

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



CardinalCare
Virginia's Medicaid Program

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

January 1, 2026 to December 31, 2026

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1 SCOPE OF 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 Code of Virginia § 32.1-325, et seq., and the Medicare Advantage Dual Eligible Special Needs Plan (herein referred to as the MA D-SNP, D-SNP, or Contractor), a corporation organized under the laws of the Commonwealth of Virginia and having a principal place of business in Virginia. This Contract is effective January 1, 2026, through December 31, 2026.

1.1 Applicable Laws and Regulations

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

1. Federal statutes 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 Commonwealth's Medicaid program. This includes, but is not limited to:

1. Virginia's State Plans for Medical Assistance Services and State Children's Health Insurance Program (CHIP);
2. The Department's 1915(b) Managed Care Waiver, 1915(c) HCBS Waivers, ARTS 1115 Waiver, and FAMIS MOMS 1115 Waiver; 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 which are available on the DMAS web portal [at this link](#).

1.3 Department and Dual Eligible Special Needs Plan Collaboration

The Contractor must work collaboratively with the Department on the Commonwealth's initiatives to enhance the D-SNP program as well as all efforts to improve the existing operations of the 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

There are no reporting requirements for this Contract at this time. The Department, at its discretion, may require reporting through separate guidance.

1.4.1 Service Account

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

1.5 Contractor Requirements to Respond

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

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

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

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

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

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

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

1.6 Department Oversight

Throughout the performance of contract monitoring activities, the Department may assess the Contractor's compliance with any requirements set forth in this Contract and in the documents referenced herein. The Department reserves the right to audit, formally and/or informally, for compliance with any term(s) of this Contract, for compliance with the laws and regulations of the Federal Government and the Commonwealth of Virginia, and for compliance in the implementation of

any term(s) of this Contract. The right to audit under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. Records must be maintained in a searchable electronic format.

1.7 Contract Termination

This Contract may be terminated under the following conditions:

1. If the Contractor loses the CCMC Contract for any reason, this Contract will terminate the same day the termination of the CCMC is effective.
2. By the Contractor, for convenience, with not less than one hundred eighty (180) calendar days advance written notice; and
3. By the Department, for convenience, with not less than ninety (90) calendar days advance written notice.
4. This Contract will automatically terminate on the final day of the Contract period included in Section 8.0, *Signature Page*, of this Contract.

2 DSNP REQUIREMENTS FOR OPERATION

2.1 Contracting Requirements

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

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

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

2.2 Contact Information

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

1. D-SNP National Lead;
2. D-SNP State Lead;
3. State Lead for D-SNP care coordination;
4. State Lead for D-SNP coordination with Medicaid Plans;

5. State Lead for D-SNP contracting; and
6. State Lead for D-SNP quality improvement and oversight.

The same individual can fulfill one or more of the roles listed.

2.3 Standards, Licensure and Solvency

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

2.3.1 Financial Stability

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

2.3.2 Statutory State Licensing and Certification Requirements

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

2.3.3 Quality Health Care and Consumer Protections

Pursuant to §32.1-137.1 through §32.137.6 Code of Virginia, and 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 § 423 and operate as a MA D-SNP to provide Medicare Covered health care benefits to qualified Medicare beneficiaries under this Contract in the Commonwealth of Virginia.

2.4 Policy of Nondiscrimination

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

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

2.5 Non-Debarment

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

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

3 COVERED POPULATIONS AND ENROLLMENT

3.1 Eligible Populations

Enrollment must be limited to individuals who 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:
 - i. Qualified Medicare Beneficiaries (QMBs);
 - ii. Special Low Income Medicare Beneficiaries (SLMBs);
 - iii. Qualified Disabled Working Individuals (QDWIs); or,
 - iv. Qualifying Individuals (QIs). Medicaid pays Part B premium.

3.2 Excluded Populations

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

1. Individuals who are entitled to benefits under Medicare Part A, B and D, and are receiving full Medicaid benefits (i.e., full benefit dual eligible individuals). 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 Cardinal Care Managed Care program.
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 enrolled in the Commonwealth's Title XXI CHIP programs (FAMIS, FAMIS MOMS).
5. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.
6. Individuals with temporary eligibility coverage (less than three [3] months), retroactive eligibility coverage, those included in presumptive eligibility groups, or who are in limited coverage groups, (other than newborns per Section 3.7 of the CCMC Contract, *Enrollment Process for Newborns*), including individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention).
7. Individuals who are incarcerated Individuals on house arrest are not considered incarcerated).
8. Medically Needy (spenddown) individuals who have a limited period of full coverage (Medically Needy LTSS participants who meet their spenddown and maintain ongoing eligibility are eligible).

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

3.3 Determining Eligibility and Enrollment Responsibilities

3.3.1 Verifying Eligibility

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

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

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

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

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

3.3.2 Non-Discrimination

Unless a Dual Eligible Individual is otherwise excluded under federal Medicare Advantage plan rules or does not meet dual eligible Medicaid eligibility as described in Section 3.1, *Eligible Populations*, the Contractor will accept all Dual Eligible Individuals who select the Contractor’s D-SNP without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation (pursuant to Governor’s Executive Order #1 and § 3.12 of the Department of General Services [Agency Procurement and Surplus Property Manual](#)), national origin, race, color, or religion. Furthermore, the Contractor will not implement any policy or practice that has the effect of such discrimination.

3.4 Disenrollment and Loss of Medicaid Eligibility

3.4.1 Loss of Medicaid Eligibility

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

4 MEDICARE-MEDICAID COORDINATION REQUIREMENTS

4.1 Coordination with State

The Contractor must meet with the Department at the Department’s request in person, virtually 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 will be required to meet, discuss, collaborate with the Department and other DMAS contracted MA D-SNPs, and implement ways to simplify processes and/or notifications to Members who are enrolled in the Contractor’s CCMC plan and the D-SNP.

4.2 Staff Training

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

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

4.3 Provider Training

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

4.4 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 MISCELLANEOUS

5.1 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.

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

Failure to implement the DIP may subject the Contractor to termination of the Contract by the Department as described in Section 1.7, *Contract Termination*, of this Contract.

5.3 Approved Service Areas

The Contractor must offer its 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 Section 8.1, *Verifying Service Area*).

5.4 Member Marketing and Education

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

Upon request of the Department, the Contractor must provide copies of any member marketing or educational materials to the Department.

5.5 Covered Services

5.5.1 Medicaid Covered Services

The Contractor is not responsible for the provision or reimbursement of any Medicaid benefits through this Contract. Partial dual eligible enrollees are not enrolled in Medicaid managed care nor are they eligible for the full suite of Medicaid benefits. The Department pays the cost-sharing, such as co-pays and deductibles, for these Members. The Contractor must work with the Department regarding cost-sharing issues for their enrollees as needed.

5.5.2 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 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.

5.6 DMAS Obligations

5.6.1 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 CCMC Contract and is also included in this Contract as Section 9.0, *Cardinal Care Managed Care Covered Services*.

5.6.2 Financial Responsibility

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

5.6.3 Medicaid Provider Information

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

6 DEFINITIONS AND ACRONYMS

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

6.1 Definitions

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

Accreditation – The process of evaluating an organization against a set number of measures of performance, quality, and Outcomes by an industry recognized accrediting agency. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and Members a standard of comparison in evaluating health care organizations.

Activities of Daily Living (ADLs) – Personal care tasks such as bathing, dressing, toileting, transferring, and eating/feeding. An individual’s degree of independence in performing these activities is a part of determining the appropriate Level of Care and service needs. Also see Instrumental Activities of Daily Living (IADLs).

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

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

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

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

Providers will be credentialed and trained to deliver these services consistent with ASAM’s published criteria and the Department’s Medical Necessity criteria using evidence-based best practices including

Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

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

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

Adult Day Health Care (ADHC) Services – Long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at-risk of placement in a Nursing Facility. ADHC Centers are federal, state or local licensed or approved centers which provide day care services to waiver individuals who are elderly or who have a disability and who are at-risk of placement in a Nursing Facility.

Agency-Directed (AD) Services – A model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals’ records, and for scheduling the dates and times of the direct support staff’s presence in the individuals’ homes.

Ameliorate – To make better or more tolerable.

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

Annual – For the purposes of this Contract, occurring once every year.

Appeal – Means:

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

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

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

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

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

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

Assess – To evaluate an individual's condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor's observation of the individual.

Assessment – Processes used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status, and other factors to determine which services, if any, should be authorized and provided. Assessment information supports the development of the person-centered Individualized Care Plan (ICP) and the determination of whether an individual requires HCBS waiver services.

Assistive Technology (AT) – Specialized medical equipment and supplies including those devices, controls, or appliances specified in the ICP, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform ADLs/IADLs and/or to perceive, control, or communicate with the environment in which they live or that are necessary for the proper functioning of the specialized equipment and are cost-effective and appropriate for the individual's assessed medical needs and deficits. Assistive Technology items are expected to be portable.

Audit – A formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

Authorized Representative – A person who is authorized to conduct the personal or financial affairs for an individual who is eighteen (18) years of age or older. Parents and other caretaker relatives are able to act on behalf of persons under eighteen (18) years of age.

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

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

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

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

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

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

Business Associate – Any entity that contracts with the Department, under the State Plan and in return for a payment, to process Claims, to pay for or provide medical services, or to enhance the Department's capability for effective administration of the program. A Business Associate includes, but is not limited to, those applicable parties referenced in 45 CFR §160.103.

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

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

Capitation Rate – The monthly amount, payable to the Contractor, per Member, for the provision of contract services as defined herein. The Contractor must accept the annually established Capitation Rates paid each month by the Department as payment in full for all Medicaid services to be provided pursuant to the Contract and all administrative costs associated therewith, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

Cardinal Care Managed Care (CCMC) – The program name for Virginia's mandatory integrated Medicaid Managed Care program. Cardinal Care Managed Care replaces Virginia's current Medicaid Managed

Care programs, Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus. Also referred to in this contract ‘Medicaid Managed Care Program’ and “Managed Care program”.

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

Case Management – As described in the Social Security Act, § 1915(g)(2), case management services include those assisting individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred. Payments for case management services may not duplicate payments made to public agencies under other program authorities for the same service.

Care Coordination – The act of organizing patient care activities, available for all MCO members including those not identified for ongoing care management. Activities include ensuring an ongoing source of care, coordinating services between settings/delivery systems and conducting initial screenings in accordance 42 CFR § 438.208.

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

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

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

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

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

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

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

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

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

Claim – An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the HCFA 1500 or UB-92.

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

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

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

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

Commonwealth or State – The Commonwealth of Virginia.

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

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

body function, and require substantial and ongoing skilled nursing care. Individuals in this waiver are eligible to participate in the Cardinal Care Managed Care program.

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

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

Community Service Board (CSB)/Behavioral Health Authority (BHA) – A citizens' board established pursuant to Code of Virginia §37.2-500 and §37.2-600 that provides mental health, DD and substance use disorder programs and services within the political subdivision or political subdivisions participating on the board. In all cases, the term CSB also includes Behavioral Health Authority (BHA).

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Health Care Policy and Research, the Research Triangle Institute and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of Managed Care plans.

Consumer-Directed (CD) Employee/Attendant – A person who is employed by a CCC Plus HCBS waiver individual who is receiving services through the CD model or their representative to provide approved personal care, companion services, or respite care, or any combination of these three (3) services, and who is exempt in Virginia from Workers' Compensation.

Consumer-Directed (CD) Services – HCBS (Personal Care and Respite Services) for which the CCC Plus HCBS waiver individual or his or her representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff.

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

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

Contract Amendment or Contract Modification – Any changes, modifications or amendments to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.

Contractor – By execution of this Contract as a Dual Eligible Special Needs Plan (D-SNP), is contracted with CMS as a Medicare Advantage health plan to provide Medicare part A, B and D benefits to individuals who are dual eligible for both Medicare and Medicaid, and is also contracted with the Department of Medical Assistance Services to provide services under the Cardinal Care Managed Care program. The Contractor is not required to be the same "single entity" or "legal entity" that is contracted with the Department for the Cardinal Care Managed Care program but must be owned by the same parent organization.

Co-payments – Fixed dollar amounts that a MA Health Plan Member normally must pay for a medical service provided under a Medicare Advantage Product. Co-payments amounts must comply with the terms of the MA Contract.

Cost Sharing – A global term that encompasses Coinsurance, Deductibles, patient pay, and Copayments.

Coverage Decision Letter (CDL) – Describes the actions required by the enrollee and the enrollee's rights in the unified appeals process, including the date the determination was made, the date the determination will take effect, and language on continuation of benefits during appeal, as required under 42 CFR § 422.631.

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

Credentialing / Recredentialing – The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care Provider to determine eligibility and to deliver Covered Services.

Crisis Support Services – Services designed for individuals experiencing circumstances such as

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

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

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

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

Days - Business days, unless otherwise specified.

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

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

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

Department of Medical Assistance Services (DMAS / Department) – The single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security

Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act.

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

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

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

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

D-SNP Improvement Plan (DIP) – A plan with structures, processes, and related activities designed to correct deficiencies performed by the Contractor which are determined by the Department. Improvements are achieved by the Contractor analyzing and identifying the root causes of the identified findings, observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and State/Federal regulations.

Dual Eligible Individuals – Individuals who are eligible for coverage from Medicare (Medicare Part A, Part B, or both) and Virginia Medicaid. (See Full Benefit Dual Eligible and Partial Benefit Dual Eligible).

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

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – A benefit under the Social Security Act that includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under twenty-one (21) years of age. EPSDT also requires coverage of services, products, or procedures for children, if those items are determined to be Medically Necessary to "correct or Ameliorate" a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service under the State Plan.

Early Intervention (EI) Services – Provided through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR §440.130(d). EI services are designed to meet the developmental needs of children and families and to enhance the development of children from birth through the day before the third (3rd) birthday who have:

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

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

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

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

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

Emergency Custody Order (ECO) – Judicial intervention to order law enforcement personnel to take into custody and transport for needed mental health evaluation and care or medical evaluation and care a person who is unwilling or unable to volunteer for such care pursuant to 42 CFR §441.150 and Code of Virginia, § 16.1- 335 et seq, § 37.2-808, § 16.1-340 (Juvenile), § 37.2-1103 (Medical), and § 16-1.340 (Court). A magistrate is authorized to order such custody on an emergency basis for short periods. Different emergency custody statutes apply to adults than to juveniles.

Emergency Department Care Coordination – Real time communication and collaboration among Hospital Emergency Departments, physicians, other health care Providers, and Health Plan clinical and Care Management personnel to improve Outcomes for populations with high utilization of EDs as required by state law through the Virginia Emergency Department Care Coordination Program.

Emergency Medical Transportation – Medically Necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.

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

Emergency Services – Covered inpatient and outpatient services that are:

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

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

Encounter Data – Data collected by the Contractor that documents all of the health care and related services provided to a Member. These services include, but are not limited to, professional services, medical supplies or equipment, and medications. Encounter data is collected on an individual Member level and includes the person’s Medicaid ID number. It is also specific in terms of the Provider, the medical procedure, and the date the service was provided. The Department and the Federal government require plans to collect and report this data. Encounter data is a critical element of measuring Managed Care Plan’s performance and holding them accountable to specific standards for health care quality, access, and administrative procedures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Foster Care (FC) – Pursuant to 45 CFR §1355.20, a twenty-four (24)-hour substitute care for children placed away from their parents or Guardians and for whom the State agency has placement and care responsibility. Transfer of the legal custody of the child is not a component when determining if a child is considered to be in FC. The federal definition is predicated upon the child being placed outside of the home and with an individual who has “placement and care” responsibility for the child. The term “placement and care” means that the Local Department of Social Services (LDSS) is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in FC. Pursuant to the Affordable Care Act, Virginia must provide Medicaid coverage to additional FC individuals (formerly Title IVE or non-Title IV-E) when the following conditions occur: the individual was under the responsibility of a Virginia-based FC agency and receiving Medicaid until discharged from FC upon turning twenty-one (21) years, the individual is not eligible for Medicaid in another mandatory Medicaid covered group, and the individual is under age twenty-six (26) years.

