 2013 1393"> <tr> <td data-bbox="970 1141 1108 1284">HN</td> <td data-bbox="1108 1141 1350 1284">Bachelor's Established Team</td> <td data-bbox="1350 1141 2013 1284">One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td> </tr> <tr> <td data-bbox="970 1284 1108 1393">HO</td> <td data-bbox="1108 1284 1350 1393">Master's/ Licensed Established Team</td> <td data-bbox="1350 1284 2013 1393">One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee</td> </tr> </table>	HN	Bachelor's Established Team	One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP	HO	Master's/ Licensed Established Team	One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
HN	Bachelor's Established Team	One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP								
HO	Master's/ Licensed Established Team	One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee								

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities		
						All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.
				HK, HN	Bachelor's New Team	One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
				HK, HO	Master's/ Licensed New Team	One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP
Psychiatric Residential Treatment Facility – (PRTF) for children under age twenty-one (21) years –	12 VAC 30-10-540 12 VAC 30-60-61 12 VAC 30-50-130 12 VAC 30-60-5 Residential Treatment Services; Manual	Yes	No	The Contractor is not responsible for covering Psychiatric Residential Treatment Facility (PRTF) services for Medicaid children under age 21. Psychiatric residential treatment (level C) is not a covered service for FAMIS MOMS and FAMIS PC. The Contractor may cover services rendered in free-standing psychiatric hospitals as an enhanced benefit.		

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
(Formerly known as Level C)				<p>Note: Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled with the Contractor and who are admitted to a Residential Treatment Center for Substance Use Disorder are not excluded and will remain enrolled with the Contractor. See Part 2C for RTC coverage through ARTS benefits.</p> <p>Department authorization for Medicaid children under age 21 into a PRTF program will result in disenrollment of the Medicaid Member from the managed care program. The PRTF provider must contact the Department’s Service Authorization Contractor for authorization and payment through the fee-for-service program.</p> <p>The Contractor must work closely with the Department’s Service Authorization Contractor 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. The Contractor must collaborate with the Department’s Service Authorization Contractor to ensure physician engagement occurs on behalf of the Member during the independent certification of need process as required prior to any residential treatment service authorization.</p>
Psychosocial Rehabilitation	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-5	Yes	Yes	The Contractor must cover medically necessary Intensive Psychosocial Rehabilitation Assessment and Services. Includes services for the severely behaviorally ill. Psychosocial rehabilitation is provided in sessions of two (2) or more consecutive hours

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Assessment and Services	12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-143 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6			per day to groups of individuals in a non-residential setting. These services include assessment, education about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature. Staff may observe medication being taken, watch and observe behaviors and note side effects of medications. These services are limited to 936 units annually. Comprehensive Needs Assessment Service Code: H0032-U6. Service Code: H2017 Not an excluded service for Members in one (1) of the DD Waivers with an appropriate service authorization for Psychosocial Rehabilitation.
Residential Crisis Stabilization Unit (RCSU)	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	The Contractor shall provide access to and cover services provided in Residential Crisis Stabilization Units which serve as diversion facilities from inpatient hospitalization. Residential Crisis Stabilization Units provide short-term, twenty-four (24) hours a day, seven (7) days a week, residential psychiatric/substance related crisis evaluation and brief intervention services. The service supports individuals experiencing abrupt and

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities				
				substantial changes in behavior noted by severe impairment or acute decompensation in functioning. Treatment Service Code: H2018 <table border="1" data-bbox="974 792 1715 867"> <tr> <td data-bbox="974 792 1052 833">32</td> <td data-bbox="1052 792 1715 833">Emergency Custody Order (ECO)</td> </tr> <tr> <td data-bbox="974 833 1052 867">HK</td> <td data-bbox="1052 833 1715 867">Temporary Detention Order (TDO)</td> </tr> </table>	32	Emergency Custody Order (ECO)	HK	Temporary Detention Order (TDO)
32	Emergency Custody Order (ECO)							
HK	Temporary Detention Order (TDO)							
Therapeutic Day Treatment (TDT) for Children and Adolescents	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-50-226 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5	Yes	Yes	The Contractor must cover medically necessary Therapeutic Day Treatment (TDT) for Children and Adolescents. TDT provides medically necessary, individualized, and structured therapeutic interventions to youth with mental, emotional, or behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. TDT treatment interventions are provided during the school day or to supplement the school day or year. This service shall include assessment, assistance with medication management, interventions to build daily living skills or enhance social skills, and individual, group, and/or family counseling and care coordination. These services shall be provided for two or more hours per day				

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	Mental Health Services Manual Chapters 2, 4 & 6			<p>Comprehensive Needs Assessment Service Code: H0032</p> <p>Service Code: H2016</p> <p>Modifiers:</p> <p>School Based TDT must be billed as H2016 (none)</p> <p>After School TDT must be billed as H2016 UG</p> <p>Summer TDT must be billed as H2016 U7</p>
Therapeutic Group Home (TGH) Children and Adolescents under twenty-one (21) – Group Home (Formerly known as Levels A&B)	<p>12 VAC 30-50-130 and 12 VAC 30-60-61</p> <p>VAC 30-60-5</p> <p>12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)]</p> <p>Residential Treatment Services Manual</p>	Yes	No	<p>The Contractor is not responsible for covering Therapeutic Group Home (TGH) services</p> <p>Any youth admitted to a TGH participants will not be excluded from the Cardinal Care Managed Care Program; however, the TGH per diem service is carved out of the Cardinal Care Managed Care Contract and will be administered through the Department’s Service Authorization Contractor. Covered services rendered to individuals in the TGH that are allowed to be billed outside the TGH per diem will be the responsibility of the Contractor. (See Chapter V of the DMAS Residential Treatment Services Manual). The Contractor must collaborate with the Department’s Service Authorization Contractor to: facilitate Independent Assessment Certification and Coordination Team (IACCT) activities on behalf of the Member, to ensure coordination of Medical, ARTS, and mental health services for its Members, and to provide coverage</p>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				for transportation and pharmacy services necessary for the provision of, and as related to, TGH carved out services. TGH Service Code: H2020 HW or HK EPSDT TGH Code: H0019
Treatment Foster Care (TFC) Case Management (CM) for children under age twenty-one (21) years.	12 VAC 30-60-170 12 VAC 30-50-480 12 VAC 30-130-900 to 950 12 VAC 30-80-111 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	Yes	Yes	The Contractor must cover medically necessary Treatment Foster Care (TFC) Case Management (CM) for children under age twenty-one (21) years. Treatment Foster Care - Case Management is a service that assists Medicaid eligible individuals in gaining and coordinating access to necessary care and services appropriate to their needs. Service Code T1016.
Twenty-three (23) Hour Crisis Stabilization	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	The Contractor shall cover Twenty-three (23)-Hour Crisis Stabilization which provides a period of up to twenty-three (23) hours in a community-based crisis stabilization clinic that provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis. This service should be accessible twenty-four (24) hours a day,

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities				
				<p>seven (7) days a week, and is indicated for those situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or crisis stabilization unit setting is necessary. This service allows for an opportunity for thorough assessment of crisis and psychosocial needs and supports throughout the full twenty-three (23) hours of service to determine the best resources available to for the individual to prevent unnecessary hospitalization.</p> <p>Treatment Service Code: S9485</p> <table border="1" data-bbox="974 987 1715 1062"> <tr> <td data-bbox="974 987 1052 1024">32</td> <td data-bbox="1052 987 1715 1024">Emergency Custody Order (ECO)</td> </tr> <tr> <td data-bbox="974 1024 1052 1062">HK</td> <td data-bbox="1052 1024 1715 1062">Temporary Detention Order (TDO)</td> </tr> </table>	32	Emergency Custody Order (ECO)	HK	Temporary Detention Order (TDO)
32	Emergency Custody Order (ECO)							
HK	Temporary Detention Order (TDO)							

SUMMARY OF COVERED SERVICES - Part 2C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
<p>INPATIENT AND RESIDENTIAL SUD TREATMENT SERVICES - The Contractor must provide coverage in IMD settings for Medicaid, FAMIS MOMS, and FAMIS PC, as appropriate based on the ASAM Criteria, including for children and adults, regardless of age. Effective July 1, 2021, FAMIS MOMS and FAMIS PC enrollees are eligible for coverage for medically necessary services in an IMD, equivalent to such benefits offered to pregnant women under the Medicaid state plan and Medicaid Section 1115 demonstration waiver. This coverage includes the following settings: ASAM Levels 3.3, 3.5, 3.7 and 4.0 in residential treatment settings, psychiatric units and free-standing psychiatric hospitals.</p>				
Medically Managed Intensive Inpatient	ASAM Level 4.0 12VAC30-130-5000 to 5040 12VAC30-130-5150	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0011 or Rev. 1002
Medically Monitored Intensive Inpatient Services	ASAM Level 3.7 12VAC30-130-5000 to 5040 12VAC30-130-5140	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H2036 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed High Intensity Residential Services	ASAM Level 3.5 12VAC30-130-5000 to 5040 12VAC30-130-5130	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed Population-Specific High Intensity Residential Services	ASAM Level 3.3 12VAC30-130-5000 to 5040 12VAC30-130-5120	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier TG

SUMMARY OF COVERED SERVICES - Part 2C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Clinically Managed Low Intensity Residential Services	ASAM Level 3.1 12VAC30-130-5000 to 5040 12VAC30-130-5150	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H2034
OUTPATIENT WITHDRAWAL MANAGEMENT				
ARTS Partial Hospitalization	ASAM Level 2.5 12VAC30-130-5000 to 5040 12VAC30-130-5110	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes S0201 Rev 0913 and S0201
ARTS Intensive Outpatient	ASAM Level 2.1 12VAC30-130-5000 to 5040 12VAC30-130-5090	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0015 Rev 0906 and H0015
Ambulatory Withdrawal Management with Extended On- Site Monitoring	ASAM Level 2WM	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. CPT codes
Ambulatory Withdrawal Management	ASAM Level 1 WM	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. CPT codes

SUMMARY OF COVERED SERVICES - Part 2C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities	
without Extended On- Site Monitoring					
Medication Assisted Treatment (MAT)					
Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM Opioid Treatment Programs 12VAC30-130-5000 to 5040 12VAC30-130-5050	Yes	Yes	Counseling Medication Medication Administration Care Coordination Physician Visit – Induction Day 1 Urine Drug Screen Labs Physician Visit – Maintenance	H0004 – individual and family counseling H0005 - group counseling S0109 Methadone five (5) mg oral billed by provider H0020 G9012 Substance Use Care Coordination H0014 80305 to 80307 and G0480- G0483 CPT codes Use CPT E&M Established patient
Buprenorphine/Naloxone and Naltrexone in Opioid Treatment Program (DBHDS-Licensed CSB and Private Methadone Clinics)	ASAM Opioid Treatment Programs 12VAC30-130-5000 to 5040 12VAC30-130-5050	Yes	Yes	Counseling Medication Medication	H0004 – individual and family counseling H0005 - group counseling J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider J2315 Naltrexone, Injection, depot form, billed by provider G9012 Substance Use Care Coordination H0020

