COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

DUAL SPECIAL NEEDS PLAN (D-SNP) CONTRACT

January 1, 2024 to December 31, 2024

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1. Scope for Contract

This Contract, by and between the Virginia Department of Medical Assistance Services (hereinafter referred to as the Department or 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., and, 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 or Contractor), a corporation organized under the laws of the State of Virginia and having a principal place of business in Virginia. This Contract is effective January 1, 2024 through December 31, 2024 and renews annually.

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 and regulations, 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. D-SNP Technical Manual; and
5. 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 Commonwealths 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; and
3. 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 and 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 DSNP program as well as all efforts to improve the existing operations of the DSNP

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 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.

1.4.1 Service Account

Unless otherwise noted in this contract or the Technical Manual, the Contractor is required to report using the Departments prescribed managed file transfer (MFT) process. To utilize 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.

When 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 to include reason for extended timeframe for response and requested date for new response date.

1.6 Department Oversight

During the conduct 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. This Contract shall automatically terminate the day this Contract expires or is terminated.
2. This Contract may be terminated by mutual agreement of the parties. Such agreement must be in writing.
3. The State may terminate this Contract in whole or in part and at any time when, in its sole discretion, it determines that termination is in the best interests of the Commonwealth of Virginia. The termination will be effective on the date specified in the State's Notice of Termination. The State will provide the Contractor written notice of such termination at least 60 (sixty) calendar days prior to the effective date of termination, unless the State determines that circumstances warrant a shorter notice period.
4. In addition to the reasons set forth above, the State reserves the right to terminate this Contract, in whole or in part, upon the following conditions:
    a. The State may terminate this Contract at any time if a court of competent jurisdiction finds the Contractor failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of the Contractor's duties under this Contract.
    b. The State may terminate the Contract at any time if the Contractor;
        i. Files for bankruptcy;
        ii. Becomes or is declared insolvent;
        iii. Does not meet the Virginia Bureau of Insurance financial requirements;
        iv. Is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar officer for it;
        v. Makes an assignment for the benefit of all or substantially all of its creditors; or,
        vi. Enters into an agreement for the composition, extension, or readjustment of substantially all of its obligations.

c. The State will have the right to terminate this Contract at any time, and in whole or in part, if it determines, at its sole discretion, that the Contractor has breached the Contract.
d. The State has the right to terminate this Contract if the Contractor, or any of its contracted entities or subsidiaries, is determined to have a Star Rating of three stars or less; has been issued a Notice of Noncompliance; or, had sanctions imposed upon them by CMS.

5. The Contractor may terminate this Contract by providing the Department written notice at least ninety (90) calendar days prior to termination. The termination will be effective on the date specified in the Contractor's Notice of Termination.
6. If at any time the Managed Care contract is terminated by either the Contractor or the Department, the Contractor's D-SNP contract with the Department shall also be terminated.

2. DSNP Requirements for Operation

2.1 Contracting Requirements

Prior to operating within the Commonwealth, the Contractor, or an approved affiliate, must have entered into a Contract with the Department to provide, primary and acute care, behavioral health, nursing facility, HCBS Waiver, and Long Term Services and Supports ("LTSS") to qualified beneficiaries through a Cardinal Care Managed Care 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 and Medicaid Services ("CMS"), whereby the Contractor provides or desires to provide Medicare Covered health care benefits to qualified Medicare beneficiaries under a Dual Eligible Special Needs Plan in the Commonwealth of Virginia.

2.2 Contact Information

The Contractor must provide the Department with name and contact information responsible for the following duties: D-SNP National Lead, D-SNP State Lead, State Lead for D-SNP care coordination, State Lead for D-SNP coordination with Medicaid Plans, State Lead for D-SNP contracting and State Lead for D-SNP quality improvement and oversight. The same individual can fulfill one or more of the roles listed. See Technical Manual for specifications.

2.3 Standards, Licensure and Solvency

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

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 12VAC5-408-10 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 123 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

The Contractor represents that neither it nor any of its employees, agents, officers or directors is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or Federal health care program.

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 2.7.2 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 legal entity holding a contract with CMS for the D-SNP covered under this Contract will receive direct capitation payments from the Department through the Cardinal Care Managed Care Program (hereinafter referred to as the Managed Care Program or the Medicaid Managed Care plan) to provide coverage of the Medicaid benefits described in Section 11.0 of this contract. This includes all primary care, acute care, behavioral health, nursing facility, HCBS waiver and LTSS services. See the Cardinal Care Managed Care contract for a list of Medicaid services excluded under the managed care program.

When a Member has not aligned their Medicare and Medicaid enrollment with the Contractor, the Contractor will not receive a direct capitated payment through the Managed Care Program for the Member's Medicaid services. In these instances, the Member is still eligible to be enrolled in the Contractor's FIDE SNP and the Contractor is required to coordinate with the Member's Medicaid health plan as described in Section 5.0 of this contract.

Regardless of whether the Member has aligned their Medicare and Medicaid enrollment, the Contractor agrees to coordinate the delivery of covered Medicare and Medicaid health and long- term care services, using aligned care management and specialty care network methods for high-risk beneficiaries, including but not limited to:

1. The coordination of care provisions described in Section 4.0 and Section 5.0 of this contract.
2. Providing a long-term care case manager who will manage care transitions and assist Members accessing the full range of medically necessary services across their Medicare and Medicaid benefits.

The Contractor agrees to employ policies and procedures to coordinate or integrate member materials, including enrollment communications, grievance and appeals, and quality assurance, including but not limited to:

1. Facilitating Medicaid eligibility redeterminations, including assisting with applications for medical assistance and conducting member education regarding Medicaid eligibility, as described in Section 5.0 of this contract;
2. Performing integrated Medicare and Medicaid Health Risk Assessments (HRA) upon enrollment and annually thereafter; and
    a. When the Member has aligned their enrollment (enrolled with the same Contractor for Medicare and Medicaid), the Contractor must integrate the results from the Cardinal Care Managed Care HRA with the DSNP HRA; and

    b. When the Member is unaligned, the Contractor must attempt to coordinate the HRA process with the Member's Managed Care plan. See Section 5.1(3).
3. Integrating member facing materials wherever possible.
    a. With the exception of Item 4 below, the Department is not requiring any specific materials be integrated but encourages the Contractor to integrate materials as it deems appropriate. The Contractor must collaborate with the Department on integrating member facing materials.
4. Contractors offering FIDE SNPs or HIDE SNPs with exclusively aligned enrollment at either the contract or Plan Benefit Package (PBP) level 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:
    a. Grievances and appeals systems that meet the standards described in §422.629;
    b. An integrated grievance process that complies with §422.630;
    c. A process for making integrated organization determinations consistent with §422.631;
    d. Continuation of benefits while an integrated reconsideration is pending consistent with §422.632;
    e. A process for making integrated reconsiderations consistent with §422.633; and
    f. A process for effectuation of decisions consistent with §422.634.

It is the intent of the Department to require exclusively aligned enrollment between the D-SNP and the Managed Care Program in the future. The Contractor must work with the Department, including attending and participating in workgroup meetings, to implement all changes required as part of this effort.

2.6.2 FIDE Exceptions

Exception Due to Legal Entity Issues

If the Contractor is not approved by CMS to operate as a FIDE SNP because they do not meet the "single entity" or "legal entity" requirement in 42 CFR 422.2, they will be allowed to operate as a Highly Integrated Special Needs Plan (HIDE SNP). In this instance, the Contractor is not required to seek preapproval from the Department to operate as a HIDE SNP but must indicate their need to do so upon signing of this Contract. See Section 8.2 of this Contract. All other requirements of this Contract will continue to apply.