Foster Care Population – Includes Members under age twenty-one (21) who are in FC, (designation code 076); Members under age twenty-six (26) who were formerly in FC until their discharge from FC at age

eighteen (18) or older, (designation code 070) or Members under age twenty-one (21) who receive AA (designation code 072).

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

Full Benefit Dual Eligible (FBDE) – A Medicare beneficiary who receives Medicare Part A, B, and/or D benefits and who also receives full Medicaid benefits (e.g., QMB Plus/Extended and SLMB Plus/Extended).

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) – As defined in 42 CFR § 422.2, is a dual eligible special needs plan:

1. That provides eligible enrollees access to Medicare and Medicaid benefits under a single entity that holds both this Contract with CMS and the [CCMC Contract](#) for Medicaid managed care in Virginia,
2. That possesses the CCMC Contract with the Department that includes coverage of the following benefits to individuals eligible to enroll in this FIDE SNP in Virginia:
 - a. Primary care and acute care including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries;
 - b. LTSS, including coverage of nursing facility services for a period of at least 180 days during the plan year;
 - c. Behavioral health services;
 - d. Home health services as defined in § 440.70; and
 - e. Medical supplies, equipment, and appliances, as described in § 440.70(b)(3)
3. That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries (See Section 4.0, *Integrated Model of Care*, of this Contract);
4. That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, and quality improvement (See Sections 5.0, *Medicare-Medicaid Coordination Requirements*, Section 6.0, *Member Communications, Marketing and Education*, and Section 7.1, *Contract Oversight and Compliance*, of this Contract);
5. That integrates appeals and grievances in accordance with 422.629 – 422.634, 438.210, 438.400, and 438.402;
6. That operates with exclusively aligned enrollment; and
7. Whose CCMC contract with the Department covers the entire service area as this D-SNP (The Contractor cannot operate in a locality where they do not meet Medicaid network standards).

Functional Family Therapy (FFT) – A short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including cooccurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT is a

primarily home-based service that addresses both symptoms of Serious Emotional Disturbance in the identified youth as well as parenting/caregiving practices and/or Caregiver challenges that affect the youth and Caregiver's ability to function as a family.

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

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

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

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

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

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

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

Health Record – Any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health Record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual. (Code § 32.1-127.1:03).

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

Health Risk Assessment (HRA) – A comprehensive assessment of a Member's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, long-term services and supports (LTSS), and social needs. The HRA is used as a tool in Care Management to assist in the development of the Member's comprehensive person-centered Individualized Care Plan (ICP).

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

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

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

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

Hospice – As defined in § 32.1-162.1 of the Code of Virginia, a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable Hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families. Children under twenty-one (21) years of age are permitted to continue to receive curative medical services even if they also elect to receive Hospice services. A Hospice utilizes a medically directed interdisciplinary team. A Hospice program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. Hospice care must be available twenty-four (24) hours a day, seven (7) calendar days a week.

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

Indian Health Care Provider (IHCP) – Per 42 CFR § 438.14, a health care program, including tribal clinic Providers and Providers of contract health services (CHS), operated by the Indian Health Service (IHS) or

by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603). Also refer to definition of AI/AN.

Individualized (Person-Centered) Care Plan (ICP) – The Contractor’s comprehensive written document developed with a Member that specifies the Member’s services and supports (both formal and informal). The ICP is developed through a person-centered planning process that incorporates the Member’s strengths, skills, needs, preferences, and goals. The ICP includes all aspects of an individual’s care needs including, but not limited to, medical, behavioral, social, and long-term services and supports, as appropriate.

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

Informal Support – The support provided by a Member’s social network and community, such as family, friends, faith-based organizations, etc., and is typically unpaid.

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

Instrumental Activities of Daily Living (IADLs) – Activities such as meal preparation, shopping, housekeeping, laundry, and money management. The extent to which an individual requires assistance in performing these activities is assessed in conjunction with the evaluation of Level of Care and service needs. Also see Activities of Daily Living (ADLs).

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

Intensive In-Home Services (IIH) for Children/Adolescents Under Age Twenty-One (21) – Time-limited interventions provided in the Member’s residence and when clinically necessary in community settings. IIH services are designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of a Member who is at-risk of being moved into an out-of-home placement or who is being

transitioned to home from an out-of-home placement due to a documented medical need of the Member.

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

Interdisciplinary Care Team (ICT) – A team of professionals that collaborate, either in-person or through other means, to develop and implement a person-centered Individualized Care Plan (ICP) built on the individual's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity and meets the medical, behavioral, LTSS, early intervention, and social needs of Members. ICTs include the MCO Care Manager and may include physicians, physician assistants, LTSS providers, nurses, specialists, pharmacists, behavior health specialists, early intervention Care Manager/providers, social workers and other appropriate entities for the individual's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A facility licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to individuals with intellectual/developmental disabilities who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming, boarding home, or group home. Such facilities must comply with Title XIX standards, provide health or rehabilitative services, and provide active treatment to Members toward the achievement of a more independent level of functioning.

Investigation – As used in this Contract related to Program Integrity activities, an Investigation is a review of the documentation of a billed Claim or other attestation by a Provider to assess appropriateness or compliance with contractual requirements. Most Investigations involve the review of Medical Records to determine if the service was correctly documented and appropriately billed. The Department reserves the right to expand upon any Investigation.

Laboratory – A place performing tests for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 CFR §493.3, as amended.

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

Level of Care (LOC) – The specification of the minimum amount of assistance that an individual requires in order to receive services in a community or institutional setting under the State Plan for Medical Assistance or to receive CCC Plus Waiver services.

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

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

List of Excluded Individuals and Entities (LEIE) – When the Office of Inspector General (OIG) excludes a Provider from participation in federally funded health care programs, information about the Provider is entered into the LEIE, a database that houses information about all excluded Providers. This information includes the Provider’s name, address, Provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

Local Education Agency – A local public school division governed by a local school board, a state-operated program that is funded and administered by the Commonwealth of Virginia, or the Virginia School for the Deaf and the Blind that has enrolled with the Department as a Provider of Local Education Agency-Based Services.

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

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

Long-Stay Hospital (LSH) – Hospitals that provide a slightly higher Level of Care than Nursing Facilities. The Department recognizes two (2) facilities that qualify the individual for exemption as Long-Stay Hospitals: Lake Taylor Transitional Care Hospital (Norfolk) and Hospital for Sick Children Pediatric Center (Washington, DC).

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

MAGI Adults (also known as the Medicaid expansion group) – This population includes adults who are aged nineteen (19) through sixty-four (64) years of age, with incomes up to one hundred thirty eight percent (138%) of the federal poverty level (one hundred thirty three percent (133%) plus a five percent

(5%) income disregard), who do not have Medicare, and who are not otherwise eligible for a Medicaid mandatory coverage group. Low-income families, qualified pregnant women and children, individuals eligible under the aged, blind, and disabled (ABD) groups are examples of mandatory eligibility groups, as described in 12 VAC 30-30-10.

Managed Care Plan or Managed Care Organization (MCO), or Health Plan – An organization which offers Managed Care Health Insurance plans (MCHIP), as defined by Code of Virginia § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which:

1. Contains one (1) or more incentive arrangements, including any Credentialing requirements intended to influence the cost or level of health care services between the health carrier and one (1) or more Providers with respect to the delivery of health care services and
2. Requires or creates benefit payment differential incentives for covered persons to use Providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred Provider Contracts or policies as defined in Va. Code § 38.2-3407 or preferred Provider subscription contracts as defined in Va. Code § 38.2-4209 must be deemed to be offering one (1) or more MCHIPs. For the purposes of this definition, the prohibition of Balance Billing by a Provider must not be deemed a benefit payment differential incentive for covered persons to use Providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single Managed Care Health Insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single Managed Care Health Insurance plan must encompass only one (1) Provider Network or set of Provider Networks. Additionally, for the purposes of this Contract, and in accordance with 42 CFR §438.2, an entity that has qualified to provide the services covered under this Contract to qualifying Members must be as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other individuals within the area served, and meets the solvency standards of 42 CFR §438.116.

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

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

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

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

Marketing Materials – Any materials that are produced in any medium, by or on behalf of an MCO, are used by the MCO to communicate with individuals, Members, or prospective Members, and can

reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.

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

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

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

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

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

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

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

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

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

Medically Necessary or Medical Necessity – Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an Enrollee’s condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age twenty-one (21)), and federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

Medication Monitoring – An electronic device only available in conjunction with Personal Emergency Response Systems (PERS) that enables certain waiver individuals who are at-risk of institutionalization to be reminded to take their medications at the correct dosages and times.

Medicare Title XVIII of the Social Security Act – The Federal health insurance program for people age sixty-five (65) or older, people under sixty-five (65) with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A provides coverage of inpatient Hospital services and services of other institutional Providers, such as skilled Nursing Facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers

Physician Services, outpatient services, some Home Health Care, Durable Medical Equipment (DME), and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare Member with the option of receiving Part A and Part B services through a private Health Plan. Medicare Part D provides outpatient prescription drug benefits.

Medicare Advantage – Sometimes referred to as “MA Plans,” includes all of an individual’s Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare Prescription Drug Coverage (Part D).

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

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

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

Medicare Part A – Insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

Medicare Part B – Insurance that helps cover medically necessary services like doctors’ services, outpatient care, durable medical equipment (DME), home health services, and other medical services. Part B also covers some preventive services

Medicare Part D – Medicare prescription drug coverage

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

Mental Health Case Management – Service to assist individuals who reside in a community setting in gaining access to needed medical, social, educational, and other services. Case Management does not include the provision of direct clinical or treatment services.

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

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

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

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

Mental Health Skill-Building Assessment and Services (MHSS) – Goal directed training to enable Members to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services must include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the Member's health and safety; Activities of Daily Living (ADLs), and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

Minimum Data Set (MDS) – Part of the federally-mandated process for assessing individuals receiving care in Certified Nursing Facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a Significant Change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for Nursing Facility residents to return to community settings. All Medicare and Medicaid certified Nursing Facilities were required to use the MDS 3.0.

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

Model of Care (MOC) – A comprehensive plan that describes the Contractor's population; identifies measurable goals for providing high quality care and improving the health of the enrolled population; describes the Contractor's staff structure and Care Management roles; describes the interdisciplinary care team; system of disseminating the Model to Contractor staff and network providers; and, provides other information designed to ensure that the Contractor provides services that meet the needs of Members.

Monitoring – The ongoing oversight to determine that services are administered according to the individual's ICP and effectively meet his or her needs, thereby assuring health, safety and welfare. Monitoring activities may include, but are not limited to, telephone contact; observation; interviewing the Member and/or the Member's family, as appropriate, in-person or by telephone; and/or interviewing service Providers.

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

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

National Provider Identifier (NPI) – A national health identifier for all health care Providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of nine (9) numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire. All Providers who provide services to individuals enrolled in this Contract will be required to have and use an NPI.

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

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

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

Nursing Facility (NF) – Any licensed skilled Nursing Facility, skilled care facility, Intermediate Care Facility, nursing care facility, or Nursing Facility, whether free-standing or a portion of a free-standing medical care facility. This includes, but is not limited to, a facility that is certified for participation as a Medicare or Medicaid Provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and the Code of Virginia, §32.1-137.

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

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

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

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

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

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

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

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

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

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

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

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

Patient Pay – When an individual’s income exceeds an allowable amount, the Member must contribute toward the cost of their LTSS. This contribution, known as the patient pay amount, is required for individuals who are not covered through MAGI adult (Medicaid expansion) and who reside in a NF (skilled or custodial) or are enrolled in a HCBS waiver. Patient pay is required to be calculated for every individual (including AI/AN) although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be the responsibility of the Contractor and must be outlined in the Contractor’s Provider agreement.

Person-Centered Planning – A process, directed by an individual or his or her family/Caregiver, as appropriate, intended to identify the needs, strengths, capacities, preferences, expectations, and desired Outcomes for the individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

Primary Care Provider (PCP) – A practitioner who provides preventive and primary medical care for eligible Members and who certifies Service Authorizations and referrals for all Medically Necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and Specialists who perform Primary Care functions such as surgeons, clinics including, but not limited to health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

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

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

Private Duty Nursing (PDN) – Nursing care services available for children under age twenty-one (21) under EPSDT that consist of Medically Necessary skilled interventions, assessment, Medically Necessary

monitoring and teaching of those who are or will be involved in nursing care for the individual. Private Duty Nursing differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services.

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

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

Protected Health Information (PHI) – Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information Transmitted or maintained in any form or medium. See 45 CFR 160.103.

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

Provider Contract – An agreement between a Contractor and a Provider which describes the conditions under which the Provider agrees to furnish Covered Services to Members under this Contract. All Provider Contract templates for Medicaid-funded services between the Contractor and a Provider must be approved by the Department.

Provider Network – A network of health care and social support Providers, including but not limited to Primary Care physicians, nurses, nurse practitioners, physician assistants, Care Managers, specialty Providers, behavioral health/substance use Providers, community and institutional long-term care Providers, pharmacy Providers, and acute Providers employed by or under Subcontract with the Contractor. Also see Network Provider.

Psychosocial Rehabilitation Services – A treatment program of two (2) or more consecutive hours per day provided to groups of adults in a non-residential setting. Members must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the Member about mental illness, substance use disorders (SUD), and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

Psychiatric Residential Treatment Facilities (PRTF) – Means the same as defined in 42 CFR §483.352 and are a twenty-four (24)-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than twenty-one (21) years of age in order to prevent or minimize the need for more intensive treatment.

Qualified Disabled Working Individual (QDWI) – An individual who has income that does not exceed two hundred percent (200%) of the Federal Poverty Level (FPL) and whose resources do not exceed \$2,000. The Medicaid agency pays Medicare Part A premiums. No other cost sharing is covered for

these individuals. The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement for individuals in the QDWI group defined in subsection 26 of [12VAC30-30-10](#).

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

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

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

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

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

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

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

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

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

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

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

Respite Services or Respite Care Services – Services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of unpaid Caregivers who normally provide the care. Respite Services may refer to skilled nursing respite or unskilled respite.

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

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

Screening – The process to:

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

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

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

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

Serious Mental Illness (SMI) – Used to refer to individuals ages eighteen (18) and older who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment.

Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or DD are included. The population is defined along three (3) dimensions: diagnosis, level of disability, and duration of illness. All three (3) dimensions must be met to meet the criteria for Serious Mental Illness. (Mental Health Services Manual, Chapter IV).

Service Authorization (SA) – A type of Program Integrity activity that requires a Provider to submit documentation to support the Medical Necessity of services before that Claim is billed and processed for payment. Pre-Payment Review is often focused on controlling utilization of specific services by a pre-determination that the service is Medically Necessary for an individual.

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

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

Service Authorization Request – A Managed Care Member’s request for the provision of a service.