SUMMARY OF COVERED SERVICES - Part 2C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				Administration Care Coordination Physician Visit – Induction Day 1 H0014 Urine Drug Screen 80305 to 80307 and G0480- G0483 Labs CPT codes Physician Visit – Maintenance Use CPT E&M Established patient
Buprenorphine/Naloxone and Naltrexone in ASAM Office Based Addiction Treatment and ASAM Level 1.0	ASAM Office Based Opioid Treatment 12VAC30-130-5000 to 5040 12VAC30-130-5160	Yes	Yes	Counseling and Medication Oversight H0004 – individual and family counseling Care Coordination H0005 - group counseling Physician Visit – Induction Day 1 G9012 Substance Use Care Coordination Drug Screen H0014 Labs 80305 to 80307 and G0480- G0483 Physician Visit – Maintenance CPT codes Use CPT E&M Established patient
ARTS CASE MANAGEMENT, OUTPATIENT, AND PEER RECOVERY SUPPORT SERVICES				
Substance Use Case Management	12 VAC 30-60-185 12 VAC 30-50-491	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. (H0006)
Outpatient ARTS Individual, Family,	ASAM Level 1.0 12VAC30-130-5000 to 5040	Yes	Yes	The Contractor must cover SUD services within ASAM criteria (CPT Codes)

SUMMARY OF COVERED SERVICES - Part 2C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
and Group Counseling Services	12VAC30-130-5080			
ARTS Peer Recovery Support Services	Regulations: 12VAC30-50-226 12VAC30-50-130 12VAC30-130-5160 through 12VAC30-130-5210 Manual: ARTS - Peer Services Manual Supplement	Yes	Yes	The Contractor must cover ARTS Peer Support Services for Adults and ARTS Family Support Partners for youth under twenty-one (21). Group – S9445 Individual – T1012
Screening, Brief Intervention and Referral to Treatment (SBIRT)	ASAM Level 0.5 12VAC30-130-5000 to 5040 12VAC30-130-5070	Yes	Yes	The Contractor must cover SUD services within ASAM criteria (99408/99409)

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
<p>EPSDT Benefit Global Coverage Guidelines</p>	<p>12 VAC 30-50-130 42 CFR § 440.40(b)(2) and 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act http://www.dmas.virginia.gov/files/links/914/EPSDT%20Specialized%20Services%20-%20Guide%20to%20Providers.pdf https://www.medicaid.gov/medicaid/benefits/epsdt/index.html</p>	<p>Yes</p>	<p>Yes</p>	<p>EPSDT includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under twenty-one (21) years of age. EPSDT also includes a federal requirement which compels state Medicaid agencies to cover services, products, or procedures for children, if those items are determined to be medically necessary to “correct or ameliorate” a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. Refer to the following for more information: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html</p> <p>Ameliorate is defined as necessary to improve or to prevent the condition from getting worse.</p> <p>For individuals under twenty-one (21) years of age EPSDT services will be provided before Technology Assisted Program services are offered.</p> <p>The Contractor must cover dental screenings and dental varnish under EPSDT.</p> <p>The Contractor must screen and assess all children; cover immunizations; educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal to increase immunization rates.</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				EPSDT Assistive Technology (T5999) is a covered EPSDT benefit. The Contractor must provide assistive technology as specified in the EPSDT Manual, Supplement B Chapter.
Assistive Technology (AT)	Same as EPSDT Global Coverage Guidelines	Yes	Yes	To correct or ameliorate physical or mental conditions identified during EPSDT screening services, the child may be referred by the EPSDT screener or PCP for Assistive Technology services. Assistive Technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia State Plan for Medical Assistance. Assistive Technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive Technology items are expected to be portable. See EPSDT Supplement B for specific coverage criteria. For children under age twenty-one (21) on the CCC Plus Waiver, assistive technology is covered through EPSDT.
Case Management for High-risk Infants (up to age two (2))	12 VAC 30-50-410	Yes	Yes	The Contractor must reimburse case management services for high-risk Medicaid-eligible children up to age two (2).
Clinical Trials	Same as EPSDT Global Coverage Guidelines	Yes	Yes	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.
Dental Screenings	Same as EPSDT Global Coverage Guidelines	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.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or her one(1)-year screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three (3) 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	Same as EPSDT Global Coverage Guidelines	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 must be covered.
Hearing Services	Same as EPSDT Global Coverage Guidelines	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 must include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening must mean, at a minimum, observation of an infant’s response to auditory stimuli. Speech and hearing assessment must be part of each preventive visit for an older child.</p>
Immunizations	Same as EPSDT Global Coverage Guidelines	Yes	Yes	According to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines, immunizations must be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination. Coverage must also be within CDC

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>guidelines. The Contractor must coordinate coverage within the Virginia Vaccines for Children (VVFC) program. See the EPSDT Supplement Manual and the VVFC website at: http://www.vdh.virginia.gov/immunization/vvfc</p>
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>The following recommended sequence of screening laboratory examinations must be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and must be obtained as necessary:</p> <ol style="list-style-type: none"> 1. Hemoglobin/hematocrit 2. Tuberculin test (for high-risk groups) 3. Blood lead testing (see row below on Lead Testing)
Lead Investigations	12 VAC 30-50-227 EPSDT Supplement	Yes	Yes	<p>The Contractor must 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 must be limited to no more than two (2) visits per residence.</p>
Lead Testing	EPSDT Guidelines 12VAC5-90-215	Yes	Yes	<p>All Medicaid children are required to receive a blood lead test at twelve (12) months and twenty-four (24) months of age. In addition, any child between twenty-four (24) and seventy-two (72) months with no record of a previous blood lead screening test must receive one (1). Testing may be performed by venipuncture or capillary. Filter</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>paper methods are also acceptable and can be performed at the provider’s office. Tests of venous blood are considered confirmatory. The providers need to use the code 83655 for Lead blood testing and one (1) of the following:</p> <ol style="list-style-type: none"> 1. 36416 for the collection of capillary blood specimen (finger, heel, ear stick) 2. 36415 for the collection of venous blood by venipuncture. <p>A blood lead test result equal to or greater than 5 ug/dL (or consistent with the most current CDC guidelines) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. All testing must be done through a blood lead level determination. Results of lead testing, both positive and negative results, must be reported to the Virginia Department of Health, Office of Epidemiology.</p>
Personal Care	Same as EPSDT Benefit Global Coverage Guidelines	Yes	Yes	<p>EPSDT Personal Care Services are designed to assist children under the age of twenty-one (21) who meet the criteria for EPSDT Personal Care as defined in the EPSDT Personal Care Services Supplement with activities of daily living (ADLs), instrumental activities of daily living (IADLs), medically necessary supervision and monitoring of self-administered medications. The child’s need for assistance with ADLs due to a health condition must be documented by the child’s primary care provider on the EPSDT Functional Status Assessment Form (DMAS-7). The form must be completed and signed by a physician, physician’s assistant or nurse practitioner and updated every year. EPSDT Personal Care criteria is utilized for children not enrolled in CCC Plus Waiver.</p> <p>For members enrolled in CCC Plus Waiver, including those members under twenty-one (21) years old, personal care will be provided under the waiver. As such CCC Plus Waiver criteria and forms are used to determine personal care hours for these</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				members. See Section 5.12.2 of the CCMC Contract, <i>Commonwealth Coordinated Care Plus Waiver</i> .
Private Duty Nursing (PDN)	42 CFR §§ 441.50, 440.80, Social Security Act §1905(a) and 1905(r) l.	Yes	Yes	<p>The Contractor must cover medically necessary PDN services for children under age twenty-one (21), in accordance with the Department’s criteria described in the DMAS EPSDT Nursing Supplement.</p> <p>The Contractor must 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 Program who require continuous nursing that cannot be met through home health. Technology Assisted Program uses form 108& 109 to determine the hours of service needed. 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 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>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				Payment by the Contractor for services provided by any network or out-of-network provider for EPSDT or Skilled Private Duty Nursing must be reimbursed no less than the Department’s fee-for-service rate.
Screenings	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>Comprehensive, periodic health assessments (or screenings) from birth through age twenty (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 must 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 must include: (1) a comprehensive health and developmental history, including assessments of both physical and mental health development, including reimbursement for developmental screens rendered by providers other than the primary care provider; and, (2) a comprehensive unclothed physical examination</p> <p>The medical screening must include: (1) a comprehensive health and developmental history, including assessments of both physical and mental health development, including 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.</p>
Vision Services	Same as EPSDT Global Coverage Guidelines	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 must include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant must mean, at a minimum, eye examination

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				and observation of responses to visual stimuli. In an older child, screening for visual acuity must be done. Effective September 1, 2022, vision assessments and eyeglasses are covered when provided in a school setting by a mobile vision provider.
Other Medically Necessary Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>EPSDT includes medically necessary health care, diagnostic services, treatment, and measures as needed to correct or ameliorate defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child’s (under twenty-one (21) years of age) current level of functioning or to prevent the child’s medical condition from getting worse.</p> <p>CMS EPSDT Guidance: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf</p> <p>NHeLP - http://www.healthlaw.org/</p> <p>State Medicaid Manual: https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html</p>

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Early Intervention (EI) Services	20USC § 1471 34 CFR § 303.12 Code of Virginia § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	<p>The Contractor must provide coverage for Early Intervention services as defined in 12 VAC 30-50-131, 12 VAC 30-50-415, and 12VAC35-225 et. seq., and within the Department’s coverage criteria and guidelines. The Department’s Early Intervention billing codes, reimbursement methodology, and coverage criteria must be used and are described in the Department’s Early Intervention Program Manual, on the Department’s website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.</p> <p>Medical necessity for Early Intervention services must be defined by the Member’s IFSP, including in terms of amount, duration, and scope. Service authorization must not be required.</p> <p>The Contractor must also cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.</p> <p>For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:</p> <ol style="list-style-type: none"> 1. Those services federally required to be provided at public expense as is the case for <ol style="list-style-type: none"> a. assessment/EI evaluation,

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<ul style="list-style-type: none"> b. development or review of the Individual Family Service Plan (IFSP); and, c. targeted case management/service coordination; <ol style="list-style-type: none"> 2. Developmental services; and, 3. Any covered early intervention services where the family has declined access to their private health/medical insurance. See Section 13.4.4 of the CCMC Contract, <i>Comprehensive Health Coverage</i>.
Early Intervention (EI) Targeted Case Management (TCM)/Service Coordination	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	The Contractor must provide coverage for EI Targeted Case Management (also referred to as EI Service Coordination). EI service coordination is a service that will assist the child and family in gaining access to needed and appropriate medical, social, educational, and other services. EI Service Coordination is designed to ensure that families are receiving the supports and services that will help them achieve their goals on their child’s Individual Family Service Plan (IFSP), through monthly monitoring, quarterly family contacts, and ongoing supportive communication with the family. The Service Coordinator can serve in a “blended” role; in other words, a single practitioner can provide both Early Intervention Targeted Case Management/Service Coordination and an IFSP service, such as physical therapy, developmental services, etc. to a child and his or her family.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
				Billing Code	Description	Limits
				T2022	Service Coordination	one (1) charge/child/month
Early Intervention (EI) Initial Assessments for Service Planning and Development and Annual Review of the Individual Family Services Plan (IFSP)	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention initial and subsequent assessments for service planning in the child’s natural environment or in a center based program.		
				Billing Code	Description	Limits
				T1023 (RC 2)	Initial assessment, development of initial IFSP, Annual IFSP	twenty-four (24) units/day and thirty-six (36) units/year
T1023 U1(RC 1)						
IFSP Team Treatment Activities (more than one (1) professional providing services during same session for an individual	12VAC30-50-131 12 VAC 35-225-120 – 12VAC35-225-160	Yes	Yes	The Contractor is required to provide coverage for Early Intervention team treatment activities where more than one (1) professional is providing services during same session for an individual child/family. These services may be provided in the child’s natural environments for team treatment activities; or the natural environment or center for IFSP reviews and assessment.		
				Billing Code	Description	Limits