Exception Due to CMS Approval Issues

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 prior to operation. The Contractor must notify the Department of the need for an exception as soon as possible. At a minimum, the notification 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 the exemption request on a case-by-case basis and inform the Contractor of its decision within thirty (30) days of receiving a complete request. Requests can submitted via traditional mail or email to the Department.

Exception for Unaligned Enrollees

It is the intent of the Department that all enrollees, with the exception of partial duals enrolled as described in Section 2.7.3, are enrolled in the Contractor's FIDE SNP. However, the Department allows the Contractor to enroll their unaligned enrollees into an additional PBP which can be a HIDE SNP. If the Contractor elects to exercise this option, they must submit their plan for enrolling all of their members into a FIDE SNP. At a minimum, the plan must include the date when the Contractor anticipates all enrollees being enrolled in a FIDE SNP.

2.6.3 Option for Additional Plan Benefit Packages

The Contractor is permitted to operate more than one PBP upon approval by the Department. With the exception of a PBP for partial benefit dual eligible individuals as described below, 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 request preapproval from the Department as soon as possible and prior to operation. 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.

Partial Dual Eligible Plan

The Contractor is granted the option to offer a DSNP to partial benefit dual eligible individuals as an additional PBP. The PBP for partial benefit dual eligible individuals must follow the requirements in Section 9.0 of this contract. The Contractor must indicate their intent to offer such a plan upon signing of this contract. See Section 8.0 of this Contract.

If the Contractor would like to offer a DSNP to partial dual eligible individuals but does not want to, or cannot, utilize an alternative PBP as granted here, the Contractor may request a separate contract from 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. 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).

3.1.2 Partial Benefit Dual Eligible Enrollees

Only when exercising the ability to offer an additional PBP as described in Section 2.7.3 is the Contractor permitted to enroll individuals whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries, also known as "partial" dual eligibles. See Section 9.0 for description of PBP for partial dual eligible plans and for approved populations under the additional PBP for partial dual eligibles.

3.2 Excluded Populations

The Contractor is prohibited from enrolling those that meet any of the following criteria:

1. Except as permitted in Section 3.1.2, Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries. Examples include:
    a. Qualified Medicare Beneficiaries (QMBs);
    b. Special Low Income Medicare Beneficiaries (SLMBs);
    c. Qualified Disabled Working Individuals (QDWIs); or,
    d. Qualifying Individuals (QIs). Medicaid pays Part B premium.
2. Individuals enrolled in the Commonwealth's Title XXI CHIP programs (FAMIS, FAMIS MOMS).
3. Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll with the Contractor if they choose to disenroll from their PACE provider.
4. Individuals with temporary coverage or who are in limited coverage groups, including Individuals enrolled in Plan First, DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention, who are not included in the Medicaid expansion population.
5. Individuals enrolled in a Medicaid-approved hospice program at the time of the enrollment request will not be auto-enrolled. However, if an individual enters a hospice program while enrolled in the Contractors DSNP, the Member will remain enrolled in the D-SNP for those services.
6. Individuals who live on Tangier Island.
7. Individuals under age twenty-one (21) years of age who are approved for DMAS Psychiatric Residential Treatment Facility (PRTF) services (formerly known as Level C (RTC) programs) as defined in Emergency Regulation 12 VAC 30-50-130.
8. Individuals who are institutionalized in State or private ICF/ID and State ICF/MH facilities. A State acute care facility is not excluded.
9. Individuals who reside at Piedmont, Catawba, Hiram Davis, and Hancock State facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS).
10. Individuals who reside in nursing facilities operated by the Veterans Administration, or individuals who elect to receive nursing facility services in The Virginia Home Nursing Facility or in local government-owned nursing homes. These include the following nursing facilities:

Excluded Nursing Facilities
Bedford County Nursing Home
Birmingham Green
Dogwood Village of Orange County Health
Lake Taylor Transitional Care Hospital *(Different from Lake Taylor Long-Stay Hospital)*
Lucy Corr Nursing Home

The Virginia Home Nursing Facility
Virginia Veterans Care Center
Sitter & Barfoot Veterans Care Center

11. Individuals who reside in the Virginia Home Nursing Facility will be temporarily excluded from the DSNP. Through the Managed Care program, DMAS will transition the enrollment for Virginia Home residents to the DSNP during a later implementation phase and through a transition plan that addresses the unique needs of the Virginia Home population and its system of care. DMAS will develop the transition plan in collaboration with the Virginia Home and the DSNPs.
12. Individuals participating in the CMS Independence at Home (IAH) demonstration (DMAS will manually exclude these individuals). However, IAH individuals may enroll with the Contractor if they choose to disenroll from IAH.
13. Individuals receiving care/treatment in facilities located outside of Virginia as authorized by DMAS prior to their Managed Care plan enrollment date.
14. Individuals who are incarcerated. (Individuals on house arrest are not considered incarcerated.)
15. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.
16. Individuals who are included in the Medicaid expansion populations.
17. Newborns whose mothers are Managed Care plan Members on their date of birth. However, the Contractor must adhere to a process that assures newborns get enrolled in Medicaid as soon as possible by completing the DMAS-213 form. This form can be found by searching the Virginia Medicaid Provider Portal at this link.

The Department shall, upon new State or Federal regulations or Department policy, modify the list of excluded individuals as appropriate. If the Department modifies the exclusion criteria, 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 Section 3.3 of this Contract.

The Department will provide the Contractor access to real-time, or near real-time, Medicaid eligibility information through a phone based system or through an online system operated by the Department or its contractor. The Department recommends the Contractor use the Virginia Medicaid Enterprise System Provider Portal or the 270/271 batch lookup process. More information on how to access the 270/271 process can be found here.

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

In the event 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 of 1996 (the "Privacy Rule"). Access to the eligibility data is conditioned on the Contractor's Contract to abide by the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act on 2009, and an executed Business Associate Agreement with the Department (see Attachment 7.2).

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 3.1, the Contractor will accept all dual eligibles 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 losses Medicaid eligibility and the Contractor determines the individual is likely to regain Medicaid eligibility within six months of the termination date, the Contractor must retain the Member for the full six 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.

3.4.2 Sharing of Member Health Information

The Contractor must provide all pertinent health information, including assessments, plan(s) of care and Medicare encounter data, to another MA D-SNP contracted by the Department when a former Member enrolls with the other D-SNP and when the new D-SNP has requested such information.

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;
3. The Member's eligibility results in Full Benefit Dual Eligible status for such Member.

The Department shall 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 Medicare Advantage dual eligible special needs plan.

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 fully integrated dual eligible special needs plan 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 this Section 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 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

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' default enrollment process prior approval notifications or correspondence to the Contractor within five (5) calendar days of receipt, in accordance with the requirements in the D-SNP Technical Manual.

<u>Default Enrollment Notice</u>

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 (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 (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 whom 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 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).

4. Model of Care and Medicare-Medicaid Coordination

The Contractor must add all provisions from Section 4.1 below, *Model of Care Required Elements*, to its Model of Care (MOC) as required in § 1859 of the Social Security Act. These provisions must be added at the next practicable opportunity and must be maintained in the Contractor's MOC throughout the contract period.

The Contractor must submit to the Department a copy of the D-SNP MOC summary document required by CMS. This summary document must be submitted to the Department upon approval by CMS and upon any significant change.