Significant Change – A change (decline or improvement) in an individual’s status that: (1) will not normally resolve itself without intervention or by implementing standard disease-related clinical or social interventions, is not “self-limiting;” or (2) impacts more than one area of the individual’s health or psychosocial status; and (3) requires interdisciplinary review and/or revision of the ICP.

Skilled Private Duty Nursing Services (“Skilled PDN”) – Skilled in-home nursing services listed in the person-centered Individualized Care Plan (ICP) that are:

1. Not otherwise covered under the State Plan for Medical Assistance Services home health benefit;
2. Required to prevent institutionalization;
3. Provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, respectively); and
4. Provided by a licensed RN, or by an LPN under the supervision of an RN, to CCC Plus HCBS waiver Members who have serious medical conditions or complex health care needs. Skilled nursing services are to be used as hands-on Member care, training, consultation, as appropriate, and oversight of direct care staff, as appropriate.

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

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

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

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

Stabilized – As defined in 42 CFR §489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a Hospital or, in the case of a pregnant individual who is having contractions, that the individual has delivered the child and the placenta.

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

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

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

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

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

Targeted Case Management (TCM) – Services that will assist individuals with specific conditions in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment, development of a specific care plan, referral and related activities, monitoring and follow-up activities. Services are designed to assist social, educational, vocational, housing, and other services. TCM services include: ARTS, brain injury, mental health, developmental disabilities, EI, TFC, and high-risk prenatal and infant Case Management services. Refer to Attachment E, *Cardinal Care Summary of Covered Services Chart*. Also see Post-Adoption Case Management (PACM) Services. In the instance of EI, this is also referred to as “EI service coordination.”

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

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

Temporary Detention Order (TDO) – An involuntary detention order by sworn petition to any magistrate to take into custody and transport for needed mental health evaluation and care or medical evaluation and care of a person who is unwilling or unable to volunteer for such care. A magistrate is authorized to order such involuntary detention on an emergency basis for short periods, pursuant to 42 CFR §441.150 and Code of Virginia § 16.1-336 et seq and § 37.2-809 et seq. Different temporary detention statutes apply for adults than for juveniles.

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

Therapeutic Day Treatment (TDT) for Children and Adolescents – A combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.) and individual, group, and family counseling offered in treatment programs of two (2) or more hours per day.

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

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

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

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

Trauma-Informed Care – An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma and adverse childhood experiences (ACEs) have played in their lives. This approach also builds on Member resiliency and strengths to address both the overall physical and emotional wellbeing of the individual.

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

Treatment Foster Care (TFC) Case Management – Serves children under age twenty-one (21) in TFC who have certain complex behavioral health needs or children with behavioral disorders who in the absence of such programs would be at-risk for placement into more restrictive residential settings such as psychiatric Hospitals, correctional facilities, residential treatment programs or group homes. TFC Case Management focuses on a continuity of services, is goal directed and results oriented.

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

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

establish contact with a Member for status updates. See Section 4.5.4 of the CCMC Contract, *Unable to Contact for HRA*.

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

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

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

Virginia Administrative Code (VAC) – Contains regulations of all the Virginia State Agencies.

Warm-Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

6.2 Acronyms

AA – Adoption Assistance

ABA – Applied Behavior Analysis

ACT – Assertive Community Treatment

AD – Agency-Directed Services

ADHC – Adult Day Health Care Services

ADL – Activities of Daily Living

AIP – Applicable Integrated Plan

ARTS – Addiction and Recovery Treatment Services

AT – Assistive Technology

BHSA – Behavioral Health Services Administrator

BHH – Behavioral Health Home

BI Waiver – Building Independence Waiver

BOI – Bureau of Insurance

BSW – Bachelor’s Level Social Worker

CAHPS® – Consumer Assessment of Healthcare Providers and Systems

CBO – Community-Based Organization

CCMC – Cardinal Care Managed Care Program or Contract

CCR – Comprehensive Care Review

CDL – Coverage Decision Letter

CFR – Code of Federal Regulations

CHIP – Children’s Health Insurance Program

CL Waiver – Community Living Waiver

CLIA – Clinical Laboratory Improvement Amendments

CMS – Centers for Medicare and Medicaid Services

CSB – Community Service Board

CYSHCN – Children and Youth with Special Healthcare Needs

DBHDS – Department of Behavioral Health and Developmental Services

DMAS – Department of Medical Assistance Services

DD – Developmental Disability

DHP – Department of Health Professions

DIP – D-SNP Improvement Plan

DME – Durable Medical Equipment

D-SNP – Dual Eligible Special Needs Plan

ECO – Emergency Custody Order

EI – Early Intervention Services

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ESRD – End Stage Renal DiseaseFBDE – Full Benefit Dual Eligible

FFS – Fee-For-Service

FFT – Functional Family Therapy

FIDE SNP – Fully Integrated Dual Eligible Special Needs Plan

FIS Waiver – Family and Individual Supports Waiver

HCBS – Home- and Community-Based Care Services

HEDIS – Healthcare Effectiveness Data and Information Set

HIDE SNP – Highly Integrated Dual Eligible Special Needs Plan

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIPP – Health Insurance Premium Payment

HOS – Health Outcome Survey

HPMS – Health Plan Management System

HRA – Health Risk Assessment

HRSN – Health Related Social Needs

IADL – Instrumental Activities of Daily Living

IAH – Independence at Home Demonstration

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

ICP – Individualized Care Plan

ICT – Interdisciplinary Care Team

IFSP – Early Intervention Individualized Family Service Plan

IHCP – Indian Health Care Provider

IIH – Intensive In-Home Services

IMD – Institution for Mental Disease

LBSW – Licensed Bachelor’s Level Social Worker

LEIE – List of Excluded Individuals and Entities

LLA – Local Lead Agency

LMHP – Licensed Mental Health Professional

LMSW – Licensed Master’s Social Worker

LOC – Level of Care

LSH – Long-stay Hospital

LTSS – Long Term Services & Supports

MA – Medicare Advantage

MCHIP – Managed Care Health Insurance Plan

MCO – Managed Care Organization

MDS – Minimum Data Set

MES – Medicaid Enterprise System

MH-IOP – Mental Health-Intensive Outpatient

MHPAEA – Mental Health Parity Addiction Equality Act

MH-PHP – Mental Health-Partial Hospitalization Program

MHSS – Mental Health Skill-Building Assessment and Services

MLTSS – Managed Long Term Services and Supports

MMHS – MCO Member Health Screening

MMIS – Medicaid Management Information System

MOC – Model of Care

MST – Multisystemic Therapy

MSW – Master’s Level Social Worker

NCQA – National Committee for Quality Assurance

NF – Nursing Facility

NPI – National Provider Identifier

PACE – Program of All-inclusive Care for the Elderly

PCP – Primary Care Provider

PDN – Private Duty Nursing

PHI – Protected Health Information

PRTF – Psychiatric Residential Treatment Facilities

QDWI – Qualified Disabled Working Individual

QI – Qualified Individual

QMB – Qualified Medicare Beneficiary

QMB+ – Qualified Medicare Beneficiary Plus

QMHP – Qualified Mental Health Professional

RCSU – Residential Crisis Stabilization Unit

RN – Registered Nurse

RTC – Residential Treatment Level C

SLMB – Special Low Income Medicare Beneficiary

SLMB+ – Special Low Income Medicare Beneficiary Plus

SMI – Serious Mental Illness

SUD – Substance Use Disorder

TCM – Targeted Case Management

TDO – Temporary Detention Order

TDT – Therapeutic Day Treatment

TGH – Therapeutic Group Home

USC – United States Code

UTC – Unable To Contact

VAC – Virginia Administrative Code

7 SIGNATURE PAGE

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

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

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

Contractor: <Health Plan>

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

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

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

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

CONTRACTOR:

<Health Plan Name>

COMMONWEALTH OF VIRGINIA:

Department of Medical Assistance Services

BY: _____

BY: _____

NAME and DATE: _____

NAME and DATE: _____

TITLE: _____

TITLE: Director

7.1 Verifying Plan Design and Coverage

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

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

Integration by Contract and PBP		
Health Plan Name	Health Plan Number Including PBP	Populations Enrolled Check All That Apply
<i>Acme Health Care</i>	<i>H-1111-001</i>	<input type="checkbox"/> Qualified Medicare Beneficiaries (QMBS) <input type="checkbox"/> Special Low Income Medicare Beneficiaries (SLMBs) <input type="checkbox"/> Qualified Disabled Working Individuals (QDWIs); <input type="checkbox"/> Qualifying Individuals (QIs)

7.2 Verifying Service Area

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

D-SNP CONTRACT LOCALITY LISTING (Place X Beside Participating Locality)			
Accomack County		Franklin County	
Albemarle County		Frederick County	
Alexandria City		Fredericksburg City	
Alleghany County		Galax City	
Amelia County		Giles County	
Amherst County		Gloucester County	
		Norton City	
		Nottoway County	
		Orange County	
		Page County	
		Patrick 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							

8 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 not eligible for 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 Other Information
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 where a physician has found, and certified in writing, that in the exercise of professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must be made at the address of the member. The Contractor is responsible for the verification and documentation of abortion services compliance with all 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, mercy killings, or any action that may secure, fund, 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 may cover this service except as medically necessary in certain circumstances.
Christian Science Sanatoria Facilities and Nurses	12 VAC 30-50-300	Yes	No	The Contractor is not required to cover this service when a member is participating in Managed Care participation when admitted to a Christian Science Sanatorium and services will be covered under the fee-for-service model when established criteria and guidelines. Christian Science Sanatoria are covered.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor must cover all clinic services, which include diagnostic, therapeutic, rehabilitative, or palliative services, including dialysis clinic visits.
Clinical Trials	SMD # 21-005	Yes	Yes	The Contractor must cover routine patient services for a Member's participation in a qualifying clinical trial as defined in the <i>Definitions</i> of the CCMC Contract, SMDL #21-005, as amended. Routine patient services include any item or service covered under the Plan.

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 referred to 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 Other Information
				Member under the qualifying clinical trial that are to monitor, or treat complications resulting from participation in a clinical trial, to the extent that such items or services are not outside the course of participation in the qualifying clinical trial. The Contractor is not required to provide coverage for any investigation or treatment of the subject of the qualifying clinical trial or for any services not covered under this Contract. The Contractor is not required to cover a service needed solely to satisfy data collection and analysis for a clinical trial, or for any services that are not used for the 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 Society, for the ages, family histories and frequencies of screening as per recommendations.
Community Intellectual Disability Case Management (T1017)	12 VAC 30-50-440	Yes	No	The Contractor must provide information and referrals to help Members in accessing these services through the 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 services in the absence of a contract otherwise, out-of-network services 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 administer routine dental services; therefore, these services are not covered under the Medicaid Care program. However, the Contractor is responsible for covering medications related to covered dental services. The Contractor must cover medically necessary anesthesia and hospitalization when determined to be medically necessary by the Department's Medicaid Administrator. Effective July 1, 2022 in accordance with Virginia Medicaid PPPP the Contractor must provide coverage for medically necessary anesthesia and hospitalization or facility charges for outpatient surgical procedures for dental care provided to a member who is determined by a licensed dentist in consultation with the treating physician to require general anesthesia and an outpatient surgery facility to effectively and safely provide care to an enrollee age ten or younger. Additionally, in accordance with

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 referred to 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 Other Information
				<p>§ 38.2-3418.12, coverage for anesthesia is required for certain individuals who are disabled, or persons who have a medical condition that requires care in a hospital or outpatient surgery facility when determined by a dentist after consultation with the covered person’s treating physician. The dentist is not required to effectively and safely provide dental care if the dentist’s determination of medical necessity shall include but not be limited to consideration of whether the age, physical condition, and medical history of the covered person requires the utilization of general anesthesia. The covered person requires the utilization of general anesthesia to a hospital or outpatient surgery facility to safely receive dental care.</p> <p>The Contractor must cover CPT codes billed by an anesthesiologist and CPT and “non-CDT” procedure codes billed for dental procedures of the mouth for adults and children. The Contractor must cover dental screenings and dental varnish under EPSDT. See the Contract for additional requirements.</p>
Developmental Disability Support Coordination (T2023)	12 VAC 30-50-490	Yes	No	These services will be covered through Medicaid for eligible individuals. The Contractor must provide information and referrals as appropriate. Individuals accessing these services through the individual’s Medicaid account. 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. Coverage must be provided in accordance with USPSTF recommendations, as described at: https://www.uspreventiveservicestaskforce.org/
Doula Services		Yes	Yes	<p>In accordance with the 2021 Virginia Acts of Assembly, the Contractor must cover certain services covered by Medicaid. The Contractor must include up to eight (8) prenatal/postpartum visits, including delivery. The Contractor must also implement up to \$100 incentive payments for postpartum and newborn care.</p> <p>Covered Services Include:</p> <ol style="list-style-type: none"> 1. 99600-HD Initial Prenatal Visit; Maximum of 15 minutes each (total max of 90 minutes for all visits) – one service only. 2. 59425-HD Standard care, prenatal; Maximum of 15 minutes each (total max of 90 minutes for all visits) – one service only (initial prenatal (see above) and the