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
child/family); IFSP Review meetings; Assessments performed after the initial assessment for service planning				T1024* (RC 2)	<ol style="list-style-type: none"> 1. Team Treatment activities (more than one (1) professional providing services during same session for an individual child/family 2. IFSP Review Meetings (must be in-person) 3. Assessments that are done after the initial Assessment for Service Planning 	The maximum daily units/per child/ per (service) code/ per individual practitioner is six (6) units with a maximum of eighteen (18) units per day per child for all agency/providers combined. Applies to all codes in this Section with “*”.
				T1024 U1* (RC 1)		
Developmental Services; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention developmental services for an individual child or for more than one (1) child, in a group (congregate) in the child’s natural environment.		
				Billing Code	Description	Limits

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
				T1027* (RC 2)	Developmental Services and other early intervention services provided for more than one (1) child, in a group (congregate).	RC 2 only. See above for limits*.
				Billing Code	Description	Limits
				T1027 U1* (RC 2)	Developmental Services and other early intervention services provided for one (1) child	RC 2 only. See above for limits*.
Center-Based Early Intervention Services (EI); individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention center-based individual and group (congregate) services.		
				Billing Code	Description	Limits
				T1026* (RC 1)	Center-based group (congregate) early intervention services	See above for limits*.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
				T1026 U1* (RC 1)	Center-based individual early intervention services	
				T1015* (RC 2)	Center-based group (congregate) early intervention services	
				T1015 U1* (RC 2)	Center-based individual early intervention services	
Early Intervention (EI) Physical Therapy (PT); individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Physical Therapy in an individual or group (congregate) setting, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0151* (RC 1)	Group (congregate) PT	See above for limits*.
G0151 U1* (RC 1)	Individual PT					

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
Early Intervention (EI) Occupational Therapy (OT); individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Occupational Therapy in an individual or group (congregate) setting, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0152* (RC 1)	Group (congregate) OT	See above for limits*.
G0152 U1* (RC 1)	Individual OT					
Early Intervention (EI) Speech Language Pathology; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Speech Language Pathology in an individual or group (congregate) setting, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0153 (RC 1)	Group (congregate) SLP	See above for limits*.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
				G0153 U1 (RC 1)	Individual SLP	
Developmental Nursing; individual and/or group	12VAC30-50-13112 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention individual and group (congregate) Nursing Services or Developmental Services provided by a nurse, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0495* (RC 1)	Group (congregate) RN Training and Education Services;	See above for limits*.
G0495 U1* (RC 1)	RN Individual Training and Education Services.					

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Nursing Facility (NF)	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual	Yes	Yes	The Contractor must cover this service. The Contractor must also be responsible for non-nursing facility services and must work with the NF on discharge planning if appropriate. The Contractor must establish strong relationships with NFs to ensure that Members in NFs receive high quality care, maintain good health, and to reduce avoidable hospital admissions among NF residents. Contractors must help facilitate Members returning to community settings when possible and desired by the Member. The Contractor may provide additional health care improvement services or other services not specified in this contract, including but not limited to step down nursing care as long as these services are available, as needed or desired by Members.
Long-stay Hospital (LSH) State Plan Only Service	12 VAC 30-60-30; 12 VAC 30-130-100 through 12 VAC 30-130-130 Additional information can be found in the Nursing Facility provider manual available on the Department's web portal at: www.virginiamedicaid.com	Yes	Yes	The Contractor must provide information and referrals as appropriate to assist Members in accessing services. The Contractor must cover all services associated with the provision of long-stay hospital services. 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 must make provisions for the collection and distribution of the individual Member's monthly patient pay for long-stay hospital services. Hospitals recognized as LSH are Lake Taylor Hospital (Norfolk) and Hospital for Sick Children (Washington, DC).

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	aid.dmas.virginia.gov OV			
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 Department's web portal at: www.virginiamedicaid.dmas.virginia.gov OV	Yes	Yes	The Contractor must cover all services associated with the provision of specialized care services for adults and children. 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 must make provisions for the collection and distribution of the individual Member's monthly patient pay for specialized care services. Transition services are covered for those individuals seeking services in the community through the Contractor.
Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)	http://www.dbhds.virginia.gov/library/developmental%20services/ods-voluntaryadmission2011.pdf	Yes	No	The Contractor is not required to cover ICF-IID services. Individuals receiving services in an ICF-ID will be excluded from MLTSS participation.

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/training-centers			

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
CCC Plus HCBS Waiver (formerly Elderly or Disabled with Consumer-Directed Services EDCD and Technology Assisted Waivers) General Requirements	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the Department's web	Yes	Yes	The Contractor must provide care coordination, information and referrals as appropriate to assist Members in accessing these services. The Contractor must cover personal care, respite care, adult day health care, personal emergency response systems, skilled private duty nursing, assistive technology, environmental modifications, services facilitation, and transition services. The Contractor must 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 are covered for those individuals seeking services in the community after transition from a qualified institution. The Contractor must make provisions for the collection and distribution of the Member's monthly patient pay for Program services (if

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library			appropriate). The Contractor must cover transportation services for the CCC Plus Waiver program Members. Rates for all CCC Plus Waiver services have both a Northern Virginia and Rest of State rate structure with the exceptions of Assistive Technology and Environmental Modifications. Rates are paid based upon the Member FIPS except for Adult Day Health Care. (See additional details below for specifics regarding AT and EM.)
CCC Plus HCBS Waiver Personal Care	Same as General Requirements	Yes	Yes	<p>Agency-or consumer-directed personal care services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within <u>at least</u> 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 Care</p> <p>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. Personal care must not be a replacement for private duty nursing services performed by a RN.</p> <p>Service Codes</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>AD = T1019</p> <p>CD = S5126</p> <p>Services are billed as hourly.</p>
<p>CCC Plus HCBS Waiver Respite Care</p>	<p>Same as General Requirements</p>	<p>Yes</p>	<p>Yes</p>	<p>Respite is for the relief of the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the Member.</p> <p>Agency- or consumer-directed respite care services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least 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>Respite coverage in children's residential facilities.</p> <p>A. Individuals with special needs who are enrolled in the CCC Plus Waiver and who have a diagnosis of developmental disability (DD) will be eligible to receive respite services in children's residential facilities that are licensed for respite services for children with DD.</p> <p>B. These respite services are covered consistent with the requirements of 12VAC30-120-924, 12VAC30-120-930, and 12VAC30-120-935, whichever is in effect at the time of service delivery.</p> <p>Service Definition - Respite Care</p> <p>Respite services are unskilled services (agency-directed or consumer-directed) or skilled services of a nurse (AD-skilled respite) that provide temporary relief for the unpaid primary</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>caregiver due to the physical burden and emotional stress of providing support and care to the individual.</p> <p>Skilled Private Duty Nursing Respite Care (Agency-Directed Only)</p> <p>Providers may be reimbursed for respite services provided by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) 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 program service, or it can be offered in conjunction with other services.</p> <p>Congregate Private Duty Nursing Respite Care (Agency-Directed Only)</p> <p>Congregate respite nursing provided to three (3) or fewer Program individuals who reside in the same primary residence.</p> <p>Service Codes AD = T1005 CD = S5150</p> <p>PDN RN Respite Services = S9125 TD PDN LPN Respite Services = S9125 TE Congregate Respite RN Nursing Services = T1030 TD Congregate Respite LPN Nursing Services = T1031 TE Services are billed as hourly</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				Respite is limited to four hundred and eighty (480) hours per fiscal year – regardless of the number of providers or whether the individual receives agency and consumer-directed respite services.
CCC Plus HCBS Waiver Adult Day Health Care (ADHC)	Same as General Requirements	Yes	Yes	<p>Adult Day Health Care (ADHC) services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least 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 community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those CCC Plus Waiver individuals who have been determined eligible for waiver services and who also require the level of care provided in either a nursing facility, specialized care nursing facility, or long-stay hospital. The program must 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 CCC Plus Waiver services.</p> <p>ADHC Service Codes = S5102 Transportation = A0120 Services are billed as a per diem. Transportation services are billed per trip.</p>
CCC Plus HCBS Waiver	Same as General Requirements	Yes	Yes	Personal Emergency Response Systems (PERS) services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
<p>Personal Emergency Response System (PERS)</p> <p>PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.</p>				<p>must be provided within at least 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 of a two(2)-way voice communication system that dials a twenty-four (24)-hour response or monitoring center upon activation via the individual’s home telephone line or other two(2)-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 (1) qualifying CCC Plus Waiver service.</p> <p>Service Codes PERS nursing = H2021 TD (RN) PERS nursing = H2021 TE (LPN) PERS installation = S5160 Person installation + medication monitoring = S5160 U1 PERS monitoring = S5161 PERS medication monitoring = S5185 PERS nursing services are billed in thirty (30) minute increments. PERS installation (w/ or w/out medication monitoring) is billed as per visit.</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
<p>CCC Plus HCBS Waiver Services Facilitation</p>	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the CCC Plus Waiver provider manual available on the Department’s web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library</p>	<p>Yes</p>	<p>Yes</p>	<p>Services Facilitation must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least 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> <p>The SF is responsible for completion of the following tasks related to service facilitation:</p> <ol style="list-style-type: none"> 1. Service Facilitation Comprehensive Visit: 2. Consumer (Individual) Training: 3. Management Training 4. Routine Onsite Visits 5. Reassessment Visit <p>Service Codes SF Initial Comprehensive Visit = H2000 (billed as visit). SF Consumer Training Visit = S5109 (billed as visit). SF Management Training Visit = S5116 (billed as visit). SF Routine Visit = 99509 (billed as visit).</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				SF Reassessment Visit = T1028 (billed as a visit).
CCC Plus HCBS Waiver Transition Services	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Waiver provider manual available on the Department’s web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library	Yes	Yes	Transition Services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least 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 – 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. Transition services do not apply to an acute care admission to a hospital. Transition Services Code T2038 (limited with a total cost regardless of the number of items to \$5,000 per lifetime
CCC Plus HCBS Waiver Assistive Technology (AT) and Assistive Technology Maintenance	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the	Yes	Yes	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 must not be authorized as a standalone service. Assistive technology devices, as defined in 12VAC30-120-924, must be portable and must be authorized per fiscal year.