4.1. MOC Required Elements

The Contractor must incorporate the following provisions into their MOC:

1. Training of Care Coordinators – The Contractor must describe how their care coordination trainings incorporate Managed Care Program care coordination requirements, covered services and benefits. The description must include:
    a. How the Contractor ensures the occurrence of regularly scheduled trainings;
    b. LTSS, HCBS and Social Determinants of Health services/benefits covered in the CCC Plus program; and
    c. Transition of care policies and procedures.
2. Incorporation of Screenings and Assessment – The Contractor must describe how:
    a. The Managed Care Program HRA and reassessment, screenings and level of care tools are coordinated with the Contractor's HRA;
    b. The assessment process meets the Managed Care Program contract requirement for face-to-face assessment, is consistent with state criteria, and continues to meet Part C requirements, including established timeframes; and
    c. Primary, acute and long-term care needs are addressed.
3. Incorporation of Individualized Care Plan (ICP) - The Contractor must describe how the ICP:
    a. Integrates Medicare and Medicaid services, including LTSS;
    b. Addresses state-required LTSS Plan of Care (POC) elements; and
    c. Addresses the process for coordinating medical and social services identified in the ICP.
4. Integrated Care Team (ICT) alignment – The Contractor must describe how information about the members' Medicare and Medicaid services, including LTSS, is communicated from the care coordinator to members' health care providers.

4.2 Care Coordinator/Manager Trainings

Upon being hired and annually thereafter, every Care Coordinator/Manager and every Care Coordinator/Manager supervisor must complete the Department's Care Coordinator/Manager training. This training will focus on understanding the Virginia Medicaid program including Medicaid services, Cardinal Care Managed Care care coordination activities and requirements, and Medicare-Medicaid integration activities. The Department will provide further guidance outside of this contract on how plans can access the training.

5.0 Medicare-Medicaid Coordination Requirements

5.1 Coordination of Member's Health Care

Pursuant to 42 CFR §422.107(c)(1), the Contractor is responsible for coordination of the Member's health care. The MA organization's responsibility is to 1) Coordinate the delivery of Medicaid benefits for individuals who are eligible for such services; and 2) If applicable, such as when a Member's enrollment is aligned, provide coverage of Medicaid services, including long-term services and supports and behavioral health services, for Members eligible for such services.

The Contractor must utilize both Medicare and Medicaid health care data to coordinate all aspects of the Member's health care including, but not limited to, Medicare Parts A, B, and D; historical data; Medicaid historical data; data from the State's Behavioral Health Services Administrator; discharge planning; disease management; chronic conditions; and care management.

The Contractor must coordinate with their Member's Medicaid health plan. In doing so, the Contractor must, at a minimum, meet the following requirements:

1. The Contractor must provide the Medicaid plan with contact information of the person and division responsible for coordination of the Member's Medicare benefit;
2. The Contractor must provide the Medicaid plan with contact information of the person or division responsible for coordination of cost sharing between Medicare and Medicaid;
3. The Contractor must request a representative from the Member's Medicaid plan to participate in all needs assessments, person centered planning and all Interdisciplinary Care Team meetings;
4. The Contractor must provide the Medicaid plan with the results of all needs assessments and person-centered planning;
5. The Contractor must, at a minimum, provide the Medicaid plan with timely notice (within 48 hours of becoming aware, either through a claim submission or other means, of hospital, emergency department and nursing facility admissions and discharges and within 72 hours of the diagnoses of, or significant change in the treatment of, a chronic illness) in order to facilitate the coordination of benefits and cost sharing between the MA D-SNP and Medicaid plan;
6. The Contractor must coordinate with the Medicaid plan regarding discharge planning from inpatient setting, including hospital and nursing facility;
7. The Contractor must be able to receive, process and utilize in a timely manner (within 72 hours at a maximum or sooner if circumstances necessitate a faster response) information, including Member-specific health data, from a Member's Medicaid plan regarding the effective coordination of benefits and cost sharing; and,
8. The Contractor must, at the request of a Medicaid plan, participate in training of the Medicaid plan's staff regarding coordination of benefits and cost sharing between Medicare and Medicaid.
9. When requested by the Member, the Contractor must educate members on Medicaid eligibility and facilitating Medicaid eligibility redeterminations.

5.2 Behavioral Health

The Contractor must coordinate all carved out or excluded behavioral health benefits with the State's contracted BHSA when appropriate and until those services are included in the Managed Care program.

5.3 Coordination with State

At the Department's request, the Contractor must meet with the Department 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 that are enrolled in the health plan's Cardinal Care Managed Care plan and the Contractor's D-SNP.

5.4 Staff Training

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

The Contractor will also be required to 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.

5.5 Provider Training

The Contractor must train network providers on available D-SNP and Cardinal Care Managed Care program benefits and services as requested by a provider or provider association.

5.6 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.

5.7 Call Center Requirements

The Contractor is required to ensure all member and provider call centers can either address a caller's Medicaid questions or be able to complete a warm-transfer to internal staff that can answer the caller's Medicaid questions. For unaligned members, the Contractor must be able to at least provide the caller with the contact information of the member's Medicaid plan.

6.0 Miscellaneous

6.1 Performance Evaluation

The Contractor may be 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.

6.2 D-SNP Improvement Plan

If, at any time, the Department reasonably determines that the Contractor is deficient in the performance of its obligations under this Contract, DMAS 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 their 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 1.7 of this contract.

6.3 Approved Service Areas

The Contractor must offer their D-SNP to eligible beneficiaries as described in Section 3.1. The Contractor must offer their D-SNP in the localities identified with the signature document (see Attachment 7.1).

It is the intent, but not yet a Contract requirement, that future Contractor D-SNP approved service area localities will exactly match (locality for locality) the Contractor's Managed Care Program approved service area. In any instance when the CMS approved D-SNP service areas do not match the State's approved Cardinal Care Managed service areas, the State may restrict the Cardinal Care Managed Care service area to align with the CMS approved D-SNP service areas, or may terminate the D-SNP contract. When appropriate, the Department may work with the Contractor to achieve fully aligned service areas prior to terminating the Contract. The Department will provide the Contractor with advance notice of this becoming a requirement.

6.4 Member Marketing and Education

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

All marketing or education materials and information that specifically discusses the Member's Medicaid health plan enrollment choice, or are generally designed to influence the Member's Medicaid health plan enrollment choice, must be considered Medicaid marketing or education and therefore must be reviewed and approved by the Department as required in the Section 4.3 of the Cardinal Care Managed Care contract. Marketing or education materials and information include, but are not limited to, letters, notices, call-scripts, scripts for in person communication, and electronic outlet platforms. The Contractor must ensure all staff interacting with Members, including contracted staff such as brokers, are aware of and follow the approved materials and information.

6.4.1 Member Materials

The Contractor is required to provide Members with all applicable materials as described in 42 CFR § 422, 42 CFR § 423 and Chapter 3 of the Medicare Managed Care Manual.

6.5 Quarterly Meetings

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

6.6 Member Advisory Committee

In accordance with 42 CFR § 422.107(f), the Contractor must establish and maintain one or more enrollee advisory committees.

The enrollee advisory committee must include at least a reasonably representative sample of the population enrolled in the dual eligible special needs plan or plans, 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 are not limited to, staff with Medicaid expertise in: Medicaid only mental health services, Medicaid only substance use disorder services, and Long-Term Services and Supports.

6.7 Covered Services

6.7.1 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 11.0, the Cardinal Care Managed Care 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.

The Contractor must coordinate Medicare and Medicaid benefits as described in Section 5.0 of this Contract and as required by CMS through federal laws, rules, policies, health plan contracts and other guidance.

6.7.2 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 assure 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.

6.8 DMAS Obligations

6.8.1 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 the Cardinal Care Managed Care contract, and is also included in this document as Section 11.0.

6.8.2 Financial Responsibility

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

6.8.3 Medicaid Provider Information

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

7.0 Definitions and Acronyms

Listed below are the Definitions and Acronyms used in this Contract. The following terms, when used in this Contract, shall 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, and other sections of this Contract, the specific language in the Contract shall govern.

7.1 Definitions

Affiliate – A State approved entity formed under a corporate entity that differs from the corporate entity of the Cardinal Care Managed Care plan, but is owned by the same corporate parent.