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 referred to 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 Other Information
				<p>fifteen (15) minute increments for each visit per visit.</p> <ol style="list-style-type: none"> 3. 59409-HD Labor support, Vaginal 4. 59514-HD Labor Support, C-section 5. 59430-HD Postpartum Care, Postpartum visits. Bill in fifteen (15) minute increments per visit. 6. 99199-HD Incentive Mother Postpartum 7. 99199-HD Incentive Newborn Postpartum billed under the newborns Medicaid benefit (All claims for Doula services must include diagnosis code Z84.0 (childbirth instruction)).
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 needed to stabilize a member when an emergency exists. The Contractor must not restrict coverage for emergency services.
Emergency Services – Post-Stabilization Care	42 CFR § 422.100(b)(1)(iv)	Yes	Yes	The Contractor must cover post-stabilization services for an emergency that a treating physician views as medical emergency condition has been stabilized.
Enhanced Services	Cardinal Care MCO Contract	No	Yes	Enhanced benefits are services offered by the Contractor that are not covered by the Cardinal Care program covered services. Enhanced services are offered to individuals in every category of eligibility. Enhanced services are available to all individuals if placed on the Cardinal Care health plan. See Section 5.4 of the CCMC Contract, <i>Enhanced Benefits</i> .
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) years of age, experimental and investigational procedures may be covered on a case-by-case basis, including using EPSDT criteria for Experimental Procedures and EPSDT Services in Section 3B.
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover family planning services that delay or prevent pregnancy. Coverage for family planning services shall include services to treat infertility or services to prevent pregnancy. Family planning services shall not cover payment for abortion services or services to perform, assist, encourage, or make direct referrals for abortion 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 referred to 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 Other Information
				<p>accordance with 42 CFR §§438.10, 438.210, and 438.212, the Contractor is prohibited from restricting a Member’s choice of provider (in-network or out-of-network) or method for family planning services or from requiring an enrollee to obtain a referral before seeing a provider.</p>
Gender Dysphoria Treatment Services	Pending Manual Citation	Yes	Yes	<p>In accordance with the 2021 Virginia Acts of Assembly (ZZZZZ), the Contractor must cover all Gender Dysphoria treatments outlined in the Department’s coverage manuals and related pharmacological, behavioral health, medical (hormone therapy) & therapeutic services. The Contractor is prohibited from imposing authorization criteria to access Gender Dysphoria treatments. The Contractor is prohibited from imposing additional authorization requirements.</p>
HIV Testing and Treatment Counseling	<p>Code of Virginia Section 54.1-2403.01.</p> <p>12 VAC 30-50-510</p> <p>Chapter IV of the Physician Manual</p>	Yes	Yes	<p>The Contractor must comply with the State requirements for HIV testing and treatment counseling for pregnant women. Testing for HIV infection as a routine component of prenatal care, every pregnant woman must be advised of the value of testing for HIV infection. A pregnant woman has the right to refuse consent to testing for HIV infection and to refuse treatment. Documentation of such refusal must be maintained in the Medical Record.</p>
Home Health Services	<p>12VAC30-10-220</p> <p>12VAC30-50-160</p> <p>12VAC30-50-200</p> <p>12 VAC 30-60-70</p> <p>42 CFR § 440.70</p> <p>41 CFR § 441.15</p>	Yes	Yes	<p>The Contractor must cover home health services, including rehabilitation therapies, and home health aide services. The number of home health aide visits per year are allowed. Skilled home health services are provided on medical necessity. The Contractor must manage care on medical necessity and regardless of whether the need is long-term or short-term. In instances where the Member cannot perform the necessary tasks, the responsible party willing and able to perform the necessary tasks cannot be performed in the PCP office/outpatient setting. The Contractor must cover these services under home health or may choose to cover these services under conditions using another safe and effective treatment.</p> <p>Medicaid home health services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to eligible, medically needy participants determined to be eligible for home health services for Medicaid must not be of any lesser quality than that provided participants not receiving Medicaid assistance for those home health services. For the Home Health Assistance Program, a home health agency is an approved provider.</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are referred to 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 Other Information
				<p>primarily engaged in providing licensed nursing services outside an institutional setting. Services covered include:</p> <ul style="list-style-type: none"> 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 0441 Speech Language Services, Home Health Follow-Up Visit 0542 Non-Emergency Transportation, Per Mile <p>Additional information can be found in the Home Health Manual available on the Department’s web portal at: www.virginiamedicaid.dmas.virginia.gov</p>
Hospice Services - See Part 4 (LTSS) of this Attachment.				
Hysterectomies	<p>42 CFR Part 441 Subpart F as amended.</p> <p>See Hospital Manual Chapter IV, Exhibits For required forms.</p>	Yes, limited.	Yes, limited.	<p>The Contractor may not impose a thirty (30)-day waiting period for hysterectomies that are not performed for rendering a patient sterile. The Contractor must inform the patient that the hysterectomy will not result in sterilization. The Contractor must have the patient acknowledge her understanding that sterilization procedures that are not for, but results in, sterilization are not covered by Medicaid. The sterilization form (DMAS-3004) or adhere to the sterilization policy. Sterilization procedures performed solely for the purpose of rendering a patient sterile are not covered. Sterilization procedures performed for other reasons are not covered by Medicaid. The Contractor must submit and Federal reporting and compliance requirements for hysterectomies, reporting the policy and processes to the Department prior to signing the initial contract request.</p>
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 Department’s policy and the Advisory Committee on Immunization Practices (ACIP) guidelines for children under age twenty-one (21) (through the

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 referred to 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 Other Information
	Provider Manual Supplement B -EPSDT Supplement			(including Expansion), and Medicaid Works, who are required to cover essential health benefits (EHB). The Contractor is required to provide coverage for the COVID-19 vaccine for all populations, including pneumonia immunizations for “at-risk” populations in accordance with CDC guidelines. The Contractor must ensure the timely reimbursement of immunizations and to work with the State to meet a goal related to increased immunization rates. See Section 5.11 of the <i>Services for MAGI Adult Medicaid Expansion Population</i> .
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 12 VAC 30-50-225 12 VAC 30-60-20 12 VAC 30-60-120 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor must cover inpatient stays in general hospitals for all Members within at least equal amount of time as available under the Medicaid State Plan for all individuals, including for children under age twenty-one (21). Contractor coverage shall not be limited to, all of the following: maternity leave, mastectomy, radical or modified radical mastectomy, total or partial mastectomy; requirements; and an early discharge follow-up visit. If a Member is discharged earlier than forty-eight (48) hours, the Contractor must determine that a shorter stay in the hospital is appropriate. Chapter 631 of 1998 Virginia Acts of Assembly, § 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.				
Laboratory, Radiology and Anesthesia Services	12 VAC 30-50-120	Yes	Yes	The Contractor must cover all medically necessary anesthesia services directed and performed within a hospital or ambulatory sites providing services under this Contract are required to comply with Laboratory Improvement Amendments (CLIA) certification 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 the following criteria: fifty-five through eighty (55-80) years of age; asymptomatic (no symptoms of lung cancer); tobacco smoking history of at least one pack day for thirty (30) or more years; current smoker or former smoker within the last fifteen (15) years; and, recommended by a licensed provider or a qualified non-physician. Prior to screening with LDCT that meets the requirements, a physician authorization may be required.

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 referred to 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 Other Information
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor must cover low-dose screening mammography for the early detection and presence of occult breast cancer. Screening mammography for women 40 years of age and over must be covered consistent with the guidelines of 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	<p>The Contractor must cover medical supplies and equipment that are covered by the Department. The Contractor's DMEPOS coverage is based upon medical necessity. There are no maximum quantities. The Contractor must cover nutritional supplements and medical equipment for children and adults. The Contractor must cover durable medical equipment that was prior authorized by the Contractor. The Contractor must specify in the DME supplies manual. The Contractor must cover the cost of any specially manufactured DME equipment that is covered by the plan, even if the Member is no longer enrolled with the plan. Retraction of the payment for specialized equipment is not allowed. A Member is retro-disenrolled for any reason by the Department. The date of the retro-disenrollment precedes the date of the invoice by the plan. The Contractor must use the valid provider invoice date.</p> <p>The MCOs must work with the Member to receive replacement of DMEPOS if they have been lost or destroyed, or the current DMEPOS is damaged as a result of a disaster or emergency in accordance with the Department's policy.</p> <p>Additional information can be found in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies provider manual available on the Department's website at www.virginiamedicaid.dmas.virginia.gov</p>
Mental Health Services - See Part 2 of this Attachment				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor must cover certified nurse-midwife services that meet 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 12 VAC 30-50-105K	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, 12 VAC 30-50-550, 12 VAC 30-50-560, 12 VAC 30-50-580, and Section 1903(i) of the Code of Virginia. The Contractor must provide for similarly situated individuals. There shall be no restriction on facilities or practitioners to be used for any restriction on accessibility of high quality care to enrollees. Transplantation of corneas, hearts, lungs, livers (from living or cadaveric sources), kidney, marrow/stem cell must be covered for all eligible

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 referred to 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
				and based on evidenced-based clinical standards. Organ transplant services, including investigational transplants are not covered. Contractor must cover organ procurement/donor related services. Transplant services for children (under twenty-one (21) years of age) per
Outpatient Hospital Services	12 VAC 30-50-110	Yes	Yes	The Contractor must cover outpatient hospital services including diagnostic, therapeutic, rehabilitative or palliative services for outpatients, and are furnished by an institution that is approved as a hospital by an officially designated health plan setting. Observation bed services must be covered when necessary to evaluate a medical condition to determine the need for treatment or non-routine observation for underlying condition. Outpatient services include emergency services, specialty professional provider services. Facility charges are
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 1905(a) of Social Security Act	Yes	Yes	The Contractor must cover medically necessary personal care services for individuals under age twenty-one (21) consistent with the Department of Social Services the EPSDT Supplement, available on the Department of Social Services https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library Individuals have the choice to receive personal care services in either a home or consumer-directed delivery model. The delivery model is chosen by the adult individual or the caregiver if the individual is not able to make a choice. This is not a State Plan covered benefit for Adults. Personal care services for children under age twenty-one (21) under EPSDT. Personal care services are available for Members through HCBS waiver program. See 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	Yes	Yes	The Contractor must provide coverage for personal care services for Medicaid Works individuals using the same coverage criteria as Medicaid Works individuals under the CCC Plus HCBS Waiver, however Medicaid Works individuals are not required to have a Medicaid LTSS screening. For Medicaid Works individuals who are not enrolled with the Medicaid Works (MW) exception program, Medicaid Works individuals also have no patient pay responsibility. Criteria information regarding personal care can be found in the

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 referred to 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 Other Information
	manual available on the DMAS web portal at: www.viriniamedicaid.dmas.virginia.gov			Coordinated Care Plus Waiver Provider Manual, Chapter 10. The manual is available on the web portal at www.viriniamedicaid.dmas.virginia.gov under the Manuals link.
Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225 12 VAC 30-60-150	Yes	Yes	The Contractor must cover physical therapy, occupational pathology, and audiology services that are provided as inpatient hospital service, outpatient rehabilitation agency service, or as a Contractor's benefits must include coverage for all such services and maybe limited based upon medical necessity. There are no limits on PT, OT, SLP, and audiology services. These services are covered regardless of where they are provided, The plan must cover Necessary, intensive physical rehabilitation services provided as Comprehensive Outpatient Rehabilitation Facility (COPRF) services.
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 by primary care providers, extenders and routine physicals for children up to age 18 and EPSDT. The Contractor must permit any female Member 18 years of age or older direct access, as provided in subsection B of 12 VAC 30-50-130, Virginia, to a participating obstetrician-gynecologist for routine health care services, including pap smears and pelvic exams from the primary care physician. Health care services include medically necessary services provided by the obstetrician or of or related to the female reproductive system in accordance with current published recommendations of the American College of Obstetrics and Gynecologists. The Contractor must provide for a second opinion and must arrange for the Member to obtain one (1) outside of the plan if the Member.
Podiatry	12 VAC 30-50-150	Yes	Yes	The Contractor must cover podiatry services including medical and surgical treatment of disease, injury, or defects of the foot. The Contractor is not required to cover preventive health care; treatment of structural misalignment not requiring surgery; removal of corns, warts, or calluses; experimental
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410 12 VAC 30-50-280	Yes	Yes	The Contractor must cover prenatal and postpartum services for all enrollees. The Contractor must cover case management services for pregnant women. The Contractor must provide to

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 referred to Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, etc.
	12 VAC 30-50-290			prenatal care services, including patient education, counseling and follow-up; homemaker services; and other programs are covered for enrolled infants. The Contractor must cover prenatal and postpartum services for sixty (60) days for the Contractor's enrolled Members. In cases in which the Member is discharged more than forty-eight (48) hours after the day of delivery, the Contractor must provide one (1) early discharge follow-up visit indicated by the American College of Obstetricians and Gynecologists (ACOG) 30-50-220, the early discharge follow-up visit must be provided to Members who meet the Department's criteria and the follow-up visit must occur within forty-eight (48) hours of discharge and meet the criteria.
Prescription Drugs	12 VAC 30-50-210 Chapter IV of the Pharmacy Manual	Yes	Yes	The Contractor must cover prescription drugs, including over-the-counter drugs, provided by a provider during a physician visit or other visit covered by Medicaid, including Behavioral Health visits. Refer to Section 12 VAC 30-50-210.
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 for children under age twenty-one (21) consistent with the requirements described in the EPSDT Nursing Supplement, available on the Medicaid website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal . This benefit is part of the Technology Assisted Program in Part 4 of this Attachment. Not a State Plan covered benefit for Adults. Coverage is provided for Members under age twenty-one (21) under EPSDT. PDN Coverage is provided 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 related digital rectal exams (DRE) for the screening of 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 attachments, breasts, eye prostheses) to the extent covered by Medicaid. The Contractor is required to cover prosthetics for children under age twenty-one (21) and for adults when recommended as part of an approved intensive rehabilitation program described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor must cover breast prostheses following the 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.

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 referred to Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, etc.
Local Education Agency-Based Services	12 VAC 30-50-130	Yes	No	State plan-approved Local Education Agency-Based Services are defined in the <i>Definitions</i> and Section 23, <i>Acronyms</i> of the CCMC. Services are provided to students in the school setting by qualified providers contracted by a Department-enrolled Local Education Agency using FFS and reimbursed using a reconciled cost-allocation methodology. Services are carved-out of the Managed Care contract for services provided in a school setting that are not part of Local Education Agency-based services covered by the Contractor in accordance with the criteria and guidelines. The Contractor may not deliver services rendered in a non-school setting based on a member receiving the same covered services as part of a local education agency-based services program. Private duty nursing and other services through EPSDT, Technology Assisted Program, Community Care, Family and Individual Supports Waiver are not covered under this category. Agency-based services, including when provided in a school setting before or after school by personnel not employed 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 members under age one (1). The Contractor must comply with State and Federal reporting requirements. The Contractor must comply with the thirty (30) calendar day waiting period specified in Code of Virginia § 54.1-2976. The Contractor must obtain informed consent form DMAS-3004 of 42 CFR § 441.258 is required prior to the performance of any sterilization under this category. There must be documentation of the Member being sterilized, written consent, and the interpreter, if applicable, must sign the form prior to the procedure being performed. The Contractor must comply with State and Federal reporting and compliance requirements for hysterectomies, reporting the policy and processes to the Department prior to signing the initial contract request.
Substance Use Disorder Treatment - See Part 2C of this Attachment.				
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginia.gov/health/medicaid.dmas.virginia)	Yes	Yes	The Contractor must provide coverage for telemedicine services defined as the real time or near real time two(2)-way audio and video information using an interactive audio/video communication technology for medical diagnosis and treatment. The Department of Health Services, practitioners, certified nurse-midwives, clinical nurse

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 referred to 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 Other Information
	.gov/wps/portal/ProviderManual)			clinical psychologists, clinical social workers, licensed professional counselors, and licensed clinical social workers for medical telemedicine services and requires on-site providers at the main (hub) and satellite (spoke) sites for a telemedicine program. Federal and state laws and regulations prohibit debarred or suspended providers from participating in the program. All telemedicine activities must be completed through the program.
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 non-emergency transportation to all Medicaid covered services covered by Medicare or another payer. The Contractor must provide transportation services provided by subcontractors as described in Section 5.14 of the CCMC Contract, <i>Non-Emergency Transportation Services (NEMT)</i> . These modes must include, but not be limited to, emergency air travel, non-emergency ground ambulance, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The Contractor must provide transportation for critical needs. The Contractor must cover transportation necessary to secure medical examinations and treatments. The Contractor must cover transportation services, even if those Medicaid covered services are not in the network payer or are carved-out services. The Contractor must provide transportation to and from Medicaid covered behavioral health services, including Community Living, Family and Individual Supports, and Waiver Members must receive acute and primary care services. The Contractor must receive waiver services and must provide 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 Medicaid covered services. The EPSDT benefit includes the provision of anticipatory guidance and counseling with regard to vaping or tobacco use. In addition to routine visits, additional counseling and pharmacotherapy must be provided when medically necessary. The Contractor must provide twenty-one (21) sessions of counseling and pharmacotherapy.
Vision Services	12 VAC 30-50-210 Chapter IV of the Vision Services Manual	Yes	Yes	The Contractor must cover vision services including vision examinations, optometric treatment procedures and services by optometrists, and opticians. The Contractor must cover vision services for Medicaid covered 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 referred to Part 6 for FAMIS Children Covered Services.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covered?	Contractor Responsibilities, Scope of Coverage, etc.
				children under age twenty-one (21). The Contractor must ensure that eye examinations and refractions must not be less than once every two years.
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 designed to assist individuals, eligible under the State Plan who are in an institutional setting, in gaining access to needed medical and behavioral health services as planned upon discharge from a facility and to remain in the community. Case management does not include direct clinical or treatment services. Service Code: Pending