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library			AT = T1999 (limited to per item with a set limit of \$5,000.00 per fiscal year) AT Maintenance = T1999 U5 (limited to per item with a set limit of \$5,000.00 per fiscal year) AT and AT maintenance combined costs cannot exceed the \$5,000.00 limit. Currently the program is operating under emergency regulations; these regulations are found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6461
CCC Plus HCBS Waiver Environmental Modifications (EM) and Environmental Modification Maintenance	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library	Yes	Yes	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. EM = S5165 (limited to per item with a set limit of \$5,000.00 per fiscal year) EM Maintenance = 99199 U4 (limited to per item with a set limit of \$5,000.00 per fiscal year) EM must be provided in conjunction with at least one (1) other qualifying CCC Plus Waiver service. EM and EM maintenance combined costs cannot exceed the \$5,000.00 limit

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>Currently the program is operating under emergency regulations; these regulations are found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6461</p>
<p>CCC Plus HCBS Waiver Skilled Private Duty Nursing (PDN)</p>	<p>Same as General Requirements</p>	<p>Yes</p>	<p>Yes</p>	<p>Private Duty Nursing (PDN) services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least 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 – Skilled Private Duty Nursing (Skilled PDN)</p> <p>In-home nursing services provided for individuals enrolled in the CCC Plus 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>Service Definition – Congregate Skilled PDN</p> <p>Skilled in-home nursing provided to three (3) or fewer CCC Plus 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 PDN hours will be determined and approved according to skilled nursing needs documented on the appropriate referral form.</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>Coverage Limits – Up to sixteen (16) hours a day; one hundred and twelve (112) hours per week</p> <p>Service Codes PDN RN Nursing Services = T1002 (billed hourly) PDN LPN Nursing Services = T1003 (billed hourly) Congregate RN Nursing Services = T1000 U1 (billed hourly). Congregate LPN Nursing Services = T1001 U1 (billed hourly).</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 Department’s web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library</p>	Yes	Yes*	<p>*Individuals receiving Hospice at time of enrollment will be excluded from Managed Care participation and will not be auto-enrolled. Managed care enrolled Members who elect hospice will remain enrolled in Managed Care.</p> <p>A Member may be in a waiver and also be receiving hospice services. The Contractor must provide information and referrals as appropriate to assist Members in accessing services. The Contractor must cover all services associated with the provision of hospice services. The Contractor must ensure that children under twenty-one (21) years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services.</p> <p>Non-institutional Hospice Services must be paid by the Contractor based on the member FIPS. The Department’s hospice revenue codes and rates for non-institutional claims are available at: http://www.dmas.virginia.gov/#/ratesetting.</p> <p>Categories of Care:</p> <p>0651- Routine Home Care: In-home care that is not continuous (less than eight (8) hours per day). (One (1) unit = one (1) day) Note: As of January 1, 2016 a higher base payment for</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>the first sixty (60) days of hospice care and a reduced base payment rate for days sixty-one (61) and thereafter.</p> <p>0652 - Continuous Home Care: In-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight (8) hours of care per day must be provided to qualify as continuous home care. (one (1) unit = one (1) hour)</p> <p>0655 - Inpatient Respite Care: Short-term inpatient care provided in an approved facility (free-standing hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five (5) consecutive days of respite care will be allowed (one (1) unit = one (1) day). Payment for the sixth (6th) day and any subsequent days of respite care is made at the routine home care rate.</p> <p>0656 - General Inpatient Care: May be provided in an approved free-standing hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one (1) unit = one (1) day)</p> <p>0658 - Nursing Facility: Beginning July 1, 2019, for Members who reside in a nursing facility and are enrolled in a Medicaid approved hospice program, the Contractor must pay the nursing facilities their share of payment directly rather than paying the hospice provider. Payments made to the nursing facility must be the full amount that would be paid to the nursing facility if the Member was not receiving hospice services.</p> <p>0551 - Skilled Nursing Visit – Used when submitting charges representative of a visit by a Registered Nurse within the Member’s last seven (7) days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one (1) unit = fifteen (15) minutes,</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>max sixteen (16) per day). Note: a corresponding 0651 - Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.</p> <p>0561 - Medical Social Service Visit – Used to be used when submitting charges representative of a visit by a Clinical Social Worker within the Member’s last seven (7) days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one (1) unit = fifteen (15) minutes, max sixteen (16) per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.</p>
<p>Program of All-Inclusive Care for the Elderly (PACE)</p>	<p>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</p>	<p>Yes</p>	<p>No</p>	<p>Individuals in PACE will be excluded from managed care program participation. Individuals in managed care have the right to transition from the managed care program to PACE, including outside of their annual open enrollment. The Contractor must ensure that Members are aware of 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, an individual must be fifty-five (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 must 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 Department’s website: http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx (based upon the member’s zip code). The Contractor must refer Members</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				interested in enrolling in PACE to their Local Department of Social Services (LDSS) to request a Medicaid LTSS 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.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

Waiver Services for Individuals in the 3 Developmental Disabilities (DD) Waivers

The Contractor is not required to cover DD Waiver Services (**including when covered under EPSDT**), DD targeted case management (T1017 & T2023), or transportation to/from DD Waiver Services. DD Waiver services covered through EPSDT include private duty nursing, personal care, and assistive technology.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Coverage Details
Building Independence Waiver formerly Day Support (DS) Waiver	Regulations and Manual are currently in process.	Yes	No	The Day Support Waiver will become the Building Independence Waiver which will include supports for adults eighteen (18+) who live independently in their own homes. Services may be complemented by non-waiver funded rent subsidies and/or other types of support.
Family and Individual Support (FIS) Waiver formerly the Individuals and Family	Regulations and Manual are currently in process.	Yes	No	The Individual and Family Developmental Disabilities Support (DD) Waiver will become the Family and Individual Supports Waiver which will include supports for children and adults living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

Waiver Services for Individuals in the 3 Developmental Disabilities (DD) Waivers

The Contractor is not required to cover DD Waiver Services (**including when covered under EPSDT**), DD targeted case management (T1017 & T2023), or transportation to/from DD Waiver Services. DD Waiver services covered through EPSDT include private duty nursing, personal care, and assistive technology.

Developmental Services (DD) Waiver				
Community Living (CL) Waiver formerly the Intellectual Disabilities (ID) Waiver	Regulations and Manual are currently in process.	Yes	No	The Intellectual Disability (ID) Waiver will become the Community Living Waiver , which will include residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs.

A description of all waiver services and a comparison of the services covered under each DD Waiver is available below

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Shared Living = T1020 (billed as either full month or partial month)

This is a new service and is available under all three (3) DD waivers.

An individual would live in an apartment, condominium, townhome, or other home in the community with a roommate of the Member's choice. The roommate acts as the individual's live-in companion. Individuals must be eighteen (18) years old or older and must be directly responsible for the residence (i.e., the individual must either rent or own it).

Individuals will be responsible for all expense associated with their housing, utilities and food as well as those for the live-in companion. Those expenses incurred by the individual and determined to be usual, reasonable and within the location's maximum reimbursement amount will be reimbursed by Medicaid consistent with the service authorization. These expenses may be covered when the live-in companion provides companionship supports, including fellowship and enhanced feelings of security, and may include limited Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) supports as long as these account for no more than twenty percent (20%) of the anticipated companionship time on a weekly basis. The individual is responsible for his own living expenses. Designated Department of Behavioral Health and Developmental Services (DBHDS) licensed providers are eligible to bill and receive payment for administering this service. After retention of an allowable amount for administrative expenses, the provider will distribute payments to the individual to reimburse for expenses incurred per the service authorization.

Tiers do not apply to this service.

Size does not apply to this service.

Community Engagement = T2021 (billed as hourly)

This service applies to all three (3) of the DD the waiver(s):

This is a new service that provides the individual with a wide variety of opportunities to build relationships and natural support systems, while utilizing the community as a learning environment. It supports and fosters the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). These services are provided to the individual at no more than a 1:3 staff to individual ratio.

Tiers 1-4 do apply to this service.

Size does not apply to this service.

Community Coaching = 97127 (billed as hourly)

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAArPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

This service applies to all three (3) of the DD waivers

This is a new service designed to engage the individual in the community and to help the individual be supported to minimize a barrier from participating in activities of community engagement. This is a one-on-one service that occurs in a community setting.

Tiers do not apply to this service.

Size does not apply to this service.

Group Day Services = 97150 (billed as hourly)

This service applies to all three (3) of the DD waivers

This includes skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability and adaptive skills. They provide opportunities for peer interactions, community integration, enhancement of social networks and assurance of an individual's health and safety. Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Group day services are delivered in a group setting of no more than 1:7 staff to individual ratio.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size does not apply to this service.

Individual Supported Employment = H2023 (billed as hourly)

This service applies to all three (3) of the DD waivers:

This is a service that is provided to an individual in work settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment.

Tiers do not apply to this service.

Size does not apply to this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Group Supported Employment = H2024 (billed as hourly using the modifier related to the size.)

This service applies to all three (3) of the DD waivers

This is a service that provides continuous staff support in a naturally occurring place of employment to groups of two (2) to eight (8) individuals with disabilities and involves interactions with the public and coworkers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group Supported Employment must be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace. These supports enable an individual to obtain and maintain a job in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Tiers do not apply to this service.

Size applies to this service. Size is defined as:

1. 2 or Fewer Individuals/Staff = Size 1 = UA
2. 2+ TO 4 Individuals/Staff = Size 2 = U2
3. 4+ Individuals/Staff = Size 3 = U3

Services Available Under the DD Waivers (Carved out of this contract and covered through fee-for-service.)

Electronic-Based Home Supports = A9279 (limited to \$5,000.00 per year)

This service applies to all three (3) of the DD waiver

This is a new service designed to give individuals support to gain more independence and freedom at home by using electronic equipment. Electronic devices can be purchased and installed in the individual's home to help monitor and support greater autonomy. To qualify for reimbursement, purchases must substitute for other Medicaid services, promote integration into the community and increase the individual's safety in the home. Providers that bill and receive payment for this service are responsible for providing emergency assistance twenty-four (24) hours a day and three hundred and sixty-five (365) or three hundred and sixty-six (366) days a year as well as furnishing, installing, maintaining, testing and providing user training of the services. Members receiving per diem residential services will not qualify to receive this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Tiers do not apply to this service.
Size does not apply to this service.

Assistive Technology (AT) = T1999 (limited to per item with a set limit of \$5,000.00 per year)
AT Maintenance = T1999 U5 (limited to per item with a set limit of \$5,000.00 per year)

This service applies to all 3 of the DD waivers.

AT and AT maintenance costs cannot exceed the \$5,000.00 limit.

This means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

Tiers do not apply to this service.
Size does not apply to this service.

Environmental Modifications (EM) = S5165 limited to per item with a set limit of \$5,000.00 per year)
EM Maintenance = 99199 U4 (limited to per item with a set limit of \$5,000.00 per year)

This service applies to all three (3) of the DD waiver.