Behavioral Health Services Administrator (BHSA) - An entity that manages or directs a behavioral health benefits program. The BHSA is currently responsible for administering the Department's behavioral health benefits for Medicaid recipients enrolled in fee-for-service and for Residential Treatment Services and Treatment Foster Care Case Management described in the Summary of Covered Services Chart for members enrolled in Managed Care including care coordination, provider management, and reimbursement of such behavioral health services.

Cardinal Care Managed Care – 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 Porgram" and "Managed Care program".

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 Coordinated Care Plus (CCC Plus) - The program name for the Department's former mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program included individuals who receive services through Nursing Facility (NF) care, or from the Department's home and community-based services (HCBS) 1915(c) waivers.

Commonwealth Coordinated Care 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.

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.

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.

Department of Medical Assistance Services (DMAS/The State/The Department) – The single State agency that administers the Medicaid Program in the Commonwealth of Virginia.

Dual Eligible – 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 (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).

Full Benefit Dual Eligible - 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) – As defined in 42 CFR 422.2, is a dual eligible special needs plan that: (1) That provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable State; (2) Whose capitated contract with the State Medicaid agency provides coverage, consistent with State policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; (3) That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.

Highly Integrated Dual Eligible Special Needs Plan (HIDE) – 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.

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.

MA Contract – The Medicare Advantage Plan Contract between the MA Health Plan and CMS to provide MA Dual-Eligible Special Needs Plan.

MA Dual Eligible 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.)

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

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.

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

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.

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.

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.

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.

7.2 Acronyms

BHSA -- Behavioral Health Services Administrator

BOI -- Bureau of Insurance

CAHPS® -- Consumer Assessment of Healthcare Providers and Systems

CFR -- Code of Federal Regulations

CMS -- Centers for Medicare and Medicaid Services

DMAS -- Department of Medical Assistance Services

D-SNP -- Dual Eligible Special Needs Plan

ESRD -- End Stage Renal Disease

FBDE -- Full Benefit Dual Eligible

FIDE – Fully Integrated Dual Eligible Special Needs Plan

GAP -- Governor's Access Plan

HEDIS -- Healthcare Effectiveness Data and Information Set

HIDE – 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

IAH -- Independence at Home Demonstration

ICF/ID -- Intermediate Care Facility/Individuals with Intellectual Disabilities

ICP – Integrated Care Plan

LTSS -- Long Term Services & Supports

MA -- Medicare Advantage

MCHIP -- Managed Care Health Insurance Plan

MLTSS -- Managed Long Term Services and Supports

PACE -- Program of All-inclusive Care for the Elderly

QDWI -- Qualified Disabled Working Individual

QI -- Qualified Individual

QIP – Quality Improvement Plan

QMB -- Qualified Medicare Beneficiary

QMB+ -- Qualified Medicare Beneficiary Plus

RTC -- Residential Treatment Level C

SLMB -- Special Low Income Medicare Beneficiary

SLMB+ -- Special Low Income Medicare Beneficiary Plus

USC -- United States Code

VAC -- Virginia Administrative Code

8.0 Signature Page

Effective Dates: January 1, 2024 through December 31, 2024

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, 2024 and shall continue through December 31, 2024.

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 2024 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 WITNESS HEREOF, the parties have caused this Contract Amendment to be duly executed intending to be bound thereby.

CONTRACTOR:	COMMONWEALTH OF VIRGINIA:
<Health Plan Name>	Department of Medical Assistance Services
BY: _____	BY: _____
NAME and DATE: _____	NAME and DATE: _____
TITLE: _____	TITLE: Director _____

8.2 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. If a Contractor has two contracts, one for full benefit duals and one for partial benefit duals, they'd need to complete two tables.

- If the Contractor has a separate contract (Health Plan Number) to serve partial benefit duals (see Section 2.7) that contract should not be included here. See Section 9.0 for this type of offering.
- The Contractor should only select "N/A" under the "Population Enrolled" column for PBPs that enroll partial duals.
- The italicized language and the checked boxes are provided as examples. Please remove the examples and checked boxes prior to submission.
- Selecting "FIDE" and "ONLY Aligned Enrollees" means that offering meets the definition of Applicable Integrated Plan in 42 CFR 422.561.
- The Contractor can add more additional tables if needed.

Integration by Contract and PBP			
Health Plan Name	Health Plan Number Including PBP	DSNP Type	Population Enrolled
Acme Health Care	*H-1111-001*	☒ FIDE ☐ HIDE ☐ Partial Enrollees	☒ ONLY Aligned Enrollees ☐ Aligned and Unaligned ☐ ONLY Unaligned Enrollees ☐ N/A

Integration by Contract and PBP			
Health Plan Name	Health Plan Number Including PBP	DSNP Type	Population Enrolled
Acme Health Care	*H-1111-002*	☒ FIDE ☐ HIDE ☐ Partial Enrollees	☒ ONLY Aligned Enrollees ☐ Aligned and Unaligned ☐ ONLY Unaligned Enrollees ☐ N/A

Integration by Contract and PBP			
Health Plan Name	Health Plan Number Including PBP	DSNP Type	Population Enrolled
Acme Health Care	*H-1111-003*	☐ FIDE ☒ HIDE ☐ Partial Enrollees	☐ ONLY Aligned Enrollees ☒ Aligned and Unaligned ☐ ONLY Unaligned Enrollees ☐ N/A

Integration by Contract and PBP			
Health Plan Name	Health Plan Number Including PBP	DSNP Type	Population Enrolled
Acme Health Care	*H-2222-001*	☐ FIDE ☐ HIDE ☒ Partial Enrollees	☐ ONLY Aligned Enrollees ☐ Aligned and Unaligned ☐ ONLY Unaligned Enrollees ☒ N/A

8.3 Verifying Service Area

The Contractor is required to identify which localities it has been approved to operating within.

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 = _____ OF 133							

9.0 Requirements for D-SNPs Enrolling Partial Dual Eligible Enrollees in Separate PBP

The Contractor, [Plan Name, Number "H-0000-000". Must include PBP number] is granted the option to offer a DSNP to partial benefit dual eligible individuals as an additional PBP. The Contractor is not required to seek separate approval to exercise this option but must indicate their intent to offer such a plan upon signing of this contract. See Section 8.2 of this contract.

All of Sections 1.0, 2.0, 3.1 through 3.4, 6.3, 6.4 and 6.7 of this contract apply to this PBP. Additionally, the Contractor is not required to complete a separate BAA, as required in Section 10.0, for this PBP.

9.1 Contract Period

The contract period for this PBP is January 1, 2024 through December 31, 2024

9.2 Service Area

The Contractor shall offer their alternative PBP for partial benefit dual eligible individuals, as described in Section 9.3, in the localities identified in Section 9.10.

9.3 Approved Populations for PBP Serving Partial Duals

Enrollment into this PBP shall be limited to individuals that meet the following criteria:

1) Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries. Examples include:
    a. Qualified Medicare Beneficiaries (QMBs);
    b. Special Low Income Medicare Beneficiaries (SLMBs);
    c. Qualified Disabled Working Individuals (QDWIs); or,
    d. Qualifying Individuals (QIs). Medicaid pays Part B premium.

The Contractor must indicate which types of partial duals they will serve through this PBP by selecting all options that apply:

☐	Qualified Medicare Beneficiaries (QMBs)
☐	Special Low Income Medicare Beneficiaries (SLMBs)
☐	Qualified Disabled Working Individuals (QDWIs);
☐	Qualifying Individuals (QIs)

9.4 Excluded Populations for PBP Serving Partial Duals

The Contractor is prohibited from enrolling those who meet any of the following criteria into the PBP:

1. Individuals who are entitled to benefits under Medicare Part A, B and D, and receiving full Medicaid benefits. Examples include:
    a. Qualified Medicare Beneficiary Plus (QMB+),
    b. Special Low Income Medicare Beneficiary Plus (SLMB+), and

    c. Other Full-Benefit Dual Eligible (FBDE).
2. Individuals enrolled in the Commonwealth's Medallion and Title XXI CHIP programs (FAMIS, FAMIS MOMS).
3. Individuals enrolled in the Cardinal Care Managed Care program.
4. Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll with the Contractor if they choose to disenroll from their PACE provider.
5. Individuals with temporary coverage or who are in limited coverage groups, including Individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention) who are not included in the Medicaid expansion population.
6. Individuals who are incarcerated. (Individuals on house arrest are not considered incarcerated.)
7. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.