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

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

*Coverage must comply with Federal Mental Health Parity law. (See Section 5.6 in the CCMC Contract, Mental Health Parity and Coordination of Benefits (MHPAEA))

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are referred to 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 hospitalization in free-standing psychiatric hospitals for covered Members under age twenty-one (21). The Contractor may authorize admission to a free-standing psychiatric hospital for "off of" inpatient psychiatric hospitalization in a general hospital for Members between the ages of twenty-one (21) and sixty (60) years of age, provided that the Contractor complies with Federal Mental Health Parity law and Federal regulations. The Contractor is required to comply with Federal Mental Health Parity law and Federal regulations if the length of stay exceeds fifteen (15) days in a calendar year. The Contractor is required to refund the capitation payment, consistent with the requirements described in 42 CFR § 438.6, 42 CFR § 438.3(e)(2) and in

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

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

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	<p>pages 27557 and 27558</p> <p>Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)</p>			<p>5.5.1.2, <i>IMD Enhanced and State Plan Substituted (“In l Medicaid Members.</i></p> <p>Exception: FAMIS MOMS and FAMIS PC are not eligible or private free-standing psychiatric mental hospital/IM care plans may elect to cover as an additional benefit for FAMIS PC enrolled members.</p>
<p>Inpatient Psychiatric Hospitalization in General Hospital</p>	<p>12 VAC 30-50-100 12VAC30-50-130 12VAC30-50-105 12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25</p> <p>Manual-Psychiatric Services, Chapter 4</p>	<p>Yes</p>	<p>Yes</p>	<p>The Contractor must provide coverage for medically necessary care rendered in a psychiatric unit of a general acute care hospital regardless of age. Coverage must comply with Federal</p>
<p>State Geriatric Hospital Placements (Piedmont, Hiram Davis, and Hancock)</p>		<p>Yes</p>	<p>No</p>	<p>Individuals in Piedmont, Hiram Davis, and Hancock state are excluded from Managed Care program participation.</p>
<p>Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO) (Revenue Codes for TDOs and Service Code 0450 for ECOs)</p>	<p>Code of Virginia § 16.1-340 and 340.1 and §§ 37.2-808 through 810 Appendix B of the Hospital Manual</p>	<p>Yes</p>	<p>Yes</p>	<p>Pursuant to 42 CFR § 441.150 and the Code of Virginia, et. seq., and the 2014 Virginia Acts of Assembly, Chapter provide, honor and be responsible for all requests for placement as a result of a Temporary Detention Order (TDO) for Member if the Member is twenty-one (21) through sixty-four (64) years of age at the facility. The Contractor is responsible for all TDO admissions regardless of age. The medical necessity of the TDO service must be established, and the Contractor may not provide services specified in a TDO. Services such as an acute inpatient treatment must be based on a diagnosis while the Member is under TDO for the duration of temporary detention must be in accordance</p>

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

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

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				Code of Virginia for individuals under age eighteen (18), adults age eighteen (18) and over. At the time of the health evaluation and treatment while under the TDO for Medicaid, the appointed judge will make a determination. A TDO may be certified by Department of Behavioral Health and Developmental Services. Exception: FAMIS MOMS and FAMIS PC coverage does not cover state or private free-standing psychiatric hospital/IMD. FAMIS PC may elect to cover as an additional benefit for their FAMIS PC enrolled members. Coverage is also available through the Medicaid program.
OUTPATIENT BEHAVIORAL HEALTH SERVICES – Psychiatric Services Manual for All				
Electroconvulsive Therapy	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	The Contractor must cover medically necessary electroconvulsive therapy. 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 (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 and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Psychiatric Diagnostic Evaluation ; with Medical Services Manual
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 testing services. Coverage must comply with Federal Mental Health Parity law. The former psychological testing CPT codes (96101-96106) and neuropsychological testing CPT codes (96118-96120) are retired, and have been replaced by 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 in the CCMC Contract, Mental Health Parity and (MHPAEA)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are excluded from 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) Neuropsychological Testing Administered by Psychologist (CPT: 96132 and 96133 for Each additional Hour; 96133 for the first thirty (30) minutes) Neuropsychological Testing Administered by Technician Each additional thirty (30) minutes) Neuropsychological Testing Administered by Computer
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 anticipatory guidance and risk reduction counseling with routine well-child visits. In addition to routine visits, additional cessation drug therapy must be provided when medically necessary for children under age twenty-one (21).
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Use the most up-to-date version of the CPT codes.

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

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt for FAMIS Children Covered Services.

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Applied Behavior Analysis (ABA)	12 VAC 30-50-130; 12 VAC 30-50-150; 12 VAC 30-60-61; 12 VAC 30-80-97; 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	The Contractor is required to provide coverage for Applied Behavior Analysis (ABA). ABA means the practice of behavioral analysis by the Virginia Board of Professional Counseling pursuant to §54.1-2900 as the design, implementation, and evaluation of behavior modification programs and modifications using behavioral stimuli and consequences to achieve a significant improvement in human behavior, including assessment, measurement, and functional analysis of the relationship between behavior and environmental factors. See the DMAS Mental Health Services Provider Manual – Community Based Support – Youth Appendix D, for services. https://www.virginiamedicaid.dmas.virginia.gov/wps/rct
Assertive Community Treatment (ACT)	Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6 and Appendix E	Yes	Yes	Assertive Community Treatment (ACT) is a highly coordinated approach to providing services by a group of medical, behavioral health, and rehabilitation professionals 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 to provide a continuum of services across multiple, disconnected providers, to address issues such as homelessness, substance use, victimization, and incarceration. ACT requires person-centered services addressing the breadth of individual needs around individuals’ personal goals. A fundamental characteristic of ACT is that the provider is the first-line (and generally sole provider) of all the services needed to address the ACT needs. Being the single point of responsibility necessitates the intensity of community-based contacts between the team and the individual, a low individual-to-staff ratio. ACT services are flexible; they adjust to the needs of care for all individuals participating in ACT, adjusting to changes in needs as they change over time.

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 for FAMIS Children Covered Services.

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities												
				<p>Assessment Service Code: See Mental Health Services Manual Community Based Support Appendix E for assessment codes.</p> <p>Treatment Service Code: H0040</p> <table border="1" data-bbox="971 835 1620 1094"> <tr> <td>U2</td> <td>Contracted as Base Small Team</td> </tr> <tr> <td>U1</td> <td>Contracted as Base Medium Team</td> </tr> <tr> <td>none</td> <td>Contracted as Base Large Team</td> </tr> <tr> <td>U5</td> <td>Contracted as High Fidelity Small Team</td> </tr> <tr> <td>U4</td> <td>Contracted as High Fidelity Medium Team</td> </tr> <tr> <td>U3</td> <td>Contracted as High Fidelity Large Team</td> </tr> </table>	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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U4	Contracted as High Fidelity Medium Team															
U3	Contracted as High Fidelity Large Team															
Community Stabilization	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	<p>The Contractor shall provide Community Stabilization services short-term and designed to support an individual and their natural environment following contact with an initial crisis response service at the appropriate level of care. Providers deliver community stabilization services in the individual’s natural environment and provide referral to community-based services at the appropriate level of care. Interventions include therapeutic and skill building interventions, engagement and supports, interventions to integrate natural supports in the environment, stabilization of the crisis, and coordination of follow-up services. Specialized services to address the needs of co-occurring mental health, disabilities and substance use are also available through the contractor.</p> <p>The goal of Community Stabilization services is to continue to support the individual within their community and support the individual and their natural environment during the period between either 1) an initial Mobile Crisis Response or 2) an established follow-up service at the appropriate level of care. Services can move down from a higher level of care if the next level of care is not immediately available for access.</p> <p>Treatment Service Code: S9482</p> <table border="1" data-bbox="971 1864 1620 1900"> <thead> <tr> <th>Modifier</th> <th>Modifier Meaning</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Modifier	Modifier Meaning										
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SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities									
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Functional Family Therapy (FFT)	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	<p>The Contractor shall cover Functional Family Therapy (FFT), an evidence-based treatment program for youth who have emotional and behavioral treatment of behavioral or emotional problems including conduct disorders by the juvenile justice, behavioral health, school, and community. FFT is a primarily home-based service that addresses behavioral and emotional disturbance in the identified youth as well as family and/or caregiver challenges that affect the youth and the functioning of a family. The FFT model is a rehabilitative service that seeks to divert youth from higher levels of care and seeks to understand and support youth within their network of systems including, family, school, neighborhood/community.</p> <p>Treatment Service Code: H0036</p> <table border="1"> <tr> <td data-bbox="971 1430 1105 1570">HN</td> <td data-bbox="1105 1430 1349 1570">Bachelor's Established Team</td> <td data-bbox="1349 1430 1620 1570">One FFT Professional (E/QMHP-C/CSAC/CSA) All other team members LMHP-S or LMHP-RP</td> </tr> <tr> <td data-bbox="971 1570 1105 1787">HO</td> <td data-bbox="1105 1570 1349 1787">Master's/Licensed Established Team</td> <td data-bbox="1349 1570 1620 1787">One FFT Professional (E/QMHP-C/CSAC/CSA) All other team members LMHP-S or LMHP-RP or the entire team is a LMHP-RP.</td> </tr> <tr> <td data-bbox="971 1787 1105 1852">HK, HN</td> <td data-bbox="1105 1787 1349 1852">Bachelor's New Team</td> <td data-bbox="1349 1787 1620 1852">One FFT Professional (E/QMHP-C/CSAC/CSA)</td> </tr> </table>	HN	Bachelor's Established Team	One FFT Professional (E/QMHP-C/CSAC/CSA) All other team members LMHP-S or LMHP-RP	HO	Master's/Licensed Established Team	One FFT Professional (E/QMHP-C/CSAC/CSA) All other team members LMHP-S or LMHP-RP or the entire team is a LMHP-RP.	HK, HN	Bachelor's New Team	One FFT Professional (E/QMHP-C/CSAC/CSA)
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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 for FAMIS Children Covered Services.

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities						
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Intensive In-Home (IIH) Assessment and Services	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-130-2000 12 VAC 30-60-5 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	Yes	Yes	The Contractor must cover medically necessary Intensive In-Home Services. Intensive in-home services (IIH) for youth and their families and therapeutic interventions provided in the youth’s residential settings as medically necessary and documented in the youth’s Comprehensive Assessment and ISP), to improve family functioning, address behavioral impairments in major life activities that have occurred or are occurring, behavioral or emotional illness in order to prevent an escalation of the youth, and gradually transition the youth to less restrictive supports. All IIH services shall be designed to specifically address the youth, provide modeling, and include clinically necessary interventions to improve functional and therapeutic interpersonal relations between the youth and home. IIH services are designed to promote benefits of the youth in the setting of a youth who is at risk of being moved into an out-of-home placement or is being transitioned to home from an out-of-home placement based on the medical need of the youth. Comprehensive Needs Assessment Service Code: H003 Treatment Service Code: H2012						
Mental Health Case Management	12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-143	Yes	Yes	The Contractor must cover medically necessary Mental Health Case Management services. Mental health Case Management is defined as services for eligible under the State Plan who reside in a community setting.						

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 for FAMIS Children Covered Services.

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	12 VAC 30-130-2000 [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			needed medical, social, educational, and other services include the provision of direct clinical or treatment services Service Code: H0023
Mental Health Intensive Outpatient (MH-IOP)	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix F	Yes	Yes	The Contractor shall cover Mental Health Intensive Outpatient (MH-IOP) services which are highly structured clinical programs designed to provide interventions that are less intensive than Partial Hospitalization and more intensive than traditional outpatient psychiatric services. MH-IOP is a time limited treatment program that integrate evidence-based practices for youth (ages six (6) – seventeen (17) years) and adults (eighteen (18) years and older) and can serve as a transition program, such as a step-down from Partial Hospitalization Program. MH-IOP focuses on maximizing functional abilities through an interdisciplinary approach. Treatment is based on a comprehensive, coordinated and individualized plan that includes the use of multiple, concurrent interventions and treatment modalities. MH-IOP focuses on symptom and functional impairment improvement, crisis planning, promoting stability and developmentally appropriate supports, community, recovery/relapse prevention and reducing hospitalizations of care. MH-IOP services are appropriate when an individual requires a minimum of 4 hours of clinical services a week (for youth ages six (6) - seventeen (17) years) and 4 hours of clinical services as week (for adults 18 years and older) per week and totaling a maximum of nineteen (19) hours per week. MH-IOP includes psychiatric oversight with at least weekly medication management. The coordinated structure of the treatment program scheduled to be provided as an individual’s symptoms improve as evidenced by treatment goals, community supports, resume daily activities or participation in community activities.

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 for FAMIS Children Covered Services.

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				Assessment Service Code: See Mental Health Services Manual Clinic Based Support Appendix for assessment billing requirements 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	<p>Mental Health Partial Hospitalization Programs (MH-PHP) are highly structured clinical programs designed to provide a range of interventions and services which are similar to an inpatient program, but available on a less than twenty-four (24)-hour basis. They are active, focused and time-limited treatment programs designed to address symptoms in youth six to seventeen (6-17 years old) and adults (18+). The average length of stay may be four (4) to six (6) weeks. Services should reflect individual symptom severity, needs, goals, and clinical criteria. MH-PHP can serve as a transition program, such as a step-down option following an inpatient hospitalization. MH-PHP is used for an individual from inpatient care, by providing an alternative to intensive clinical services without hospital admission. The program is for individuals that would likely require inpatient hospitalization if not receiving this service. MH-PHPs services may occur in either a clinic or home-based location.</p> <p>MH-PHP services are appropriate when an individual requires intensive clinical services a day, over several days a week and totaling more than 8 hours per week. A MH-PHP requires psychiatric oversight and medication management included in the coordinated service plan. The treatment program schedule. MH-PHP tapers in intensity as the individual’s symptoms improve, they are able to establish community supports, and they are able to resume daily activities of living in a lower level of care.</p> <p>Assessment Service Code: See Mental Health Services Manual Clinic Based Support Appendix for assessment billing requirements Treatment Service Code: H0035</p>

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

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt for FAMIS Children Covered Services.