EM and EM maintenance costs cannot exceed the \$5,000.00 limit.

This means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals.

Tiers do not apply to this service.
Size does not apply to this service.

Personal Emergency Response System (PERS)

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

This service applies to all three (3) of the DD waivers.

PERS NURSING = H2021 TD (RN)

PERS NURSING = H2021 TE (LPN)

PERS INSTALLATION = S5160

PERSON INSTALLATION + MEDICATION MONITORING = S5160 U1

PERS MONITORING = S5161

PERS MEDICATION MONITORING = S5185

PERS nursing services are billed in thirty (30) minute increments.

PERS installation (w/ or w/out medication monitoring) is billed as per visit.

PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.

Personal emergency response systems (PERS): an electronic device and monitoring service that enables certain individuals at high-risk of institutionalization to secure help in an emergency. PERS services must be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

Transition Services = T2038 (limited to per item with a total cost regardless of the number of items is a set limit of \$5,000.00)

This service applies to all three (3) of the DD waivers.

This means 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.

Tiers do not apply to this service.

Size does not apply to this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Peer Mentoring = H0038

This service applies to all three (3) of the DD waivers.

Peer Mentor Supports provide information, resources, guidance, and support from an experienced, trained peer mentor to an individual receiving CL, FIS, or BI waiver supports. This service is delivered by individuals with developmental disabilities who are or have received services, have shared experiences with the individual, and provide support and guidance to him/her. The service is designed to foster connections and relationships which build individual resilience. Peer mentors share their successful strategies and experiences in navigating a broad range of community resources with waiver participants. Waiver participants become better able to advocate for and make a plan to achieve integrated opportunities and experiences in living, working, socializing, and staying healthy and safe in his/her own life. Peer mentoring is intended to assist with empowering the individual receiving the service. This service is provided based on the support needs of the individual as outlined in his/her person-centered plan. This service is designed to be a short-term, periodically intermittent, intense service associated with a specific outcome. Peer Mentor Supports may be authorized for up to six (6) consecutive months, and the cumulative total across that timeframe may be no more than sixty (60) hours in a plan year.

For allowable activities, refer to Medicaid Memo located at <https://vamedicaid.dmas.virginia.gov/memo/three-new-services-added-developmental-disabilities-dd-waivers>

Community Guide = H2015

This service applies to all three (3) of the DD waivers.

Community Guide Services include direct assistance to promote individuals' self-determination through brokering community resources that lead to connection to and independent participation in integrated, independent housing or community activities so as to avoid isolation.

Includes the following components:

General Community Guide services: Utilizes an individual's existing assessment information regarding the individual's general interests in order to determine specific activities and venues that are available in the community (e.g., clubs, special interest groups, physical activities/sports teams, etc.) to promote inclusion and independent participation in community life.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Community Housing Guide services: Supports an individual's move to independent housing by helping with transition and tenancy sustaining activities. The community housing guide collaborates with the support coordinator, regional housing specialist, and others to enable the individual to achieve and sustain integrated, independent living.

Benefits Planning = T1023 (billed as hourly)

This service applies to all 3 of the DD waivers.

Benefits planning is an individualized analysis and consultation service provided to assist individuals receiving waiver services and social security benefits (SSI, SSDI, SSI/SSDI) to understand their benefits and explore the possibility of work, to start work, and the effect of work on local, state, and federal benefits. This service includes education and analysis about current benefits status and implementation and management of state and federal work incentives as appropriate.

For allowable activities, refer to Medicaid Memo issued on 9/4/2018 located at <https://vamedicaid.dmas.virginia.gov/memo/three-new-services-added-developmental-disabilities-dd-waivers>

Employment & Community Transportation = A0080, A0090, A0110, A0120 This service applies to all 3 of the DD waivers.

This service is offered in order to enable individuals to gain access to an individual's place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available. The goal of this service is to promote the individual's independence and participation in the life of his/her community. Use of this services must be related to the individual's desired outcomes as stated in the ISP. This service is offered in addition to medical transportation required under 42 CFR § 431.53 and transportation services under the State plan, defined at 42 CFR § 440.170(a), and does not replace them.

Crisis Support Services = T2034 (billed as hourly)

This service applies to all 3 of the DD waivers.

Includes the following components:

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAAPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Crisis Prevention: unit of service = one (1) hour and billing may occur up to twenty-four (24) hours per day if necessary. Medically necessary crisis prevention may be authorized for up to sixty (60) days per ISP year.

Crisis Intervention: unit of service = one (1) hour and billing may occur up to twenty-four (24) hours per day if necessary. Medically necessary crisis intervention may be authorized in increments of no more than fifteen (15) days at a time for up to ninety (90) days per ISP year.

Crisis Stabilization: unit of service = one (1) hour and billing may occur up to twenty-four (24) hours per day if necessary. Medically necessary crisis stabilization may be authorized in increments of no more than fifteen (15) days at a time for up to sixty (60) days per ISP year.

Services may be authorized for an individual who has a history of at least one (1) of the following: (i) previous psychiatric hospitalization or hospitalizations; (ii) previous incarceration; (iii) previous residential/day placement or placements were terminated; or (iv) behaviors that have significantly jeopardized placement.

Services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

Tiers do not apply to this service.

Size does not apply to this service.

Center-Based Crisis Supports = H2019 UA and H2019 U1 (billed as hourly)

This service applies to the following waiver(s):

1. Building Independence Waiver formerly Day Support (DS) Waiver
2. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
3. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

The service includes crisis prevention and stabilization services in a residential setting (a crisis therapeutic home) using plan and emergency admissions. Services are approved for those individuals who will need ongoing crisis supports for long-term. Services may be authorized for individuals who are at-risk of at least one (1) of the following: 1) psychiatric hospitalization; 2) emergency ICF/IID placement; 3) immediate threat of loss of community service due to severe situational reaction; or 4) causing harm to himself or others.

Tiers do not apply to this service.

Size does not apply to this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Community-Based Crisis Supports = S9484 U1 (billed as hourly for up to six (6) months per year in thirty (30) day increments)

This service applies to the following waiver(s):

1. Building Independence Waiver formerly Day Support (DS) Waiver
2. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
3. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

In order to be approved to receive this service, the individual must:

1. Have a history of at least one (1) of the following:
 - a. previous psychiatric hospitalization or hospitalizations;
 - b. previous incarceration;
 - c. lost previous residential/day placement or placements; or
 - d. behavior or behaviors have jeopardized his/her community placement.
2. Meet at least one (1) of the following:
 - a. is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
 - b. is experiencing an increase in extreme emotional distress;
 - c. needs continuous intervention to maintain stability; or
 - d. is actually causing harm to himself or others.
3. Also:
 - a. be at-risk of psychiatric hospitalization;
 - b. be at-risk of emergency ICF/IID placement;
 - c. be at immediate threat of loss of community service due to a severe situational reaction; or
 - d. is actually causing harm to himself or others.

The service provides ongoing supports to individuals in their homes and community settings or both.

Tiers do not apply to this service.

Size does not apply to this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Supported Living Residential (formerly part of Congregate Residential Supports) = H0043 (billed as per diem with a maximum of three hundred and forty-four (344) days/year)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This service provides access to twenty-four (24) hour supports in an apartment setting operated by a DBHDS licensed provider. Services are provided to the individual in the form of 'round the clock availability of paid staff who have the ability to respond in a timely manner. These supports may be provided individually or simultaneously to more than one (1) individual living in the apartment, depending on the required support. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. The unit of service billed will be "daily" when the new waivers take effect.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size does not apply to this service.

In-Home Supports (formerly In-home Residential Supports) = H2014 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is a supplemental service that take place in an individual's home, family's home or community setting. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Usually, In-home supports involve one (1) staff person to one (1) individual, but now may include 1:2 or 1:3 as appropriate. The latter is a change from previous allowances. The unit of service billed remains "hourly."

Tiers do not apply to this service.

Size applies to this service. Size is defined as:

1. 2 or Fewer Individuals/Staff = Size 1 = UA

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

2. 2+ TO 4 Individuals/Staff =Size 2 = U2
3. 4+ Individuals/Staff = Size 3 = U3

Skilled Nursing:

RN = S9123 (TD)

LPN = S9124 (TE)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Services are billed as 15 minute increments.

This is an existing service that will not change as part of the waiver redesign; however, individuals receiving this service may be assessed to determine whether private duty nursing is now the appropriate service.

Skilled nursing services: means both skilled and hands-on care, as rendered by either licensed RN or LPN, of either a supportive or health-related nature nursing services ordered by a physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual enrolled in the waiver.

Tiers do not apply to this service.

Size does not apply to this service.

Private Duty Nursing:

RN = T1002 (TD)

LPN = T1003 (TE)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Services are billed as fifteen (15) minute increments.

This is a new service that is designed to provide individual and continuous medically necessary care as certified by a physician, physician assistant or nurse practitioner to individuals with a serious medical condition and/or complex health care need. It allows individuals to remain at home to receive care instead of in a nursing facility, hospital or ICF-IID. This service is provided to an individual at his place of residence or other community setting.

Tiers do not apply to this service.

Size does not apply to this service.

Therapeutic Consultation - Therapists/Behavior Analysts/Rehab Engineer = 97139 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.

Size does not apply to this service.

Therapeutic Consultation - Psychologist/Psychiatrist = H2017* (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.

Size does not apply to this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

In the absence of a service authorization, billing is likely for Therapeutic Consultation (billed with procedure type I or M) and is excluded. Not an excluded MHS service for Members in one (1) of the DD Waivers with an appropriate service authorization for Psychosocial Rehabilitation H2017. Refer to Coverage Chart Part 2B.

Therapeutic Consultation - Other Professionals = 97530 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.

Size does not apply to this service.

Personal Assistance

AD = T1019 (billed as hourly)

CD = S5126 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Personal assistance: means assistance with ADL's, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.

Size does not apply to this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Respite Services

AD = T1005 (billed as hourly)

CD = S5150 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Respite: means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.

Size does not apply to this service.

Workplace Assistance Services = H2025 (billed as hourly). Cannot exceed forty (40) hours/week. Cannot exceed sixty-six (66) hours/week alone or in combination with 97150, T2021, H2023, H2024, 97127, and/or H2025.

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Workplace Assistance Services: supports provided to someone who has completed job development and completed or nearly completed and job placement training (i.e., supported employment) but requires more than typical job coach services to maintain stabilization in their employment. Workplace Assistance services are supplementary to the services rendered by the job coach services; the job coach still provides professional oversight and job coaching intervention. The provider provides onsite habilitative supports related to behavior, health, time management or other skills that otherwise would endanger the individual's continued employment. The provider is able to support the person related to personal care needs as well; however, this cannot be the sole use of Workplace Assistance services.

In order for an activity to qualify under Workplace Assistance services it must include all three (3) of the following:

1. The activity must not be work skill training related which would normally be provided by a job coach

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

2. Services are delivered in their natural setting (where and when they are needed)
2. Services must facilitate the maintenance of and inclusion in an employment situation
3. The ratio is 1:1

Allowable activities include:

1. Skill building and supports around non-work skills necessary for the individual to maintain employment
2. Skill building and supports in the home, community, or workplace of employment maintenance related skills
3. Support to make and strengthen community connections
4. Safety supports to ensure the individual's health and safety.