9.5 Covered Services

The Contractor is not responsible for the provision or reimbursement of any Medicaid benefits through this contract. Medicaid benefits will be provided and reimbursed by the Department through the Fee-For-Service program.

The Contractor is required to maintain knowledge and familiarity with current Medicaid covered services as described in Section 11.0 and through ongoing review of state laws, rules, policies, health plan contracts, and guidance as well as through information posted on its website.

The Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medicaid benefits. The Contractor is responsible for coordinating the Member's Medicare and Medicaid benefits, including, but not limited to discharge planning, disease management, and care management.

9.6 Cost Sharing Protections

The Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on enrollees of this PBP that would exceed the amounts permitted under 42 CFR §422.504(g) for individuals for whom the State only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries.

9.7 Medicaid Provider Participation

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

9.8 Verifying Eligibility

The Department will provide the Contractor access to real-time Medicaid eligibility information through an online system operated by the Department or its Eligibility Contractor.

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

In the event 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 of 1996 (the "Privacy Rule"). Access to the eligibility data is conditioned on the Contractor's Contract to abide by the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act on 2009, and an executed Business Associate Agreement with the Department (see Attachment 10.0).

9.9 Encounter Submission

The Contractor shall submit encounter data to the Department, in a format and frequency determined by the Department. Specifications are provided in the *Encounter Technical Manual* and *837 Companion Guide*. Encounters must be submitted within thirty (30) days of the remittance.

9.10 Approved Service Area for PBP for Partial Duals

The Contractor is required to identify which localities it has been approved to operate within for this 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 = _____ OF 133

10.0 Business Associate Agreement

THIS ATTACHMENT supplements and is made a part of the Business Associate Agreement (herein referred to as "Agreement") by and between the Department of Medical Assistance Services (herein referred to as "Covered Entity") and [name Business Associate] (herein referred to as "Business Associate").

General Conditions

This BAA ("Agreement" or "BAA") is made as of January 1, 2024 by the Department of Medical Assistance Services ("Covered Entity"), with offices at 600 East Broad Street, Richmond, Virginia, 23219, and _____ ("Business Associate"), with an office at _____. This is a non-exclusive agreement between the Covered Entity, which administers Medical Assistance, and the Business Associate named above.

The Covered Entity and Business Associate, as defined in 45 CFR § 160.103, have entered into this Business Associate Agreement to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, as amended, the current and future Privacy and Security requirements for such an Agreement, the Health Information Technology for Economic and Clinical Health (HITECH) Act, (P.L. 111-5) Section 13402, requirements for business associates regarding breach notification, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements.

DMAS and Business Associate ("parties") shall fully comply with all current and future provisions of the Privacy and Security Rules and regulations implementing HIPAA and HITECH, as well as Medicaid requirements regarding Safeguarding Information on Applicants and Recipients of 42 CFR 431, Subpart F, and Virginia Code § 32.1-325.3. The parties desire to facilitate the provision of or transfer of electronic PHI in agreed formats and to assure that such transactions comply with relevant laws and regulations. The parties intending to be legally bound agree as follows:

Definitions. As used in this agreement, the terms below will have the following meanings:

a. Business Associate has the meaning given such term as defined in 45 CFR § 160.103.
b. Covered Entity has the meaning given such term as defined in 45 CFR § 160.103.
c. Provider: Any entity eligible to be enrolled and receive reimbursement through Covered Entity for any Medicaid-covered services.
d. MMIS: The Medicaid Management Information System, the computer system that is used to maintain Member, provider, and claims data for administration of the Medicaid program.
e. Protected Health Information (PHI) has the meaning of individually identifiable health information as those terms are defined in 45 CFR § 160.103.
f. Breach has the meaning as that term is defined at 45 CFR § 164.402.
g. Required by law shall have the meaning as that term is defined at 45 CFR § 160.103.
h. Unsecured Protected Health Information **has** the meaning as that term is defined at 45 CFR § 164.402.
i. Transport Layer Security (TLS): A protocol (standard) that ensures privacy between communicating applications and their users on the Internet. When a server and client communicate, TLS ensures that no third party may eavesdrop or tamper with any message. TLS is the successor to the Secure Sockets Layer (SSL).

Terms used, but not otherwise defined, in this Agreement shall have the same meaning given those terms under HIPAA, the HITECH Act, and other applicable federal law.

I. Notices

1. Written notices regarding impermissible use or disclosure of unsecured protected health information by the Business Associate shall be sent via email or general mail to the DMAS Chief Financial Officer (with a copy to the DMAS contract administrator in II.2) at:

DMAS Chief Financial Officer
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
DSNP@dmas.virginia.gov

2. Other written notices to the Covered Entity should be sent via email or general mail to DMAS contract administrator at:

Contact: DMAS Division of Integrated Care
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
DSNP@dmas.virginia.gov

II. Special Provisions to General Conditions

1) Uses and Disclosure of PHI by Business Associate. The Business Associate
   a. May use or disclose PHI received from the Covered Entity, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business.
   b. Shall not use PHI otherwise than as expressly permitted by this Agreement, or as required by law.
   c. Shall have a signed confidentiality agreement with all individuals of its workforce who have access to PHI.
   d. Shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, and who have signed a confidentiality agreement.
   e. Shall ensure that any agents and subcontractors to whom it provides PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, agree in writing to all the same restrictions, terms, special provisions and general conditions in this BAA that apply to Business Associate. In addition, Business Associate shall ensure that any such subcontractor or agent agrees to implement reasonable and appropriate safeguards to protect Covered Entity's PHI. In instances where one DMAS Business Associate is required to access DMAS PHI from another DMAS Business Associate, the first DMAS Business Associate shall enter into a business associate agreement with the second DMAS Business Associate.

f. Shall provide Covered Entity access to its facilities used for the maintenance and processing of PHI, for inspection of its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI, for purpose of determining Business Associate's compliance with this BAA.
g. Shall make its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary of Department of Health and Human Services (DHHS) or its designee and provide Covered Entity with copies of any information it has made available to DHHS under this section of this BAA.
h. Shall not directly or indirectly receive remuneration in exchange for the provision of any of Covered Entity's PHI, except with the Covered Entity's consent and in accordance with 45 CFR§ 164.502. Shall make reasonable efforts in the performance of its duties on behalf of Covered Entity to use, disclose, and request only the minimum necessary PHI reasonably necessary to accomplish the intended purpose with the terms of this Agreement.
i. Shall comply with 45 CFR § 164.520 regarding Notice of privacy practices for protected health information.

2. Safeguards - Business Associate shall

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 and the HITECH Act.
b. Include a description of such safeguards in the form of a Business Associate Data Security Plan.
c. In accordance with the HIPAA Privacy Rule, the Security Rule, and the guidelines issued by the National Institute for Standards and Technology (NIST), Business Associate shall use commercially reasonable efforts to secure Covered Entity's PHI through technology safeguards that render PHI unusable, unreadable and indecipherable to individuals unauthorized to access such PHI.
d. Business Associate shall not transmit PHI over the Internet or any other insecure or open communication channel, unless such information is encrypted or otherwise safeguarded using procedures no less stringent than described in 45 CFR § 164.312(e).
e. Business Associate shall cooperate and work with Covered Entity's contract administrator to establish TLS-connectivity to ensure an automated method of the secure exchange of email.