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Mental Health Peer Recovery Support Services	Regulations: 12 VAC 30-50-226 12 VAC 30-50-130 12 VAC 30-130-5160 through 12 VAC 30-130-5210 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] Manual: Mental Health Services Manual – Peer Recovery Support Services Supplement	Yes	Yes	The Contractor must cover medically necessary MH Peer Recovery Support Partners for youth under 21. MH Family Support Partners are peer recovery support partners who provide support, education, and support a member’s self-help efforts to improve resiliency, and wellness to assist members in achieving positive outcomes despite the effects of mental illness, addiction or both. Service Code H0024 (Individual) H0025 (Group)
Mental Health Skill-building Assessment and Services (MHSS)	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 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) provide training and supports to enable restoration of an individual to baseline functioning and achieve and maintain community in the most appropriate, least restrictive environment. MHSS includes face activities, instruction, interventions, and goal directed activities to restore functioning and that are defined in the ISM Manual Medicaid. MHSS must include goal directed training in the following areas: (i) skills and appropriate behavior related to the instrumental activities of daily living, and use of community resources; with medication management; and (iii) monitoring and self-reliance condition with goals towards self-monitoring and self-reliance. Comprehensive Needs Assessment Service Code: H003 Treatment Service Code: H0046

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 MCO. Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for qualifications, and service limitations. **Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities														
Mobile Crisis Response	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	<p>The Contractor shall cover Mobile Crisis Response which includes assessment and early intervention to individuals experiencing a mental health crisis. This service is provided twenty-four (24) hours a day. The purpose of this service includes prevention of acute exacerbation, prevention of harm to the individual or others, provision of services in the least restrictive setting, and development of an immediate care plan in order to prevent the need for a higher level of care. Mobile Crisis Response is a mechanism by which pre-admission screenings for hospitalization are conducted by DBHDS pre-admission screening clinicians, when clinically appropriate.</p> <p>Treatment Service Code: H2011</p> <table border="1" data-bbox="971 1062 1620 1619"> <thead> <tr> <th>Modifier</th> <th>Modifier Meaning</th> </tr> </thead> <tbody> <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 and 1 PRS or 1 QMHP-A/QMHP-C/CSAC^x and 1 CSAC-A</td> </tr> <tr> <td>HT, HO</td> <td>1 Licensed^x and 1 PRS or 1 Licensed^x and 1 CSAC-A or</td> </tr> <tr> <td>HT, HN</td> <td>2 QMHPs (QMHP-A, QMHP-C and/or QMHP-N) 1 QMHP-A/QMHP-C and 1 CSAC^x</td> </tr> <tr> <td>HT</td> <td>1 Licensed^x and 1 QMHP(QMHP-A, QMHP-C, QMHP-N) 1 Licensed^x and 1 CSAC^x</td> </tr> </tbody> </table> <p>^x = Includes supervisees and residents</p>	Modifier	Modifier Meaning	HO	1 Licensed ^x	32	Emergency Custody Order 1 Licensed ^x	HT, HM	1 QMHP-A/QMHP-C/CSAC ^x and 1 PRS or 1 QMHP-A/QMHP-C/CSAC ^x and 1 CSAC-A	HT, HO	1 Licensed ^x and 1 PRS or 1 Licensed ^x and 1 CSAC-A or	HT, HN	2 QMHPs (QMHP-A, QMHP-C and/or QMHP-N) 1 QMHP-A/QMHP-C and 1 CSAC ^x	HT	1 Licensed ^x and 1 QMHP(QMHP-A, QMHP-C, QMHP-N) 1 Licensed ^x and 1 CSAC ^x
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Multisystemic Therapy (MST)	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	<p>The Contractor shall cover Multi-systemic therapy (MST) which is an evidence-based treatment program provided in home or community settings to youth (eleven (11) – seventeen (17) years of age) who have a diagnosis of treatment of behavioral or emotional problems by the mental health, school, or child welfare systems. MST is appropriate for youth with clinical impairment in disruptive behavior, mood, and/or conduct, with an emphasis on engagement with the youth’s family, community, and school.</p>														

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

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt for FAMIS Children Covered Services.

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

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities												
				<p>and professionals delivering interventions in the recovery term and rehabilitative service that may serve as a step to higher levels of care and seeks to understand and interact with a network of systems including family, peers, school, and community.</p> <p>Treatment Service Code: H2033</p> <table border="1" data-bbox="971 873 1620 1591"> <tr> <td data-bbox="971 873 1109 1014">HN</td> <td data-bbox="1109 873 1352 1014">Bachelor's Established Team</td> <td data-bbox="1352 873 1620 1014">One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP</td> </tr> <tr> <td data-bbox="971 1014 1109 1230">HO</td> <td data-bbox="1109 1014 1352 1230">Master's/ Licensed Established Team</td> <td data-bbox="1352 1014 1620 1230">One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP or the entire team is a LMHP-RP.</td> </tr> <tr> <td data-bbox="971 1230 1109 1371">HK, HN</td> <td data-bbox="1109 1230 1352 1371">Bachelor's New Team</td> <td data-bbox="1352 1230 1620 1371">One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP</td> </tr> <tr> <td data-bbox="971 1371 1109 1591">HK, HO</td> <td data-bbox="1109 1371 1352 1591">Master's/ Licensed New Team</td> <td data-bbox="1352 1371 1620 1591">One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP or the entire team is a LMHP-RP</td> </tr> </table>	HN	Bachelor's Established Team	One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP	HO	Master's/ Licensed Established Team	One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP or the entire team is a LMHP-RP.	HK, HN	Bachelor's New Team	One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP	HK, HO	Master's/ Licensed New Team	One MST Professional E/QMHP-C/CSAC/CSA All other team members LMHP-S or LMHP-RP or the entire team is a LMHP-RP
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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 under Medicaid and FAMIS PC. The Contractor may cover services rendered in inpatient hospitals as an enhanced benefit.												

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

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				<p>Note: Medicaid, FAMIS MOMS, and FAMIS PC Members who are admitted to a Residential Treatment Facility for Substance Use Disorder are not excluded and will remain with the Contractor. See Part 2C for RTC coverage through the Contractor.</p> <p>Department authorization for Medicaid children under the PRTF provider must contact the Department’s Service Authorization and payment through the fee-for-service contract.</p> <p>The Contractor must work closely with the Department’s Authorization Contractor to ensure physician engagement with the Member during the independent certification of need for residential treatment service authorization.</p>
<p>Psychosocial Rehabilitation Assessment and Services</p>	<p>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</p>	<p>Yes</p>	<p>Yes</p>	<p>The Contractor must cover medically necessary Intensive Psychosocial Assessment and Services. Includes services for the severe and persistent mental illness. Psychosocial rehabilitation is provided in sessions of two hours per day to groups of individuals in a non-residential setting. Services include assessment, education about the diagnosed mental illness, medication management, and support in obtaining independent living skills and to enhance social and interpersonal skills. Interventions are rehabilitative in nature. Staff may observe and observe behaviors and note side effects of medication. Limited to 936 units annually.</p> <p>Comprehensive Needs Assessment Service Code: H003 Service Code: H2017</p>

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

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities				
				Not an excluded service for Members in one (1) of the service authorization for Psychosocial Rehabilitation.				
Residential Crisis Stabilization Unit (RCSU)	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	<p>The Contractor shall provide access to and cover services for Residential Crisis Stabilization Units which serve as diversion facilities from the community. Residential Crisis Stabilization Units provide short-term (up to seven (7) days a week, residential psychiatric/substance use disorder) and brief intervention services. The service supports individuals with substantial changes in behavior noted by severe impairment in functioning.</p> <p>Treatment Service Code: H2018</p> <table border="1" data-bbox="971 1087 1620 1163"> <tr> <td data-bbox="971 1087 1052 1125">32</td> <td data-bbox="1052 1087 1620 1125">Emergency Custody Order (ECO)</td> </tr> <tr> <td data-bbox="971 1125 1052 1163">HK</td> <td data-bbox="1052 1125 1620 1163">Temporary Detention Order (TDO)</td> </tr> </table>	32	Emergency Custody Order (ECO)	HK	Temporary Detention Order (TDO)
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Therapeutic Day Treatment (TDT) for Children and Adolescents	<p>12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-50-226 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 Mental Health Services Manual Chapters 2, 4 & 6</p>	Yes	Yes	<p>The Contractor must cover medically necessary Therapeutic Day Treatment (TDT) for Children and Adolescents. TDT provides medically necessary, individualized, and structured interventions to youth with mental, emotional, or behavioral diagnoses that support and are consistent with the TDT. Youth are causing significant functional impairments in major areas of functioning need the structured treatment interventions offered by TDT. These interventions are provided during the school day or to the extent possible during the school year. This service shall include assessment, assistance with implementation of interventions to build daily living skills or enhance social skills and/or family counseling and care coordination. These services shall be provided two or more hours per day.</p> <p>Comprehensive Needs Assessment Service Code: H003</p> <p>Service Code: H2016 Modifiers: School Based TDT must be billed as H2016 (none)</p>				

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

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				After School TDT must be billed as H2016 UG Summer TDT must be billed as H2016 U7
Therapeutic Group Home (TGH) 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)] Residential Treatment Services Manual	Yes	No	The Contractor is not responsible for covering Therapeutic Group Home (TGH) participants. Any youth admitted to a TGH participants will not be eligible for the Medicaid Managed Care Program; however, the TGH per diem services are covered under the Cardinal Care Managed Care Contract and will be a carved out service of the Department’s Service Authorization Contractor. Coverage for TGH participants is the responsibility of the Contractor. (See Chapter V of the Residential Treatment Services Manual). The Contractor must collaborate with the Service Authorization Contractor to: facilitate Independent Assessment and Care Coordination Team (IACCT) activities on behalf of the Medicaid Managed Care of Medical, ARTS, and mental health services for its Medicaid Managed Care for transportation and pharmacy services necessary for TGH participants, 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 - Case Management (CM) for children under age twenty-one (21) years. Treatment Foster Care - Case Management is a service provided to Medicaid Managed Care individuals in gaining and coordinating access to necessary services appropriate to their needs. Service Code T1016.
Twenty-three (23) Hour Crisis Stabilization	Mental Health Services Manual	Yes	Yes	The Contractor shall cover Twenty-three (23)-Hour Crisis Stabilization for a period of up to twenty-three (23) hours in a community-based setting that provides assessment and stabilization intervention.

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

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities				
	Chapters 2, 4, and 6 and Appendix G			behavioral health crisis. This service should be accessible seven (7) days a week, and is indicated for those situations involving an acute crisis and requires a safe environment for observation to determination of whether admission to an inpatient setting is necessary. This service allows for an opportunity to address crisis and psychosocial needs and supports throughout the course of service to determine the best resources available to avoid unnecessary hospitalization. Treatment Service Code: S9485 <table border="1"> <tr> <td>32</td> <td>Emergency Custody Order (ECO)</td> </tr> <tr> <td>HK</td> <td>Temporary Detention Order (TDO)</td> </tr> </table>	32	Emergency Custody Order (ECO)	HK	Temporary Detention Order (TDO)
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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. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS PC.

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 members as appropriate based on the ASAM Criteria, including for children and adults, regardless of age. Effective July 1, 2021, FAMIS MCO is eligible for coverage for medically necessary services in an IMD, equivalent to such benefits offered to pregnant women under the Medicaid Section 1115 demonstration waiver. This coverage includes the following settings: ASAM Levels 3.3, 3.5, 3.7 and 4.0 in inpatient 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

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
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 d 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 d 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 d Service Codes H0010 / Rev 1002 and Modifier TG
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 d 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 d 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 d 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 d CPT codes
Ambulatory Withdrawal Management	ASAM Level 1 WM	Yes	Yes	The Contractor must cover SUD services within ASAM d 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 a H0005 - group coun S0109 Methadone fi provider H0020 G9012 Substance U H0014 80305 to 80307 and CPT codes Use CPT E&M Estab
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 Administration Care Coordination Physician Visit – Induction Day 1 Urine Drug Screen Labs Physician Visit – Maintenance	H0004 – individual a H0005 - group coun J0572, J0573, J057 Buprenorphine/Nal provider J0571 Buprenorphin provider J2315 Naltrexone, I billed by provider G9012 Substance U H0020 H0014 80305 to 80307 and CPT codes Use CPT E&M Estab

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
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 Care Coordination Physician Visit – Induction Day 1 Drug Screen Labs Physician Visit – Maintenance H0004 – individual a H0005 - group coun G9012 Substance U H0014 80305 to 80307 and CPT codes Use CPT E&M Estab
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 d (H0006)
Outpatient ARTS Individual, Family, and Group Counseling Services	ASAM Level 1.0 12VAC30-130-5000 to 5040 12VAC30-130-5080	Yes	Yes	The Contractor must cover SUD services within ASAM d (CPT Codes)
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 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 d (99408/99409)

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
<p>EPSDT Benefit Global Coverage Guidelines</p>	<p>12 VAC 30-50-130 42 CFR § 440.40(b)(2) and 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act http://www.dmas.virginia.gov/files/links/914/EPSDT%20Specialized%20Services%20-%20Guide%20to%20Providers.pdf https://www.medicaid.gov/medicaid/benefits/epsdt/index.html</p>	<p>Yes</p>	<p>Yes</p>	<p>EPSDT includes periodic screening, vision, dental and hearing services for eligible beneficiaries under twenty-one (21) years of age. EPSDT includes a requirement which compels state Medicaid agencies to cover certain procedures for children, if those items are determined to be necessary to "correct or ameliorate" a defect, physical or mental illness (or a problem) identified through routine medical screening. For children, whether coverage for the same service/support is an option for adults under the state plan. Refer to the following for more information: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html</p> <p>Ameliorate is defined as necessary to improve or to prevent from getting worse.</p> <p>For individuals under twenty-one (21) years of age EPSDT includes hearing services before Technology Assisted Program services are offered.</p> <p>The Contractor must cover dental screenings and dental services.</p> <p>The Contractor must screen and assess all children; cover immunizations and inform providers regarding reimbursement of immunizations and refer to the Department to achieve its goal to increase immunization rates.</p> <p>EPSDT Assistive Technology (T5999) is a covered EPSDT service. Contractors must provide assistive technology as specified in the EPSDT Manual.</p>
<p>Assistive Technology (AT)</p>	<p>Same as EPSDT Global Coverage Guidelines</p>	<p>Yes</p>	<p>Yes</p>	<p>To correct or ameliorate physical or mental conditions identified through screening services, the child may be referred by the EPSDT contractor for Assistive Technology services. Assistive Technology is defined as equipment, supplies, devices, controls, and appliances that are used by the State Plan for Medical Assistance. Assistive Technology services are provided to individuals to increase their abilities to perform ADLs or IADLs or to communicate with the environment in which they live. Assistive Technology is expected to be portable. See EPSDT Supplement B for services.</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				children under age twenty-one (21) on the CCC Plus Waiver are 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 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. Services must be evaluated on a case-by-case basis using EPSDT criteria.
Dental Screenings	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>An oral inspection must be performed by the EPSDT screening provider or a physical examination for a child screened at any age. The screening provider must note tooth decay, developmental anomalies, malocclusion, periodontal disease, and dental injuries must be noted. The oral inspection is not a full dental evaluation provided through direct referral to a dentist.</p> <p>Contracted PCPs or other screening providers must make a referral to a dentist when the child receives his or her one(1)-year screening. A dental screening must be provided at the initial medical screening regardless of the child's age 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 provider, including a neonatal examination, indicates a need for dental services, a referral must be made for needed dental services. The Contractor must also ensure the testing of fluoridation levels in well water.</p>
Dental Varnish	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Dental fluoride varnish provided by a non-dental medical professional in accordance with the American Academy of Pediatrics guidelines and bill of materials must be covered.
Hearing Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>Those children who did not pass the newborn hearing screening or were missed, and those who are at-risk for potential hearing loss, must be evaluated by a licensed audiologist.</p> <p>Periodic auditory assessments appropriate to age, hearing level, and/or hearing aid use includes assessments by observation (subjective) and/or objective testing provided at a minimum at intervals recommended in the hearing screening periodicity schedule. At a minimum, these services must include treatment for defects in hearing, including hearing aids and hearing aids fitting. At a minimum, observation of an infant's response to a hearing assessment must be part of each preventive visit.</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
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 immunizations must be reviewed at each screening examination, and immunizations must be administered at the time of the examination. Coverage is consistent with the ACIP guidelines. The Contractor must coordinate coverage with the Vaccines for Children (VVC) program. See the EPSDT Supplement Manual for more information. http://www.vdh.virginia.gov/immunization/vvfc
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	The following recommended sequence of screening laboratory tests shall be provided by the Contractor; additional laboratory tests may be ordered if medically indicated (e.g., for ova and parasites) and mutually agreed upon: <ol style="list-style-type: none"> 1. Hemoglobin/hematocrit 2. Tuberculin test (for high-risk groups) 3. Blood lead testing (see row below on Lead Testing)
Lead Investigations	12 VAC 30-50-227 EPSDT Supplement	Yes	Yes	The Contractor must provide coverage for investigation and testing to determine the source of lead contamination in the home and the management and treatment of Medicaid-eligible children with elevated blood lead levels. Environmental investigations shall be performed by health departments. Coverage includes costs that are not covered by the Member's participation in accordance with current Federal regulations. The Contractor shall provide testing of environmental substances such as water, paint, and soil. The Contractor shall provide laboratory for analysis. Contact the Member's local health department if the Member qualifies for a risk assessment. More information is available at http://www.vdh.virginia.gov/environmental-epidemiology/health/elevated-blood-lead-levels-in-children . Payment for environmental investigations must be limited to no more than two (2) investigations per year.
Lead Testing	EPSDT Guidelines 12VAC5-90-215	Yes	Yes	All Medicaid children are required to receive a blood lead test at twelve (12) 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 test must receive one (1). Testing may be performed by venous or capillary blood. Paper methods are also acceptable and can be performed by the provider. Tests of venous blood are considered confirmatory. The providers need to use the code 83655 for Lead blood lead testing. The following: <ol style="list-style-type: none"> 1. 36416 for the collection of capillary blood specimen 2. 36415 for the collection of venous blood by venipuncture A blood lead test result equal to or greater than 5 ug/dl (or 5 ug/dl (current CDC guidelines) obtained by capillary specimen collection) requires using a venous blood sample. All testing must be done in a laboratory setting.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SER