Tiers do not apply to this service.

Size does not apply to this service.

Individual & Family Caregiver Training = S5111 (billed as hourly). Limited to eighty (80) hours per ISP year.

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Individual & Family Caregiver Training: service that provides training and counseling services to individuals, families, or caregivers of individuals receiving waiver services. All individual and family/caregiver training must be included in the individual's written person-centered plan. "Family" does not include people who are employed to care for the individual.

Allowable activities:

1. Participation in educational opportunities designed to improve the family's or caregiver's ability to give care and support.
2. Participation in educational opportunities designed to enable the individual to gain a better understanding of his/her disability or increase his/her self-determination / self-advocacy abilities.
3. Travel expenses and room and board expenses are not covered.

Tiers do not apply to this service.

Size does not apply to this service.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Companion Services:

AD Companion = S5135 (billed as hourly)

CD Companion = S5136 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support (FIS) Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living (CL) Waiver formerly the Intellectual Disabilities (ID) Waiver

Companion: means non-medical care, or support and socialization provided to an adult (ages eighteen (18) years and over). The provision of companion services does not entail (routine) hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature. Companions may assist or support the individual (enrolled in the waiver) with such tasks as meal preparation, community access and activities, laundry, and shopping but companions do not perform these activities as discrete services. Companions may also perform light housekeeping, tasks (such as bed-making, dusting, and vacuuming, laundry, grocery shopping, etc.) which such services are specified in the individual's Plan for Supports and essential to the individual's health and welfare in the context of providing non-medical care, socialization or support, as may be needed in order to maintain the individual's home environment in an orderly and clean manner. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.

Size does not apply to this service.

Services Facilitation (SF)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

SF Initial Comprehensive Visit = H2000 (billed as visit).

SF Consumer Training Visit = S5109 (billed as visit).

SF Management Training Visit = S5116 (billed as visit).

SF Routine Visit = 99509 (billed as visit).

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

SF Reassessment Visit = T1028 (billed as a visit).

Service Definition – Services Facilitation

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.

The SF is responsible for completion of the following tasks related to service facilitation:

1. Service Facilitation Comprehensive Visit:
2. Consumer (Individual) Training:
3. Routine Onsite Visits
4. Reassessment Visit
5. Management Training

Tiers do not apply to this service.

Size does not apply to this service.

Group Home Residential (formerly part of Congregate Residential Supports) = H2022 (billed as per diem with a maximum of three hundred and forty-four (344) days/year)

This service applies to the following waiver(s):

1. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Provides services in a home in which an individual lives with other individuals with developmental disabilities receiving supports from paid staff. These supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Providers must be licensed by DBHDS and follow state and federal guidelines to participate in the service. The unit of service billed will be “daily” when the new waivers take effect.

Tiers 1-4 do apply to this service and are stand-alone tiers.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Size applies to this service. Size is defined as:

1. Four (4) or Fewer Individuals/Staff = Size one (1) = UA
2. Five (5) individuals/staff = Size two (2) = U2
3. Six (6) individuals/staff = Size three (3) = U3
4. Seven (7) individuals/staff = Size four (4) = U4
5. Eight (8) individuals/staff = Size five (5) = U5
6. Nine (9) individuals/staff = Size six (6) = U6
7. Ten (10) individuals/staff = Size seven (7) = U7
8. Eleven (11) individuals/staff = Size eight (8) = U8
9. Twelve (12) individuals/staff = Size nine (9) = U9

Sponsored Residential (formerly part of Congregate Residential Supports) = T2033 (billed as per diem)

This service applies to the following waiver(s):

1. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Effective January 1, 2017:

Provides individuals the ability to live with a family or single “sponsor” in the community. No more than two (2) individuals can live in the sponsor’s home. The supports provided by the sponsor may include skill building, supports with ADLs and IADLs, community access and recreation/social supports, as well as general supports. Sponsors are generally not related to the individual unless all other alternatives were investigated and found not to be appropriate for the individual. Sponsors are affiliated with a DBHDS licensed agency.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size does not apply to this service.

Independent Living = T2032 (full month)

T2032 U1 (partial month)

This service applies to the following waiver(s):

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

See full list of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

1. Building Independence Waiver formerly Day Support (DS) Waiver

This is a new service provided to adults (eighteen (18) and older) that offers skill building and supports necessary to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills. Individuals typically live alone or with a roommate in their own homes or apartments. The roommate may be paid (see Shared Living above) or unpaid. The unit of service billed is “monthly” or “partial month.”

Monthly services = no modifier

Partial Month services = U1 modifier

Tiers do apply to this services

There are only two (2) Tiers for this service.

Tier 1 (stand-alone)

Tiers 2-4 (combined together)

Size does not apply to this service.

SUMMARY OF COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Annual Adult Wellness Exams	<p>CMS Bulletin 1/28/17</p> <p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>US Preventive Services Task Force</p> <p>https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>42 U.S.C. § 300gg–13</p>	No	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>CPT Codes and Limitations*:</p> <ol style="list-style-type: none"> 1. 99385 (New patient, eighteen to thirty-nine (18-39 years)); one (1) per calendar year 2. 99386 (New patient, forty to sixty-four (40-64 years)); one (1) per calendar year 3. 99387 (New patient, sixty-five years and older (65+)); one (1) per calendar year 4. 99395 (Established patient, eighteen to thirty-nine (18-39 years)); one (1) per calendar year 5. 99396 (Established patient, forty to sixty-four (40-64 years)); one (1) per calendar year 6. 99397 (Established patient, forty to sixty-five (> 65 years)); one (1) per calendar year <p>*CPT Code descriptions above subject to change</p>
Individual and Group Smoking Cessation Counseling	<p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>42 U.S.C. § 300gg–13</p>	Limited	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>CPT Codes and Limitations*:</p> <ol style="list-style-type: none"> 1. 99406 (Individual counseling visit, three through ten (3-10) minutes); six (6) units per calendar year; no preauthorization 2. 99407 (Individual counseling visit, > ten (10) minutes); six (6) units per calendar year; no preauthorization

SUMMARY OF COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS

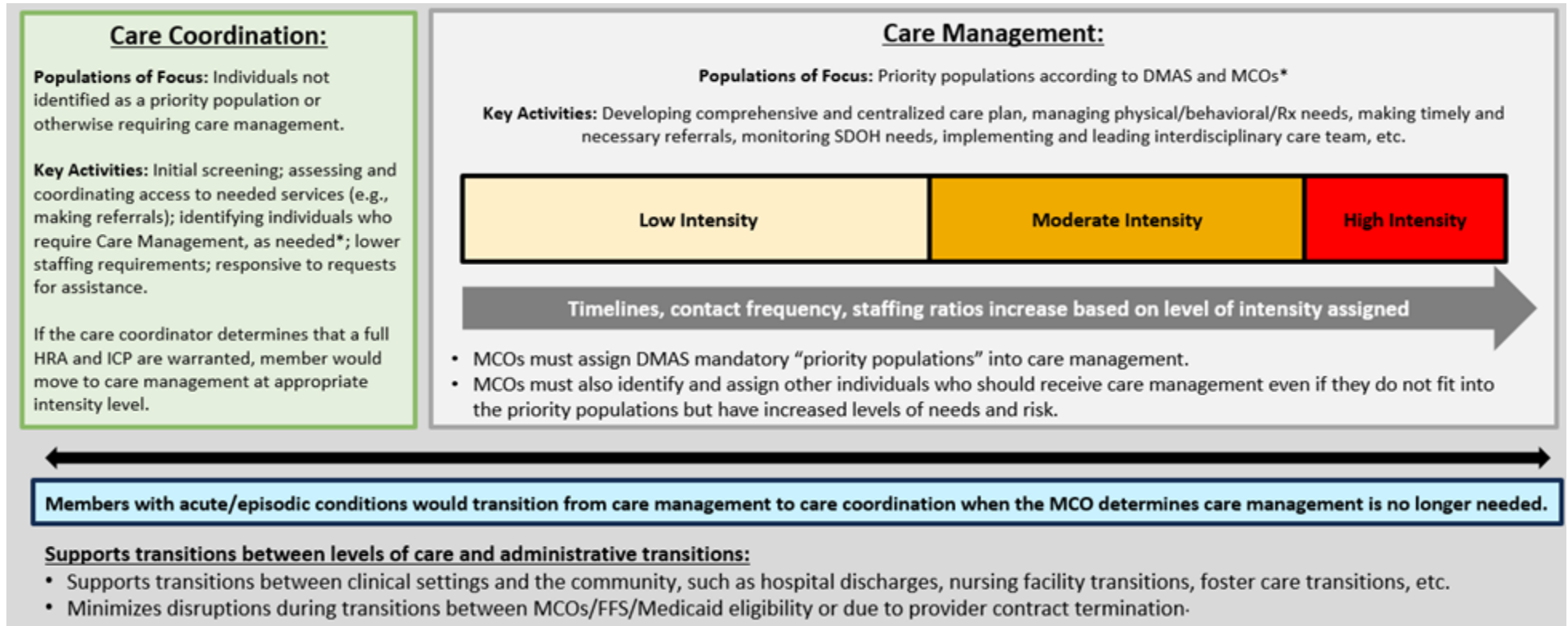
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				S9446 (Group patient education, not otherwise classified, non-physician provider); six (6) units per calendar year; no preauthorization *CPT Code descriptions above subject to change
Nutritional Counseling for Individuals with Obesity or Chronic Disease	CMS Bulletin 1/28/17 https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf US Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations 42 U.S.C. § 300gg–13	Limited	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: <ol style="list-style-type: none"> 1. 97802 (Medical Nutrition Therapy, Initial Assessment and Intervention, Indiv., Face-to-Face with the patient, each fifteen (15) minutes; twelve (12) units per calendar year; no prior authorization 2. 97803 (Medical Nutrition Therapy Reassessment and Intervention, Indiv., Face-to-Face with the patient, each fifteen (15) minutes; twelve (12) units per calendar year; no preauthorization 3. 97804 (Medical Nutrition Therapy, Group (two (2) or more individual(s), each thirty (30) minutes; four (4) units per calendar year; no preauthorization 4. G0270 (Medical Nutrition Therapy; Reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each fifteen (15) minutes; eight (8) units per calendar year; no prior authorization 5. G0271 (Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in