3. Accounting of Disclosures - Business Associate shall

a. Maintain an ongoing log of the details relating to any disclosures of PHI outside the scope of this Agreement that it makes. The information logged shall include, but is not limited to;
    i. the date made,
    ii. the name of the person or organization receiving the PHI,
    iii. the recipient's (Member) address, if known,
    iv. a description of the PHI disclosed, and the reason for the disclosure.
b. Provide this information to the Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

4. Sanctions - Business Associate shall

    a. Implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Agreement or the HIPAA privacy regulations.
    b. As requested by Covered Entity, take steps to mitigate any harmful effect of any such violation of this agreement.

5. Business Associate also agrees to all of the following:

    a. In the event of any impermissible use or disclosure of PHI or breach of unsecured PHI made in violation of this Agreement or any other applicable law, the Business Associate shall notify the DMAS Privacy Officer.
        i. Initial notification regarding any impermissible use or disclosure by the Business Associate must be immediate or as soon as possible after discovery. Formal notification shall be delivered within 5 business days from the first day on which such breach is known or reasonably should be known by Business Associate or an employee, officer or agent of Business Associate other than the person committing the breach, and

        ii. Written notification to DMAS Privacy Officer shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Business Associate shall confer with DMAS prior to providing any notifications to the public or to the Secretary of HHS.

    b. Breach Notification requirements.
        i. In addition to requirements in 5.a above, in the event of a breach or other impermissible use or disclosure by Business Associate of PHI or unsecured PHI, the Business Associate shall be required to notify in writing all affected individuals to include,
            a) a brief description of what happened, including the date of the breach and the date the Business Associate discovered the breach;
            b) a description of the types of unsecured PHI that were involved in the breach;
            c) any steps the individuals should take to protect themselves from potential harm resulting from the breach;
            d) a brief description of what Business Associate is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches, and, if necessary,
            e) Establishing and staffing a toll-free telephone line to respond to questions.
        ii. Business Associate shall be responsible for all costs associated with breach notifications requirements in 5b, above.

        iii. Written notices to all individuals and entities shall comply with 45 CFR § 164.404(c)(2), 164.404(d)(1), 164.406, 164.408 and 164.412.

6. Amendment and Access to PHI - Business Associate shall

a. Make an individual's PHI available to Covered Entity within ten (10) days of an individual's request for such information as notified by Covered Entity.
b. Make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within ten (10) days of notification by Covered Entity per 45 CFR § 164.526.
c. Provide access to PHI contained in a designated record set to the Covered Entity, in the time and manner designated by the Covered Entity, or at the request of the Covered Entity, to an individual in order to meet the requirements of 45 CFR § 164.524.

7. Termination

b. Covered Entity may immediately terminate this agreement if Covered Entity determines that Business Associate has violated a material term of the Agreement.
c. This Agreement shall remain in effect unless terminated for cause by Covered Entity with immediate effect, or until terminated by either party with not less than thirty (30) days prior written notice to the other party, which notice shall specify the effective date of the termination; provided, however, that any termination shall not affect the respective obligations or rights of the parties arising under any Documents or otherwise under this Agreement before the effective date of termination.
d. Within thirty (30) days of expiration or earlier termination of this agreement, Business Associate shall return or destroy all PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form and retain no copies of such PHI.
e. Business Associate shall provide a written certification that all such PHI has been returned or destroyed, whichever is deemed appropriate by the Covered Entity. If such return or destruction is infeasible, Business Associate shall use such PHI only for purposes that make such return or destruction infeasible and the provisions of this agreement shall survive with respect to such PHI.

8. Amendment

a. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, Covered Entity may, by written notice to the Business Associate, amend this Agreement in such manner as Covered Entity determines necessary to comply with such law or regulation.
b. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within thirty (30) days of Covered Entity's notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, either of them may terminate this Agreement by written notice to the other.

9. Indemnification. Business Associate shall indemnify and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs

of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

10. This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

a. The names and contact information for at least one primary contact individual from each party to this Agreement.
b. A complete list of all individuals, whether employees or direct contractors of Business Associate, who shall be authorized to access Covered Entity's PHI
c. A list of the specific data elements required by Business Associate in order to carry out the purposes of this Agreement.
d. The purposes for which such data is required.
e. A description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

Business Associate agrees to update the above noted information as needed in order to keep the information current. Covered Entity may request to review the above-referenced information at any time, including for audit purposes, during the term of this Agreement.

11. Disclaimer. COVERED ENTITY MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE HIPAA REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES OR THAT ANY INFORMATION IN BUSINESS ASSOCIATE'S POSSESSION OR CONTROL, OR TRANSMITTED OR RECEIVED BY BUSINESS ASSOCIATE, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL COVERED ENTITY BE LIABLE TO BUSINESS ASSOCIATE FOR ANY CLAIM, LOSS OR DAMAGE RELATED TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY BUSINESS ASSOCIATE FROM COVERED ENTITY OR FROM ANY OTHER SOURCE. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PHI.

11.0 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, *Definitions*, 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	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. 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,

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**
				§ 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. 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 this Contract for additional requirements.
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. f Coverage must be provided in accordance with U.S. Preventive Task Force recommendations, as described at: https://www.uspreventiveservicestaskforce.org/

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Doula Services		Yes	Yes	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. Covered Services Include: 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. All claims for Doula services must include diagnosis code Z32.2 (encounter for childbirth instruction).

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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, *Enhanced Benefits* 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

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				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

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	42 CFR §440.70 41 CFR § 441.15			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. 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: 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 0444 Speech-Language Services, Home Health Assessment

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				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.				
Immunizations	12 VAC 30-50-130 Physician Manual, Chapter IV.	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

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	Provider Manual Supplement B -EPSDT Supplement			(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, *Covered Services for MAGI Adult Medicaid Expansion Population*.
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.
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID); state or private. - See Part 4 of this Attachment.				

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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 equipment that was prior authorized by the Contractor per requirements

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				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. 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. 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
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 12 VAC 30-50-100G	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 for any restriction on facilities or practitioners to be consistent with the

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	12 VAC 30-50-105K			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 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

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	1905(a) of Social Security Act			adult individual or the caregiver if the individual is under age eighteen (18) or is not able to make a choice. 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.
Personal Care Medicaid Works See CCC Plus Waiver services in Part 4b.	12VAC30-60-200 12 VAC 30-120-900 through 12 VAC 30-120-995 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	Yes	Yes	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.
Physical Therapy, Occupational Therapy, Speech	12 VAC 30-50-200 12 VAC 30-50-225 12 VAC 30-60-150	Yes	Yes	The Contractor must cover physical therapy, occupational therapy, speech pathology, and audiology services that are provided as an inpatient, outpatient hospital service, outpatient rehabilitation agencies, or home health service. The Contractor's benefits must include coverage for acute and non-acute conditions

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Pathology and Audiology Services				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	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. 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.
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 care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture.

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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, *Pharmacy Services*.
Private Duty Nursing (PDN) under EPSDT	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 CFR §441.50 1905(a) of Social Security Act	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 website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal (Also see Technology Assisted Program in Part 4 of this Attachment)

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				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.
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, *Definitions* and Section 23, *Acronyms*) 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 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

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				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.
Skilled Nursing Facility Care - See Part 4A (LTC Facility Services) of this Attachment.				
Sterilizations	42 CFR§ 441, Subpart F, as amended Code of Virginia § 54.1-2974	Yes, limited.	Yes, limited.	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 to the Department prior to signing the initial contract, upon revision or upon request.
Substance Use Disorder Treatment - See Part 2C of this Attachment.				