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Appli
				determination. Results of lead testing, both positive and negative, must be reported to the Virginia Department of Health, Office of Lead Response and
Personal Care	Same as EPSDT Benefit Global Coverage Guidelines	Yes	Yes	<p>EPSDT Personal Care Services are designed to assist children (21) who meet the criteria for EPSDT Personal Care Services Supplement with activities of daily living (IADLs), medically necessary supervised activities of daily living (IADLs), medically necessary supervised administered medications. The child's need for assistance with condition must be documented by the child's primary care provider on a Functional Status Assessment Form (DMAS-7). The form must be signed by a physician, physician's assistant or nurse practitioner every year. EPSDT Personal Care criteria is utilized for children with a CCC Plus Waiver.</p> <p>For members enrolled in CCC Plus Waiver, including those who are (21) years old, personal care will be provided under the terms of the Waiver criteria and forms are used to determine personal care for members. See Section 5.12.2 of the CCMC Contract, <i>CCC Plus Waiver</i>.</p>
Private Duty Nursing (PDN)	42 CFR §§ 441.50, 440.80, Social Security Act §1905(a) and 1905(r) l.	Yes	Yes	<p>The Contractor must cover medically necessary PDN services for children twenty-one (21), in accordance with the Department's EPSDT Nursing Supplement.</p> <p>The Contractor must use the Department's criteria, as outlined in the Nursing Supplement when determining the medical necessity for PDN. The Contractor may use an alternate assessment instrument approved by the Department. However, the Department's guidelines must be used as the basis for the amount, duration and benefit.</p> <p>Skilled PDN is also covered for Members who are enrolled in the Home Care Program who require continuous nursing that cannot be provided by a Technology Assisted Program uses form 108& 109 to document the care needed. Under EPSDT or Skilled PDN, the Member's continuous nursing care including but not limited to, nursing level and skilled interventions. EPSDT and Skilled PDN differ from Home Care provides for short-term intermittent care where the member requires caregiver teaching. Examples of Members that may qualify for PDN but are not limited to those with health conditions requiring parenteral nutrition (TPN); suctioning; oxygen monitoring; tracheostomy catheterizations; blood pressure monitoring (i.e., for au</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>monitoring/intervention for uncontrolled seizures; or monitoring of a child requiring continuous nursing care, assessment, monitoring, and intervention.</p> <p>Payment by the Contractor for services provided by any provider for EPSDT or Skilled Private Duty Nursing must be at the Department's fee-for-service rate.</p>
Screenings	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>Comprehensive, periodic health assessments (or screenings) at least every twenty (20) at intervals specified by the American Academy of Pediatrics, which recommends surveillance (assessing for risk) at all well-child visits using a standardized tool routinely. Developmental screening must be documented in the medical record using a standardized screening tool. The Contractor must bill for any SA associated with the appropriate billing of these services (e.g., CPT96110) in accordance with AAP recommendations.</p> <p>The medical screening must include: (1) a comprehensive history, including assessments of both physical and mental health; and (2) a comprehensive physical examination including reimbursement for developmental screens reported to the primary care provider; and, (2) a comprehensive urine and stool screening. The medical screening must include: (1) a comprehensive history, including assessments of both physical and mental health; and (2) a comprehensive physical examination including reimbursement for developmental screens reported to the primary care provider; and, (2) a comprehensive urine and stool screening including vision and hearing screening, dental inspection, height/weight, and BMI assessment.</p>
Vision Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>Periodic vision assessments appropriate to age, health status, and family history. Vision assessments by observation (subjective) and/or standardized vision screening provided according to the Department's EPSDT periodic screening guidelines. These services must include diagnosis of and treatment of refractive errors, eyeglasses. Vision screening in an infant must mean, at a minimum, observation and observation of responses to visual stimuli. In an older child, visual acuity must be done. Effective September 1, 2022, vision services are covered when provided in a school setting by a school nurse.</p>
Other Medically Necessary Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>EPSDT includes medically necessary health care, diagnostic and treatment services as needed to correct or ameliorate defects and physical, mental, and emotional substance use illnesses and conditions discovered, or discovered or suspected to maintain the child's (under twenty-one (21) years of age) health, or to prevent the child's medical condition from getting worse.</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				CMS EPSDT Guidance: https://www.medicaid.gov/medicaid/benefits/download NHeLP - http://www.healthlaw.org/ State Medicaid Manual: https://www.cms.gov/Regulations-and-Guidance/guidance/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 provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Provider Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification, contact the Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located at <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Early Intervention (EI) Services	20USC § 1471 34 CFR § 303.12 Code of Virginia § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	The Contractor must provide coverage for Early Intervention services under 12 VAC 30-50-131, 12 VAC 30-50-415, and 12VAC35-225 et. seq. The Department’s coverage criteria and guidelines. The Department’s billing codes, reimbursement methodology, and coverage criteria are described in the Department’s Early Intervention Provider Manual on the Department’s website at https://www.virginiamedicaid.com . 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 early developmental therapies, when medically necessary, in accordance with the Department’s policies, where appropriate. For children with commercial insurance coverage, providers must bill commercial insurance first for covered early intervention services e

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 Applied
				<ol style="list-style-type: none"> 1. Those services federally required to be provided in the case for <ol style="list-style-type: none"> a. assessment/EI evaluation, b. development or review of the Individualized Family Service Plan, and, c. targeted case management/service coordination. 2. Developmental services; and, 3. Any covered early intervention services where the parent is not covered to their private health/medical insurance. See Section 5 of the Contract, <i>Comprehensive Health Coverage</i>.
Early Intervention (EI) Targeted Case Management (TCM)/Service Coordination	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	The Contractor must provide coverage for EI Targeted Case Management (referred to as EI Service Coordination). EI service coordination is to assist the child and family in gaining access to needed educational, and other services. EI Service Coordination is for families are receiving the supports and services that are outlined on their child’s Individual Family Service Plan (IFSP), through quarterly family contacts, and ongoing supportive communication. The Service Coordinator can serve in a “blended” role; in other words, they can provide both Early Intervention Targeted Case Management and an IFSP service, such as physical therapy, developmental services, and his or her family.
				<table border="1"> <thead> <tr> <th data-bbox="959 1514 1268 1570">Billing Code</th> <th data-bbox="1268 1514 1624 1570">Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="959 1570 1268 1675">T2022</td> <td data-bbox="1268 1570 1624 1675">Service Coordination</td> </tr> </tbody> </table>
Billing Code	Description			
T2022	Service Coordination			
Early Intervention (EI) Initial Assessments for Service Planning and Development and Annual Review of	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 center based program.
				<table border="1"> <thead> <tr> <th data-bbox="959 1812 1268 1875">Billing Code</th> <th data-bbox="1268 1812 1624 1875">Description</th> </tr> </thead> </table>
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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 Applied	
the Individual Family Services Plan (IFSP)				T1023 (RC 2)	Initial assessment, development of initial IFSP, Annual IFSP
				T1023 U1(RC 1)	
IFSP Team Treatment Activities (more than one (1) professional providing services during same session for an individual child/family); IFSP Review meetings; Assessments performed after the initial assessment for service planning	12VAC30-50-131 12 VAC 35-225-120 – 12VAC35-225-160	Yes	Yes	The Contractor is required to provide coverage for Early Intervention services for activities where more than one (1) professional is providing services during the same session for an individual child/family. These services must be provided in the child's natural environments for team treatment activities; or in a center for IFSP reviews and assessment.	
				Billing Code	Description
				T1024* (RC 2)	1. Team Treatment activities where more than one (1) professional is providing services during the same session for an individual child/family
				T1024 U1* (RC 1)	2. IFSP Review Meetings (more than one in-person) 3. Assessments that are done after the initial Assessment for Service Planning
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 services for an individual child or for more than one (1) child in the child’s natural environment.	
				Billing Code	Description
				T1027*	Developmental Services and early intervention services provided

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 Applied	
				(RC 2)	for more than one (1) child, in a group (congregate) setting.
				Billing Code	Description
				T1027 U1* (RC 2)	Developmental Services and early intervention services provided for one (1) child
Center-Based Early Intervention Services (EI); individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Services in an individual and group (congregate) services.	
				Billing Code	Description
				T1026* (RC 1)	Center-based group (congregate) early intervention services
				T1026 U1* (RC 1)	Center-based individual early intervention services
				T1015* (RC 2)	Center-based group (congregate) early intervention services
				T1015 U1* (RC 2)	Center-based individual early intervention services
Early Intervention (EI) Physical Therapy (PT); individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Physical Therapy in an individual or group (congregate) setting, in the child's home or in a group (congregate) setting.	
				Billing Code	Description
				G0151* (RC 1)	Group (congregate) PT

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 Applied	
				G0151 U1* (RC 1)	Individual PT
Early Intervention (EI) Occupational Therapy (OT); individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Occupational Therapy in an individual or group (congregate) setting, in the child's natural environment.	
				Billing Code	Description
				G0152* (RC 1)	Group (congregate) OT
G0152 U1* (RC 1)	Individual OT				
Early Intervention (EI) Speech Language Pathology; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Speech Language Pathology in an individual or group (congregate) setting, in the child's natural environment.	
				Billing Code	Description
				G0153 (RC 1)	Group (congregate) SLP
G0153 U1 (RC 1)	Individual SLP				
Developmental Nursing; 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 Nursing Services in the child's natural environment.	
				Billing Code	Description

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 lists early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Provider Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification, contact the Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located 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 Applied	
				G0495* (RC 1)	Group (congregate) RN Training and Education Services;
				G0495 U1* (RC 1)	RN Individual Training and Education Services.

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applied	
Nursing Facility (NF)	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The Contractor must cover this service. The Contractor must cover non-nursing facility services and must work with the NF to ensure appropriate care. The Contractor must establish strong relationships that Members in NFs receive high quality care, maintain and avoid avoidable hospital admissions among NF residents. Coordinate Members returning to community settings when possible. The Contractor may provide additional health care improvement services not specified in this contract, including but not limited to care as long as these services are available, as needed.	
Long-stay Hospital (LSH) State Plan Only Service	12 VAC 30-60-30; 12 VAC 30-130-100 through 12 VAC 30-130-130 Additional information can be	Yes	Yes	The Contractor must provide information and referrals to Members in accessing services. The Contractor must coordinate the provision of long-stay hospital services. Long-stay Hospital is a state plan only service which covers individuals requiring mechanical ventilation, communicable diseases requiring universal or respiratory protection, requiring ongoing intravenous medication or nutrition, and requiring comprehensive rehabilitative therapy services.	

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	found in the Nursing Facility provider manual available on the Department's web portal at: www.virginiamedicaid.dmas.virginia.gov			provisions for the collection and distribution of the individual patient pay for long-stay hospital services. Hospitals receiving Hospital (Norfolk) and Hospital for Sick Children (Washington)
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 specialized care services for adults and children. Specialized care services include complex trach and ventilator-dependent services which covers complex trach and ventilator-dependent services at a higher reimbursement rate. The Contractor must make provisions for the collection and distribution of the individual Member's monthly payments for specialized care services. Transition services are covered for those individuals 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 http://www.dbhds.virginia.gov/individuals-and-families/developmental-	Yes	No	The Contractor is not required to cover ICF-IID services and 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 Applied
	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 Applied
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 portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library	Yes	Yes	The Contractor must provide care coordination, information, and assist Members in accessing these services. The Contractor must provide respite care, adult day health care, personal emergency response, on-duty nursing, assistive technology, environmental modifications, and transition services. The Contractor must cover both consumer-directed services as a service delivery model for personal emergency response systems may include transition services are covered for those individuals after transition from a qualified institution. The Contractor must collect and distribute the Member's monthly (if appropriate). The Contractor must cover transportation program Members. Rates for all CCC Plus Waiver services have both a N structure with the exceptions of Assistive Technology. Rates are paid based upon the Member FIPS except for additional details below for specifics regarding AT a
CCC Plus HCBS Waiver Personal Care	Same as General Requirements	Yes	Yes	Agency-or consumer-directed personal care services must meet the screening criteria, described at 12VAC30-60-303. Services must be provided within <u>at least</u> equal amount, duration, and fee-for-service. Fee-for-service amount, duration, and fee-for-service at 12VAC30-120-924. Service Definition – Personal Care A range of support services necessary to enable an individual to remain in their home rather than enter a nursing facility or Long-Stay Hospital. Services include ADLs and IADLs, access to the community, self-administration of medication, medical needs, supervision, and the monitoring of h