SUMMARY OF COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS

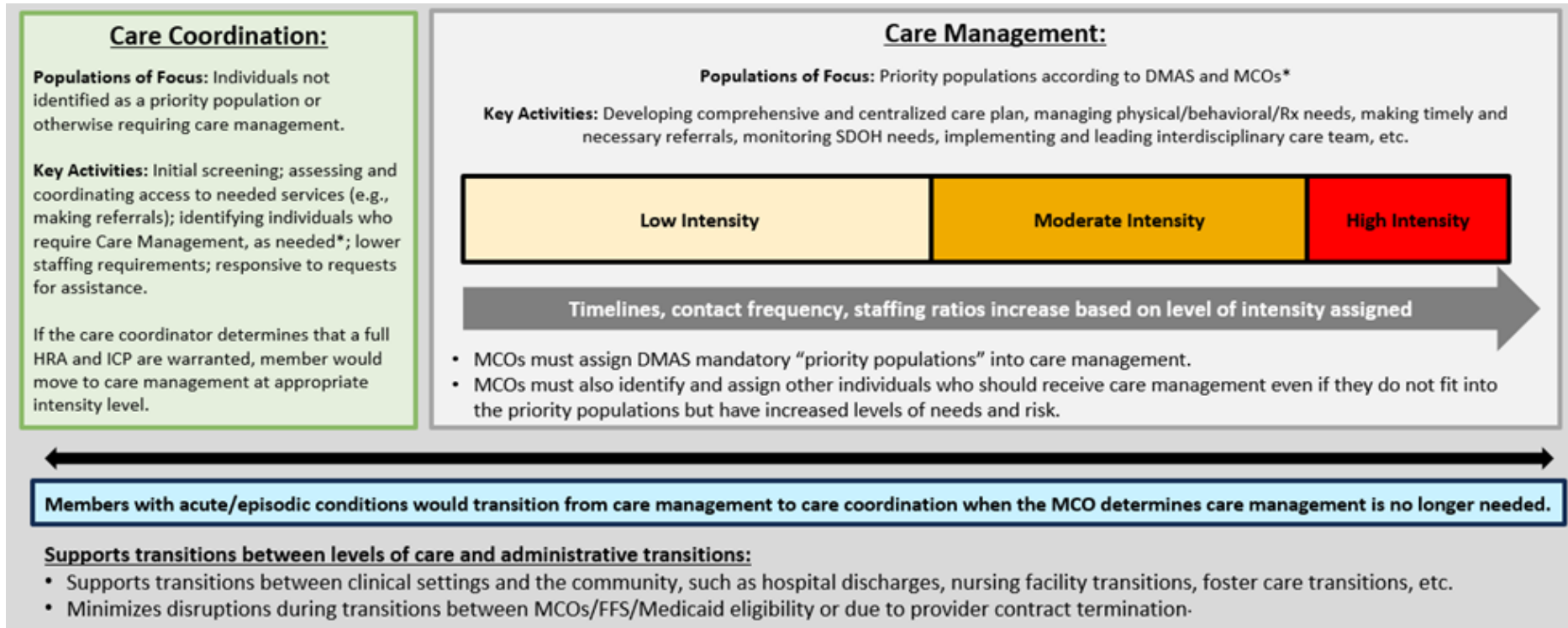
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
				<p>diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (two (2) or more individuals), each thirty (30) minutes; four (4) units per calendar year; no prior authorization</p> <p>6. S9470 (Nutritional Counseling, Dietician visit, eight (8) units per calendar year; no preauthorization</p> <p>*CPT Code Descriptions above subject to change</p>
ACIP Recommended Adult Vaccines	<p>2023 Appropriations Act, Chapter 1, Item 304. EEEE.</p> <p>CMS Bulletin 1/28/16</p> <p>CDC Adult Immunization Schedule</p> <p>42 U.S.C. § 300gg-13</p>	Yes	Yes	<p>Coverage in accordance with Centers for Disease Control and Prevention. Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p>

11 Cardinal Care Model of Care Overview

Overview of Cardinal Care Model of Care, including Care Coordination and three tiers of Care Management intensity levels:



Overview of Cardinal Care Model of Care, including Care Coordination and three tiers of Care Management intensity levels:



Summary of required credentials and experience for Care Manager positions:

Care Manager Position	Required Credentials*	Required Experience
<p>Care Managers serving:</p> <ul style="list-style-type: none"> Members in Low or Moderate Intensity Care Management Members in High Intensity Care Management other than populations listed in the two rows below 	<p>Bachelor's degree in a health or human services field, LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW</p>	<p>One year of experience working directly with individuals who meet the Cardinal Care priority population criteria.</p>
<p>Care Managers serving Members in High Intensity Care Management with the following conditions:</p> <ul style="list-style-type: none"> Members receiving private duty nursing services; Life-sustaining Ventilator-dependent members; Vulnerable infant members, including those diagnosed with neonatal abstinence syndrome, classified as substance-exposed, or admitted to the NICU Level 3. 	<p>RN</p>	<p>One year of experience working directly with Members who meet the conditions listed in this row.</p>
<p>Care Managers serving Members in High Intensity Care Management who are in Foster Care</p>	<p>LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW</p>	<p>One year of experience working directly with individuals involved in the foster care/Child Protective Services system and/or former foster youth.</p>
<p>ARTS Care Manager</p>	<p>LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW, CSAC, CSAC-Assistant</p>	<p>One year of experience working directly with individuals with SUD.</p>
<p>Care Manager Supervisor</p>	<p>LMHP or RN</p>	<p>Two years of experience working directly with individuals who meet the Cardinal Care priority population criteria</p>

*Credentials that require licensure or certification must be current/active in Virginia. RN/LPNs must be licensed in Virginia or hold an RN/LPN license with multi-state privilege recognized by Virginia.

REVISED 5/9/23 - Cardinal Care Priority Populations; Person Centered Care Management

1) Mandatory High Priority Populations; members must receive high intensity Care Management

- **CCC Plus Waiver members receiving PDN**
- **Children receiving PDN through EPSDT**
- **Ventilator-dependent members**
- **Members transitioning from a NF to the community** (for a minimum of 3 months prior to the transition and 6 months after the transition, or longer if determined necessary by the MCO)
- **Foster Care / Former Foster Youth:**
 - Members in foster care or former foster youth for 3 months after enrollment into the Medicaid program, the child welfare system or a new foster care home
 - **Members in foster care 3 months prior to aging out of the child welfare system**
 - Former foster youth for the first 3 months after aging out of the child welfare system
- **Very Vulnerable Infants:**
 - Substance-exposed infants for first 3 months of Medicaid enrollment;
 - Neonatal abstinence syndrome infants (following diagnosis or identification as part of this population, whichever is later) for first 3 months of Medicaid enrollment
 - Infants admitted to the NICU Level 3 for first 3 months of Medicaid enrollment

2) Mandatory Priority Populations; members must receive care management, MCO determines intensity (high, moderate, low)

- **Members Enrolled in Waivers or with I/DD**
 - CCC Plus Waiver members (not receiving PDN)
 - Members enrolled in the DD Waivers (Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers)
 - Members with intellectual/developmental disabilities (I/DD)
- **Members in Hospice, Nursing Facilities or with Dementia**
 - Members receiving hospice benefits
 - Nursing facility members (except for members in the “Mandatory High Priority Population”)
 - Members with cognitive or memory problems (e.g., dementia)
- **Members with brain injuries**
- **Members with SMI or SED**
 - Members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling);
 - Members who receive Mental Health Services, as reflected in the Cardinal Care Summary of Covered Benefits Chart
- **Individuals in foster care and former foster youth who are not in the “Mandatory High Priority Population”**

3) MCO-Determined Priority Populations; MCO Determines Care Management and appropriate intensity (high, moderate, low)

- **Pregnant Women and Children with High Needs/Risk**
 - Members with a high-risk pregnancy, as defined by the Contractor
 - Children and Youth with Special Health Care Needs
 - Children identified as at risk for developing developmental disabilities or delays (early intervention program)
- **Members with Other Complex/Chronic Conditions**
 - Members with other complex or multiple chronic conditions (e.g., respiratory conditions, heart disease/heart failure, diabetes, cancer, etc.)
 - Members with end stage renal disease
 - Members with physical or sensory disabilities
- **Members Meeting Utilization-Based Criteria**
 - Patient Utilization Management and Safety (PUMS) Program Members
 - Members with 3 or more ED visits or hospitalizations related to their chronic medical, physical health condition in the past 90 calendar days
 - Members with 1 or more ED visits or hospitalizations related to their behavioral health or substance use condition in the past 3 months;
 - Members 18 years of age or older who have had 2 or more falls resulting in an ED visit, hospitalization, or physician office visit within the past 90 calendar days
- **Members with Behavioral Health (BH/SUD)**
 - Members with behavioral health and substance use disorders
- **Members with High Social Needs**
 - Members who are experiencing homelessness
 - Justice-involved populations (includes individuals who have a history of incarceration, probation or parole supervision)
 - Members who have other, high social needs that pose a significant risk to their health, safety and welfare
- **Other Populations Based on MCO Determination**

12 Virginia Medicaid Aid Category List

Also known as Recipient Program Designation or Scope of Coverage code. This is the program category under which a recipient is eligible for Medicaid or DMAS- administered programs. It is also used to identify an enrollee's eligibility for certain Benefit Plans. **Individuals in aid categories highlighted in green are dually eligible for Medicare and full Medicaid benefits;** individuals in **aid categories highlighted in yellow eligible for Medicare, but not full Medicaid coverage.**

005	FAMIS Moms Pregnant Woman, Income > 133% FPL & <= 166% FPL
006	FAMIS Child under age 6, income >150% poverty and <=200% poverty.
007	FAMIS Child 6-19 years old, income >150% poverty and <=200% poverty.
008	FAMIS Child under age 6, income>133% poverty and <=150% poverty.
009	FAMIS Child 6-19 years old, income>133% poverty and <=150% poverty
010	FAMIS Deemed Newborn <1 year old
011	Aged SSI Recipient - Includes Dually Eligible QMB
012	Aged AG Recipient - Includes Dually Eligible QMB
014	FAMIS DEEMED NEWBORN ABOVE 150% FPL
018	MN Aged; December 1973 Individual ; Not Also QMB
020	Aged - Individual in Medical Institution or receiving Waivered Services with income <=300% SSI; Hospice Recipient; Not also QMB.
021	Aged - Protected Covered individual; Former Money Payment Recipient - August 1972; Former SSI/AG Recipient; Protected Widow(er); Qualified Severely Disabled Individual; Protected Adult Disabled Child.
022	Aged - Individuals in Medical Institution or receiving Waivered Services with Income <=300% SSI; Hospice Recipient. Includes Dually Eligible QMB.
023	Aged - QMB Only
024	M/N-Aged SLMB Plus
025	300% SSI Aged SLMB Plus
028	MN Aged Individual - December 1973 Individual; Dually Eligible QMB
029	Aged, 80% FPL Group. Includes Dually Eligible QMB.
031	Blind SSI Recipient - Includes Dually Eligible QMB.
032	Blind AG Recipient - Includes Dually Eligible QMB.
035	Presumptive Eligibility Adult (Pregnant). Age range 19 but less than 57
038	MN Blind Individual; December 1873 Individual; Not also QMB.
039	Blind, 80% FPL Group. Includes Dually Eligible QMB.
040	Blind - Individual in Medical Institution or WS with income <=300% SSI; Hospice Recipient; Not also QMB
041	Blind - Protected Covered Individual; Former Money Pymt Recipient - August 1972; Former SSI/AG recipient; Protected Widow(er); Qualified Severely Disabled Individual; Protected Adult Disabled Child.
042	Blind - Individual in Medical Institution or receiving Waivered Services with Income <=300% SSI; Hospice Recipient in Medical Facility. Includes Dually Eligible QMB.
043	Blind - QMB only.