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Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
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, *Non-Emergency Medical Transportation Services (NEMT).* 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 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

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**
				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.
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4 2021 Virginia Acts of Assembly, Chapter 552.	Yes	Yes	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).
Vision Services	12 VAC 30-50-210 Chapter IV of the Vision Services Manual	Yes	Yes	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.
Brain Injury Services Case Management	*New Service-Regulations Pending Brain Injury Services Manual (Pending)	Yes	Yes	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 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.

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**
				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, 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 12VAC30-50-105 Manual-Psychiatric Services Chapter 4 Final Rule: 42 CFR Part 438.6 page 27861 and	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). 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

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, 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**
	pages 27557 and 27558 Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)			described in 42 CFR §438.6, 42 CFR §438.3(e)(2) and Section 5.5.1.2, *IMD Enhanced and State Plan Substituted (In Lieu Of) Services of for Certain Medicaid Members*. 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.
Inpatient Psychiatric Hospitalization in General Hospital	12 VAC 30-50-100 12VAC30-50-130 12VAC30-50-105 12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 Manual-Psychiatric Services, Chapter 4	Yes	Yes	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.
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.

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, 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**
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 appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services. 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.
OUTPATIENT BEHAVIORAL HEALTH SERVICES – Psychiatric Services Manual for All				

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, 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**
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)
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:

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, 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**
				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) 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).

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, 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
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	12 VAC 30-50-130; 12 VAC 30-50-150; 12 VAC 30-60-61;	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

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**
	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			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	Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6 and Appendix E	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 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

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
				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. Assessment Service Code: See Mental Health Services Provider Manual, Intensive Community Based Support Appendix E for assessment requirements, including billing codes. Treatment Service Code: H0040 U2 – Contracted as Base Small Team U1 – Contracted as Base Medium Team none – Contracted as Base Large Team U5 – Contracted as High Fidelity Small Team U4 – Contracted as High Fidelity Medium Team U3 – Contracted as High Fidelity Large Team

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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**
Community Stabilization	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	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. 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-down from a higher level of care if the next level of care service is identified but not immediately available for access. Treatment Service Code: S9482

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

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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
				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] [x] = Includes supervisees and residents
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 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.

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
				Treatment Service Code: H0036

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
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

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
Intensive In-Home 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 is being transitioned to home from an out-of-home placement due to a documented medical need of the youth. Comprehensive Needs Assessment Service Code: H0031 Treatment Service Code: H2012

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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 Case Management	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)] 12 VAC 30-60-5 Mental Health Services Manual (formerly CMHRS) Manual Chapters 2, 4 & 6	Yes	Yes	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. Service Code: H0023
Mental Health Intensive Outpatient	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

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**
				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 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. Assessment Service Code: See Mental Health Services Provider Manual, Intensive Clinic Based Support Appendix for assessment billing requirements.

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
				Treatment Service Code: S9480/ S9480 GO (Occupational Therapy)
Mental Health – Partial Hospitalization Program	Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	Yes	Yes	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 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. 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

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**
				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. Assessment Service Code: See Mental Health Services Provider Manual, Intensive Clinic Based Support Appendix for assessment billing requirements. Treatment Service Code: H0035
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)]	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)

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Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
	Manual: Mental Health Services Manual – Peer Recovery Support Services Supplement			
Mental Health Skill-building Assessment and Services	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	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 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. Comprehensive Needs Assessment Service Code: H0032-U8

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

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<table>
<tr><th>Service</th><th>State Plan Reference or Other Relevant Reference</th><th>Medicaid Covered?</th><th>MCO Covers?</th><th>Contractor Responsibilities</th></tr>
<tr><td></td><td></td><td></td><td></td><td>Treatment Service Code: H0046</td></tr>
<tr><td>Mobile Crisis Response</td><td>Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G</td><td>Yes</td><td>Yes</td><td>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 mechanism by which pre-admission screenings for hospitalization may be performed by DBHDS pre-admission screening clinicians, when clinically necessary.

Treatment Service Code: H2011

<table>
<tr><th>Modifier</th><th>Modifier Meaning</th></tr>
<tr><td>HO</td><td>1 Licensed[x]</td></tr>
<tr><td>32</td><td>Emergency Custody Order
1 Licensed[x]</td></tr>
<tr><td>HT, HM</td><td>1 QMHP-A/QMHP-C/CSAC[x] <u>and</u> 1 PRS or
1 QMHP-A/QMHP-C/CSAC[x] <u>and</u> 1 CSAC-A</td></tr>
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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
				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] [x] = Includes supervisees and residents
Multisystemic Therapy (MST)	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	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.

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
				Treatment Service Code: H2033

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 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

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**
Psychiatric Residential Treatment Facility – (PRTF) for children under age twenty-one (21) years – (Formerly known as Level C)	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. **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.** 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. 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

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**
				Member during the independent certification of need process as required prior to any residential treatment service authorization.
Psychosocial Rehabilitation Assessment and Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-5 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	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 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.

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
Residential Crisis Stabilization Unit	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 substantial changes in behavior noted by severe impairment or acute decompensation in functioning. Treatment Service Code: H2018 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)]	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,

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**
	12 VAC 30-60-5 Mental Health Services Manual Chapters 2, 4 & 6			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 Comprehensive Needs Assessment Service Code: H0032 Service Code: H2016 Modifiers: School Based TDT must be billed as H2016 (none) After School TDT must be billed as H2016 UG Summer TDT must be billed as H2016 U7
Therapeutic Group Home Children and Adolescents under twenty-one (21) – Group Home (Formerly known as Levels A&B)	12 VAC 30-50-130 and 12 VAC 30-60-61 VAC 30-60-5 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)]	Yes	No	The Contractor is not responsible for covering Therapeutic Group Home (TGH) services 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

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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**
	Residential Treatment Services Manual			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 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.

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

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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
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, 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. Treatment Service Code: S9485 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
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.				
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)*

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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)*

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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 H0005 - group counseling Care Coordination G9012 Substance Use Care Coordination Physician Visit – Induction Day 1 H0014 Drug Screen 80305 to 80307 and G0480- G0483 Labs CPT codes Physician Visit – Maintenance 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)*

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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**
EPSDT Benefit Global Coverage Guidelines	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	Yes	Yes	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 Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. For individuals under twenty-one (21) years of age EPSDT services will be provided before Technology Assisted Program services are offered. The Contractor must cover dental screenings and dental varnish under EPSDT. 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.

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	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	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. 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.
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**
				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/imunization/vvfc
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	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: 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	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.
Lead Testing	EPSDT Guidelines 12VAC5-90-215	Yes	Yes	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

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**
				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: 1. 36416 for the collection of capillary blood specimen (finger, heel, ear stick) 2. 36415 for the collection of venous blood by venipuncture. 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.
Personal Care	Same as EPSDT Benefit Global Coverage Guidelines	Yes	Yes	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. 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

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**
				Waiver criteria and forms are used to determine personal care hours for these members. See Section 5.12.2, *Commonwealth Coordinated Care Plus Waiver*.
Private Duty Nursing	42 CFR §§441.50, 440.80, Social Security Act §1905(a) and 1905(r) l.	Yes	Yes	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. 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. 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.

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	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. 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 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.
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	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. CMS EPSDT Guidance: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf NHeLP - http://www.healthlaw.org/ State Medicaid Manual: https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

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 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	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. 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. The Contractor must also cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate. For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for: 1. Those services federally required to be provided at public expense as is the case for 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**
				b. development or review of the Individual Family Service Plan (IFSP); and, c. targeted case management/service coordination; 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, *Comprehensive Health Coverage*.
Early Intervention Targeted Case Management/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

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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 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) T1024 U1* (RC 1)	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 "*".
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.

<table>
<tr><th>Service</th><th>State Plan Reference or Other Relevant Reference</th><th>Medicaid Covered?</th><th>MCO Covers?</th><th colspan="3">Contractor Responsibilities and Service Codes as Applicable</th></tr>
<tr><td rowspan="4"></td><td rowspan="4"></td><td rowspan="4"></td><td rowspan="4"></td><td>T1027*
(RC 2)</td><td>Developmental Services and other early intervention services provided for more than one (1) child, in a group (congregate).</td><td>RC 2 only.
See above for limits *.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>T1027 U1*
(RC 2)</td><td>Developmental Services and other early intervention services provided for one (1) child</td><td>RC 2 only.
See above for limits *.</td></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td></tr>
<tr><td rowspan="4">Center-Based Early Intervention Services; individual and/or group</td><td rowspan="4">12VAC30-50-131
12 VAC 35-225-120</td><td rowspan="4">Yes</td><td rowspan="4">Yes</td><td colspan="3">The Contractor is required to provide coverage for Early Intervention center-based individual and group (congregate) services.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>T1026*
(RC 1)</td><td>Center-based group (congregate) early intervention services</td><td>See above for limits*.</td></tr>
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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 Physical Therapy; 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

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<tr><th>Service</th><th>State Plan Reference or Other Relevant Reference</th><th>Medicaid Covered?</th><th>MCO Covers?</th><th colspan="3">Contractor Responsibilities and Service Codes as Applicable</th></tr>
<tr><td rowspan="4">Early Intervention Occupational Therapy; individual and/or group</td><td rowspan="4">12VAC30-50-131
12 VAC 35-225-120</td><td rowspan="4">Yes</td><td rowspan="4">Yes</td><td colspan="3">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.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>G0152*
(RC 1)</td><td>Group (congregate) OT</td><td rowspan="2">See above for limits*.</td></tr>
<tr><td>G0152 U1*
(RC 1)</td><td>Individual OT</td></tr>
<tr><td rowspan="4">Early Intervention Speech Language Pathology; individual and/or group</td><td rowspan="4">12VAC30-50-131
12 VAC 35-225-120</td><td rowspan="4">Yes</td><td rowspan="4">Yes</td><td colspan="3">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.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>G0153
(RC 1)</td><td>Group (congregate) SLP</td><td>See above for limits*.</td></tr>
</table>

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.

<table>
<tr><th>Service</th><th>State Plan Reference or Other Relevant Reference</th><th>Medicaid Covered?</th><th>MCO Covers?</th><th colspan="3">Contractor Responsibilities and Service Codes as Applicable</th></tr>
<tr><td></td><td></td><td></td><td></td><td>G0153 U1
(RC 1)</td><td>Individual SLP</td><td></td></tr>
<tr><td rowspan="4">Developmental Nursing; individual and/or group</td><td rowspan="4">12VAC30-50-13112
VAC 35-225-120</td><td rowspan="4">Yes</td><td rowspan="4">Yes</td><td colspan="3">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.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>G0495*
(RC 1)</td><td>Group (congregate) RN Training and Education Services;</td><td rowspan="2">See above for limits*.</td></tr>
<tr><td>G0495 U1*
(RC 1)</td><td>RN Individual Training and Education Services.</td></tr>
</table>

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	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 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.virginiamedic	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			
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	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 Waiver Personal Care	Same as General Requirements	Yes	Yes	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 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 – Personal Care** A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long-Stay Hospital and which includes assistance with ADLs and IADLs, access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home- and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The individual must require assistance with ADLs in order for personal care services to be authorized. Personal care must not be a replacement for private duty nursing services performed by a RN. Service Codes

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**
				AD = T1019 CD = S5126 Services are billed as hourly.
CCC Plus Waiver Respite Care	Same as General Requirements	Yes	Yes	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. 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. Respite coverage in children's residential facilities. 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. 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. **Service Definition - Respite Care** 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

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**
				caregiver due to the physical burden and emotional stress of providing support and care to the individual. **Skilled Private Duty Nursing Respite Care (Agency-Directed Only)** 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. Respite care can be authorized as a sole program service, or it can be offered in conjunction with other services. **Congregate Private Duty Nursing Respite Care (Agency-Directed Only)** Congregate respite nursing provided to three (3) or fewer Program individuals who reside in the same primary residence. Service Codes AD = T1005 CD = S5150 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

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 Waiver Adult Day Health Care ADHC	Same as General Requirements	Yes	Yes	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. **Service Definition – Adult Day Health Care** 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). ADHC may be offered either as the sole home- and community-based care service or in conjunction with other CCC Plus Waiver services. ADHC Service Codes = S5102 Transportation = A0120 Services are billed as a per diem. Transportation services are billed per trip.
CCC Plus 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**
Personal Emergency Response System (PERS) PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.				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 – Personal Emergency Response System (PERS)** 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. PERS is not a stand-alone service. It must be authorized in conjunction with at least one (1) qualifying CCC Plus Waiver service. 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.

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 Waiver Services Facilitation	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	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. **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. Management Training 4. Routine Onsite Visits 5. Reassessment Visit 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).

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 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 Waiver Assistive Technology 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 Waiver Environmental Modifications 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**
				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 Waiver Skilled Private Duty Nursing	Same as General Requirements	Yes	Yes	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. **Service Definition – Skilled Private Duty Nursing (Skilled PDN)** 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. **Service Definition – Congregate Skilled PDN** 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.

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**
				Coverage Limits – Up to sixteen (16) hours a day; one hundred and twelve (112) hours per week 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).
Hospice Services	12 VAC 30-50-270 and 12 VAC 30-60-130 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	Yes	Yes*	*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. 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. 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. Categories of Care: 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

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**
				the first sixty (60) days of hospice care and a reduced base payment rate for days sixty-one (61) and thereafter. 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) 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 (6^{th}) day and any subsequent days of respite care is made at the routine home care rate. 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) 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. 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,

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**
				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. 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.
Program of All-Inclusive Care for the Elderly (PACE)	12VAC30-50-320 http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx http://www.dmas.virginia.gov/Content_atchs/ltc/(11)%20Fact%20Sheet%20PACE%2011%2015.pdf	Yes	No	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. 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

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 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 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/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/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/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/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
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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.

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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/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/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.

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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.

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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, A0120This 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:

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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.

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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
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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

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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

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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
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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
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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

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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.

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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 Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living 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/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/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/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/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/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/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	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	No	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: 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 *CPT Code descriptions above subject to change
Individual and Group Smoking Cessation Counseling	https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf 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*: 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*: 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**
				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 6. S9470 (Nutritional Counseling, Dietician visit, eight (8) units per calendar year; no preauthorization *CPT Code Descriptions above subject to change
ACIP Recommended Adult Vaccines	12 VAC 30-50-130 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	Yes	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes & Limitations*: 1. 90714 (Td) 2. 90715 (Tdap) 3. 90736 (Singles zoster, > age sixty (60)) 4. 90750 (> age fifty (50)) 5. 90620 (Meningococcal, IM, two (2) dose) 6. 90621 (Meningococcal, IM, two to three (2-3) dose) 7. 90733 (Meningococcal, SQ) 8. 90734 (Meningococcal, IM) 9. 90707 (MMR) 10. 90649 (HPV, quadrivalent, three (3) dose schedule, Males through twenty-one (21) years of age, Females through twenty-six (26) years of age)

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**
	42 U.S.C. § 300gg–13			11. 90650 (Bivalent, 3 dose schedule, Males through twenty-one (21) years of age, Females through twenty-six (26) years of age) 12. 90651 (Nonavalent, two to three (2-3) dose schedule, Males through twenty-one (21) years of age, Females through twenty-six (26) years of age) 13. 90716 (Chickenpox) 14. 90632 (Hepatitis A) 15. 90739 (Hepatitis B, Adult, two (2) dose) 16. 90746 (Hepatitis B, Adult, three (3) dose) 17. 90647 (Hemophilus influenza, three (3) dose) 18. 90648 (Hemophilus influenza, four (4) dose) *CPT Code Descriptions above subject to change