044	M/N-Blind/Disabled SLMB Plus
045	300% SSI Blind/Disabled SLMB Plus
048	MN Blind - Blind Individual; December 1973 Individual; Dually Eligible QMB.
049	Disabled, 80% FPL Group. Includes Dually Eligible QMB.
051	Disabled SSI Recipient. Includes Dually Eligible QMB.
052	Disabled AG Recipient. Includes Dually Eligible QMB.
053	Special Low Income Medicare Beneficiary (SLMB).
054	Hospice Individual.
055	Qualified Disabled Working Individual (QDWI).
056	Qualified Individual (QI1).
058	MN Disabled Individual; December 1973 Individual; Not also QMB.
059	AC 059 - MEDICAID WORKS, Disabled, 80% FPL Group. Includes Dually Eligible QMB.
060	Disabled - Individual in Medical Institution or receiving Waiver Services with income <= 300% SSI; Hospice recipient in Medical Facility. Not also QMB.
061	Disabled - protected Covered Individual; Former Money Payment Recipient--August 1972; Protected Widow(er); Qualified Severely Disabled Individual; Protected Adult Disabled Child. Includes Dually Elig
062	Disabled - Individual in Medical Institution or receiving Waiver Services with Income <=300% SSI; Hospice Recipient. Includes Dually Eligible QMB.
063	Disabled - QMB Only
064	Presumptive Eligibility (PE) Child. Age less than 19
065	Presumptive Eligibility (PE) Parent/Caretaker Relative
066	Breast or Cervical Cancer Group
067	PE Breast or Cervical Cancer Group
068	MN Disabled Individual; December 1973 Individual; Dually Eligible QMB.
070	Former Foster Care. Age 19<26
072	Non-IVE Adoption-assistance Child; special Medical Needs Adoption-assistance Individual. Includes Dually-eligible QMB.
074	IVE Foster-care or IVE Adoption-assistance Recipient. Includes Dually eligible QMB. Note: Enrollment in this group was discontinued effective 01-31-2013.
075	Juvenile Justice Department Child. Includes Dually Eligible QMB.
076	Non-IVE Foster Care Child. Includes Dually Eligible QMB.
077	PE FORMER FOSTER CARE.
078	Refugee Other or Refugee Medicaid Other.
079	Refugee Medicaid Unaccompanied Minor
080	Plan First. [family planning services only]
081	Protected Covered Individual: Former Money payment Recipient--August 1972; Low-income Family with Child(ren) (LIFC) Individual; 4-month or 12 month-extended Medicaid Recipient. Includes Dually Eligible
082	Individual Under Age 21 in ICF or ICF-MR. Includes Dually-eligible QMB.
083	Former Money Payment Recipient--August 1972; Low-Income Family with Child(ren)-Unemployed Parent (LIFC-UP) Individual; 4-month or 12-month extended Medicaid Recipient
084	PE PLAN FIRST [time-limited family planning services only]

085	MN Individual Under age 21; Juvenile Justice Department Child. Includes Dually-Eligible QMB.
086	MN Individual under age 21; Non-IVE Foster-care Child or Non-IVE Adoption-assistance Child; Special Needs Adoption Assistance Child. Includes Dually-Eligible QMB.
087	GOVERNOR'S ACCESS PLAN (GAP)
088	MN Child Under Age 18. Includes Dually-Eligible QMB
090	Child Under Age 6 with income between 100% and 133% of poverty. Includes Dually-Eligible QMB.
091	Pregnant Woman; Child under age 6 with income <=100% of poverty. Includes Dually-Eligible QMB.
092	Child Age 6 to 19 with income <= 100% poverty (insured or uninsured); Child age 6 to 19 with income > 100% and <=133% poverty (insured). Includes Dually-Eligible QMB.
093	Newborn Child Under Age 1. Includes Dually Eligible QMB.
094	Child Age 6 to 19. Income > 100% poverty and <= 133% poverty (uninsured).
097	MN Pregnant Woman. Includes Dually Eligible QMB.
098	MN Individual Under Age 21 in a Nursing Facility. Includes Dually-Eligible QMB.
099	MN Newborn Child UNDER Age 1. Includes Dually-Eligible QMB.
100	Caretaker Adult, age 19 to 65 , LE 100% FPL
101	Caretaker Adult, age 19 to 65 , GT 100% FPL
102	Adults, age 19 to 65 , LE 100% FPL
103	Adults, age 19 to 65 , GT 100% FPL
106	PE Adults, age 19 to 65, LE 133% FPL
107	Pregnant Women, age 19 to 65
108	DOC Adults, age 19 to 65 [hospitalization only]
109	DOC FC/ABD [hospitalization only]
214	TDO - General District Court
215	TDO - Juvenile and Domestic Court
216	TDO - Combined District Court
401	Premium Payment - COBRA
402	Premium Payment - Conversion
404	Premium Payment - Individual
501	ACR
601	HIDP
801	ASSM Level 1
802	ASSM Level 2
803	ASSM ACR

13 Health Plan Management System (HPMS) Material Review Requirements

Name	Description	File and Use	Replacements	Review Days	Review Type	Prospective review by state?
"Snail" Mail	Information provided through physical mail delivery such as USPS, UPS, or FedEx.	N	N	0/45	Dual	Y
Billboard	Information provided on a billboard.	N	N	0/45	Dual	Y
Brochure	A small booklet, often tri-folded, containing pictures and plan information.	N	N	0/45	Dual	Y
Email	Information provided through email.	N	N	0/45	Dual	Y
Enrollment Scripts	Scripts used for enrollment into a plan	Y	N	45	CMS	N
Envelope	Information provided on the outside of an envelope	Y	Y	0/45	CMS	N
Hold Time Message	Information provided during telephone "hold times".	Y	Y	0/45	CMS	N
Mobile Applications	Information provided through an application used on a smartphone or tablet	N	N	0/45	Dual	Y
Newsletter	Information provided in a plan newspaper	N	N	0/45	Dual	Y
Newspaper/Magazine	Information provided in a newspaper or a magazine.	N	N	0/45	Dual	Y
Other	Select 'Other' if the Media type you are trying to submit for is NOT listed in above selection list. And specify the media type name in the text box next to it.	N	N	0/45	Dual	Y
Posters/Flyers/Signs	Information provided on posters, flyers, or signs (such as flyer on a public board).	N	N	0/45	Dual	Y
Provider Office	Information provided at a provider office.	N	N	0/45	Dual	Y
Radio	Information provided through radio, including advertisements, news segments, "shows", etc.	N	N	0/45	Dual	Y
Sales Presentation	Script and powerpoint presentation used for sales events, including one on one events.	N	N	45	Dual	Y
Social Media	Information provided on social media platforms such as YouTube, Facebook, Instagram, Twitter, etc.	N	N	0/45	Dual	Y
Telephonic Messages	Information provided on telephone messages	N	N	0/45	Dual	Y
Telephonic Sales Scripts	Scripts used for telephonic sales	N	N	45	Dual	Y
Television	Information provided through television, including advertisements, news segments, "shows", etc.	N	N	45	Dual	Y
Text Messages	Information provided via a text message.	N	N	0/45	Dual	Y
Website	For submitting web-based marketing OTHER than the plan website as required under 42 CFR §§ 422.2265, 422.2265 (which can be submitted under "CMS Required")	N	N	0/45	Dual	Y

Name	Description	File and Use	Model Language	Submitted-Not Reviewed	Replacements	Review Days	PBP Designation	Review Type	Prospective review by state?
ANOC	Annual Notice of Change	N	N	N	Y	45	Y	Dual	Y
ANOC Errata	Annual Notice of Change Errata	N	N	N	N	45	Y	Dual	Y
Communications with VBID Content	To be used when submitting non-marketing (i.e. communications) materials that include VBID content. VBID materials that meet the definition of marketing must be submitted under "Plan Created".	N	N	N	N	0	N	CMS	N
EOC/Member Handbook	Evidence of Coverage/Member Handbook	N	N	N	Y	0	Y	Dual	N
EOC Errata	Evidence of Coverage Errata	N	N	N	N	45	Y	Dual	Y
Online Enrollment Form/Request	Online Enrollment Form/Request	Y	N	N	Y	0/45	N	CMS	N
Paper Enrollment Form/Request	Enrollment Form/Request	Y	N	N	Y	10/45	N	CMS	Y
Plan Required Website	Plan website as required under Section 422/423 2265	Y	N	N	N	0/45	N	CMS	N
SB	Summary of Benefits	N	Y	N	Y	45	Y	Dual	Y
Star Ratings	Star Ratings document	Y	Y	N	Y	0/10/45	Y	CMS	N
VBID-Member Engagement Strategy	Used to ensure each enrollee understands the Model Benefits and/or Model Rewards that he or she may be eligible for and how to access them and for CMS to understand how Model Benefits and Model Rewards are being communicated to enrollees.	N	N	N	N	45	N	CMS	N
Integrated Denial Notice	Notice to members, generally by mail, provided at least ten days in advance of any adverse benefit determination	Y	N	N	N	10/45	N		N
Errata - Formularies	Statement identifying plan errors in Formulary and sent to current members	N	N	N	N	10	Y	State	Y
Errata - Summary of Benefits	Statement identifying plan errors in Summary of Benefits and sent to all enrollees	N	N	N	N	10	Y	Dual	Y
Formulary	Comprehensive, integrated list of Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan	N	N	N	Y	10/45	Y	State	N
Formulary Change Notices	Notices related to plan changes in the formulary or prescription Part D or Medicaid drugs	N	N	N	N	45	N	State	Y
Formulary/Drug - CMS-specified Documents	Formulary/Drug - CMS-specified Documents	N	N	N	N	45	N		N
DUPLICATE ROW Integrated Denial Notice	Notice to members, generally by mail, provided at least ten days in advance of any adverse benefit determination	N	Y	N	N	10/45	N		N
Medicaid-only Beneficiary Services Communications	Medicaid-only Beneficiary Services Communications	N	N	N	N	45	N	State	Y
Member ID Card	Single card for all pharmacy and health benefits offered under the plan	N	Y	N	N	10/45	Y	State	Y
Non-Part D Claims/Org Det/Appeals/Grievance	Form or letter plan sends to member in response to health care claims or non-Part D drugs, organization determination, appeals, or grievances	N	N	N	N	45	N		N
Non-renewal Notice	Notice to each affected member, before the effective date, when plan decides to non-renew or reduce its service area	N	N	N	N	10/45	Y		N
Other Post-enrollment Documents	General documents that plan provides to members after enrollment effective date	N	N	N	N	45	N		N
Other Pre-enrollment Documents	Documents other than the pre-enrollment checklist that plan provides to 2 members	N	N	N	N	45	N		N
Post-enrollment Member Outreach Scripts	Script for plan follow up with new members	N	N	N	N	45	Y		N
Provider/Pharmacy Directory, Formulary, and/or E/Member Handbook Notice	Notice informing members how to access materials electronically instead of by mail in hard copy	N	N	N	N	45	N		N