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 A
				<p>Personal care is available as either agency-directed services may be provided in home- and community maintain the health status and functional skills needed to participate in community activities. The individual must be in order for personal care services to be authorized. Payment for private duty nursing services performed by a RN.</p> <p>Service Codes</p> <p>AD = T1019</p> <p>CD = S5126</p> <p>Services are billed as hourly.</p>
<p>CCC Plus HCBS Waiver Respite Care</p>	<p>Same as General Requirements</p>	<p>Yes</p>	<p>Yes</p>	<p>Respite is for the relief of the unpaid primary caregiver from the emotional stress of providing support and care to the individual.</p> <p>Agency- or consumer-directed respite care services must meet the screening criteria, described at 12VAC30-60-303, and be provided within at least equal amount, duration, and frequency, fee-for-service. Fee-for-service amount, duration, and frequency are defined at 12VAC30-120-924.</p> <p>Respite coverage in children's residential facilities.</p> <p>A. Individuals with special needs who are enrolled in a program with a diagnosis of developmental disability (DD) will be eligible for respite services in children's residential facilities that are licensed for residential care.</p> <p>B. These respite services are covered consistent with 12VAC30-120-924, 12VAC30-120-930, and 12VAC30-120-935, which describe the delivery.</p> <p>Service Definition - Respite Care</p> <p>Respite services are unskilled services (agency-directed) or services of a nurse (AD-skilled respite) that provide relief to the caregiver due to the physical burden and emotional stress on the individual.</p> <p>Skilled Private Duty Nursing Respite Care (Agency-</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as A
				<p>Providers may be reimbursed for respite services provided by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) with a current, active license in the Commonwealth of Virginia as long as the service is medically necessary and can document the individual’s skilled needs.</p> <p>Respite care can be authorized as a sole program or in conjunction with other services.</p> <p>Congregate Private Duty Nursing Respite Care (Age 18 and Over)</p> <p>Congregate respite nursing provided to three (3) or more individuals living in the same primary residence.</p> <p>Service Codes AD = T1005 CD = S5150</p> <p>PDN RN Respite Services = S9125 TD PDN LPN Respite Services = S9125 TE Congregate Respite RN Nursing Services = T1030 TD Congregate Respite LPN Nursing Services = T1031 TE Services are billed as hourly Respite is limited to four hundred and eighty (480) hours per year, regardless of number of providers or whether the individual receives in-home or community respite services.</p>
<p>CCC Plus HCBS Waiver Adult Day Health Care (ADHC)</p>	<p>Same as General Requirements</p>	<p>Yes</p>	<p>Yes</p>	<p>Adult Day Health Care (ADHC) services must be offered in accordance with the criteria, described at 12VAC30-60-303 and 12VAC30-60-304, and must be provided within at least equal amount, duration, and scope as the comparable fee-for-service service. Fee-for-service amount, duration, and scope are defined in 12VAC30-60-924.</p> <p>Service Definition – Adult Day Health Care</p> <p>Long-Term maintenance or supportive services offered through a community-based program providing a variety of health, therapeutic, and social services to meet the specialized needs of those CCC Plus Waiver individuals who are not eligible for waiver services and who also require the services of a nursing facility, specialized care nursing facility, or long-term care center licensed by the Virginia Department of Social Services (ADCC).</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as A
				<p>ADHC may be offered either as the sole home- and conjunction with other CCC Plus Waiver services.</p> <p>ADHC Service Codes = S5102 Transportation = A0120 Services are billed as a per diem. Transportation services are billed per trip.</p>
<p>CCC Plus HCBS Waiver</p> <p>Personal Emergency Response System (PERS)</p> <p>PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.</p>	<p>Same as General Requirements</p>	<p>Yes</p>	<p>Yes</p>	<p>Personal Emergency Response Systems (PERS) services must meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-304. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Personal Emergency Response System</p> <p>Electronic device capable of being activated by a resident to secure help in an emergency. PERS equipment is installed in the home and provides access to emergency services in the home and provides access to emergency services in the home and provides access to emergency services in the home through the provision of a system that dials a twenty-four (24)-hour response via the individual’s home telephone line or other two-way communication system. When appropriate, PERS may also include medication monitoring.</p> <p>PERS is not a stand-alone service. It must be authorized as a component of a qualifying CCC Plus Waiver service.</p> <p>Service Codes PERS nursing = H2021 TD (RN) PERS nursing = H2021 TE (LPN) PERS installation = S5160 Person installation + medication monitoring = S5161 PERS monitoring = S5161 PERS medication monitoring = S5185 PERS nursing services are billed in thirty (30) minutes. PERS installation (w/ or w/out medication monitoring) = S5160</p>
<p>CCC Plus HCBS Waiver</p> <p>Services Facilitation</p>	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be</p>	<p>Yes</p>	<p>Yes</p>	<p>Services Facilitation must be offered to persons who are eligible for services under Medicaid at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Services Facilitation</p>

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 A
	<p>found in the CCC Plus Waiver provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library</p>			<p>During visits with an individual, the Service Facilitator consult with the individual/EOR, family/caregiver as to the adequacy and appropriateness of the consumer-directed services, the individual's current functioning and cognitive status, and the established Plan of Care. The individual's satisfaction with services must be discussed. The SF must determine if the Plan of Care meets the individual's needs, and document the review of the Plan of Care.</p> <p>The SF is responsible for completion of the following:</p> <ol style="list-style-type: none"> 1. Service Facilitation Comprehensive Visit: 2. Consumer (Individual) Training: 3. Management Training 4. Routine Onsite Visits 5. Reassessment Visit <p>Service Codes SF Initial Comprehensive Visit = H2000 (billed as visit) SF Consumer Training Visit = S5109 (billed as visit). SF Management Training Visit = S5116 (billed as visit) SF Routine Visit = 99509 (billed as visit). SF Reassessment Visit = T1028 (billed as a visit).</p>
<p>CCC Plus HCBS Waiver Transition Services</p>	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the CCC Plus Waiver provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library</p>	<p>Yes</p>	<p>Yes</p>	<p>Transition Services must be offered to persons who are eligible for services at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided in the amount, duration, and scope as available under Medicaid. The amount, duration, and scope provisions are described in 12VAC30-60-303 and 12VAC30-60-313.</p> <p>Service Definition – Transition Services</p> <p>Services that are “set-up” expenses for individuals who are residing in a licensed or certified provider-operated living arrangement at a private residence, where the person is directly responsible for the expenses. 12 VAC 30-120-2010 provides the service definition, limitations, and provider requirements for this service. Transition Services are not an acute care admission to a hospital.</p> <p>Transition Services Code T2038 (limited with a total cost regardless of the number of visits)</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as A
<p>CCC Plus HCBS Waiver Assistive Technology (AT) and Assistive Technology Maintenance</p>	<p>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</p>	<p>Yes</p>	<p>Yes</p>	<p>Service Definition – Assistive Technology (AT) Specialized devices, including those devices, controls, or appliances, that are used for Medical Assistance, that enable individuals to in ADLs/IADLs, or to perceive, control or communicate live. This service includes ancillary supplies and equ functioning of such items. AT must not be authorize Assistive technology devices, as defined in 12VAC30 be authorized per fiscal year. AT = T1999 (limited to per item with a set limit of \$ AT Maintenance = T1999 U5 (limited to per item with year) AT and AT maintenance combined costs cannot exceed the \$5,000.00 limit. Currently the program is operating under emergency found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6</p>
<p>CCC Plus HCBS Waiver Environmental Modifications (EM) and Environmental Modification Maintenance</p>	<p>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</p>	<p>Yes</p>	<p>Yes</p>	<p>Service Definition – Environmental Modifications (E Physical adaptations to an individual’s primary residence necessary to ensure the individual’s health, safety, individual to function with greater independence and require institutionalization. EM = S5165 (limited to per item with a set limit of \$ EM Maintenance = 99199 U4 (limited to per item with year) EM must be provided in conjunction with at least one service. EM and EM maintenance combined costs cannot exceed the \$5,000.00 limit Currently the program is operating under emergency found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as A
<p>CCC Plus HCBS Waiver Skilled Private Duty Nursing (PDN)</p>	<p>Same as General Requirements</p>	<p>Yes</p>	<p>Yes</p>	<p>Private Duty Nursing (PDN) services must be offered under the same eligibility criteria, described at 12VAC30-60-303 and 12VAC30-60-304, as services provided within at least equal amount, duration, and scope as services provided under a fee-for-service. Fee-for-service amount, duration, and scope are defined in 120-1720.</p> <p>Service Definition – Skilled Private Duty Nursing (SPDN)</p> <p>In-home nursing services provided for individuals with a chronic or serious medical condition and/ or complex health care needs requiring specific skilled and continuous nursing care on a regular basis. Services performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse.</p> <p>Service Definition – Congregate Skilled PDN</p> <p>Skilled in-home nursing provided to three (3) or fewer individuals who reside in the same primary residence. Congregate services are provided in conjunction with skilled PDN in instances where individuals reside in the home for part of the authorized PDN hours. Coverage is determined and approved according to skilled nursing services and appropriate referral form.</p> <p>Coverage Limits – Up to sixteen (16) hours a day; or eight (8) hours a week</p> <p>Service Codes PDN RN Nursing Services = T1002 (billed hourly) PDN LPN Nursing Services = T1003 (billed hourly) Congregate RN Nursing Services = T1000 U1 (billed hourly) Congregate LPN Nursing Services = T1001 U1 (billed hourly)</p>
<p>Hospice Services</p>	<p>12 VAC 30-50-270 and 12 VAC 30-60-130</p> <p>Additional information can be found in the Hospice provider manual available on the Department’s web portal at:</p>	<p>Yes</p>	<p>Yes*</p>	<p>*Individuals receiving Hospice at time of enrollment are not eligible for participation and will not be auto-enrolled. Managed Care members receiving hospice will remain enrolled in Managed Care.</p> <p>A Member may be in a waiver and also be receiving hospice services. The Contractor must provide information and referrals as appropriate to the Member. The Contractor must cover all services associated with hospice care. The Contractor must ensure that children under two years of age are permitted to continue to receive curative medical services while receiving hospice services.</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as A
	<p>https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library</p>			<p>Non-institutional Hospice Services must be paid by FIPS. The Department’s hospice revenue codes and available at: http://www.dmas.virginia.gov/#/rates</p> <p>Categories of Care:</p> <p>0651- Routine Home Care: In-home care that is not per day). (One (1) unit = one (1) day) Note: As of Jan the first sixty (60) days of hospice care and a reduce (61) and thereafter.</p> <p>0652 - Continuous Home Care: In-home care that is provided as short-term crisis care. Home health aid provided in addition to nursing care. A minimum of provided to qualify as continuous home care. (one (</p> <p>0655 - Inpatient Respite Care: Short-term inpatient (free-standing hospice or hospital) to relieve the pri care for the recipient. No more than five (5) consec allowed (one (1) unit = one (1) day). Payment for th days of respite care is made at the routine home ca</p> <p>0656 - General Inpatient Care: May be provided in a hospital. This care is usually for pain control or acut which cannot be successfully treated in another set</p> <p>0658 - Nursing Facility: Beginning July 1, 2019, for M and are enrolled in a Medicaid approved hospice pr nursing facilities their share of payment directly ratl Payments made to the nursing facility must be the f nursing facility if the Member was not receiving hos</p> <p>0551 - Skilled Nursing Visit – Used when submitting Registered Nurse within the Member’s last seven (7 be billed in conjunction with procedure code G0299 max sixteen (16) per day). Note: a corresponding 06 same date of service must also be submitted for con</p> <p>0561 - Medical Social Service Visit – Used to be used representative of a visit by a Clinical Social Worker v of life. Revenue code 0561 must be billed in conjun (1) unit = fifteen (15) minutes, max sixteen (16) per</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as A
				Routine Home Care charge for the same date of ser consideration of SIA payment.
Program of All-Inclusive Care for the Elderly (PACE)	12VAC30-50-320 http://www.dmas.virginia.gov/ContentPages/ltc-pace.aspx http://www.dmas.virginia.gov/ContentAttachments/ltc/(11)%20Fact%20Sheet%20PACE%2011%2015.pdf	Yes	No	Individuals in PACE will be excluded from managed care. Individuals in managed care have the right to transition from managed care to PACE, including outside of their annual open enrollment. Transitioning to PACE. Members are aware of PACE. PACE provides quality of care that is a community alternative to nursing home care, and provides services covered by Medicare/Medicaid, and may include enhanced services not covered by Medicare/Medicaid. PACE coverage includes prescription drugs, transportation, home care, hospital visits, adult day care, physical, occupational, and speech therapies, and nursing home stays, when necessary. In order to qualify for PACE, an individual must be financially eligible, live in a PACE service area, and be able to reside safely with family or friends. Upon enrollment. When a Member requests additional information, the contractor must assist the Member with obtaining information. The contractor must check to see if there is a PACE site in the Member's service area, which is available via the Department's website: http://www.dmas.virginia.gov/pace.aspx (based upon the member's zip code). The contractor must inform interested in enrolling in PACE to their Local Department of Social Services request a Medicaid LTSS Screening. Meeting the functional criteria for level of care is a requirement for PACE enrollment and is not a requirement for the Member's LDSS.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

Services for Individuals in the 3 Developmental Disabilities (DD) Waivers

Contractor is not required to cover DD Waiver Services (including when covered under EPSDT), DD targeted case management (T1017 & T1018) or transition to/from DD Waiver Services. DD Waiver services covered through EPSDT include private duty nursing, personal care, and assistive technology.

	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Coverage Details
Building Independence (formerly Day Support Services) Waiver	Regulations and Manual are	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.

OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

Services for Individuals in the 3 Developmental Disabilities (DD) Waivers

Factor is not required to cover DD Waiver Services (including when covered under EPSDT), DD targeted case management (T1017 & transition to/from DD Waiver Services. DD Waiver services covered through EPSDT include private duty nursing, personal care, and assistive technology.

	currently in process.			Services may be complemented by non-waiver funded rent subsidies and/or other types of support.
Individual (IS) Waiver and Family Developmental (FD) Waiver	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, and additional supports for those with some medical or behavioral needs.
Community Living (CL) Waiver (formerly the Intellectual Disabilities 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 children with exceptional medical and/or behavioral support needs.

A comparison of all waiver services and a comparison of the services covered under each DD Waiver is available below

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

ng = T1020 (billed as either full month or partial month)

w service and is available under all three (3) DD waivers.

al would live in an apartment, condominium, townhome, or other home in the community with a roommate of the Member's choice. The acts as the individual's live-in companion. Individuals must be eighteen (18) years old or older and must be directly responsible for the res (individual must either rent or own it).

will be responsible for all expense associated with their housing, utilities and food as well as those for the live-in companion. Those exper the individual and determined to be usual, reasonable and within the location's maximum reimbursement amount will be reimbursed by with the service authorization. These expenses may be covered when the live-in companion provides companionship supports, including f ed feelings of security, and may include limited Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) supports as unt for no more than twenty percent (20%) of the anticipated companionship time on a weekly basis. The individual is responsible for his Designated Department of Behavioral Health and Developmental Services (DBHDS) licensed providers are eligible to bill and receive paym ng this service. After retention of an allowable amount for administrative expenses, the provider will distribute payments to the individua For expenses incurred per the service authorization.

t apply to this service.

ot apply to this service.

r Engagement = T2021 (billed as hourly)

e applies to all three (3) of the DD the waiver(s):

w service that provides the individual with a wide variety of opportunities to build relationships and natural support systems, while utilizi as a learning environment. It supports and fosters the ability of the individual to acquire, retain, or improve skills necessary to build posit interpersonal competence, greater independence, employability and personal choice necessary to access typical activities and functions of life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activ ities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons v (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 ra

o apply to this service.

ot apply to this service.

r Coaching = 97127 (billed as hourly)

e applies to all three (3) of the DD waivers

w service designed to engage the individual in the community and to help the individual be supported to minimize a barrier from particip of community engagement. This is a one-on-one service that occurs in a community setting.

t apply to this service.

ot apply to this service.

Services = 97150 (billed as hourly)

e applies to all three (3) of the DD waivers

es skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability, ills. They provide opportunities for peer interactions, community integration, enhancement of social networks and assurance of an individ safety. Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case

OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

ny focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing s
services are delivered in a group setting of no more than 1:7 staff to individual ratio.

o apply to this service and are stand-alone tiers.

ot apply to this service.

upported Employment = H2023 (billed as hourly)

e applies to all three (3) of the DD waivers:

ervice that is provided to an individual in work settings in which persons without disabilities are typically employed. It includes training in sp
paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid
nt.

t apply to this service.

ot apply to this service.

upported Employment = H2024 (billed as hourly using the modifier related to the size.)

e applies to all three (3) of the DD waivers

ervice that provides continuous staff support in a naturally occurring place of employment to groups of two (2) to eight (8) individuals with
s interactions with the public and coworkers without disabilities. Examples include mobile crews and other business-based workgroups e
s of workers with disabilities in the community. Group Supported Employment must be provided in a community setting that promotes in
rkplace and interaction between participants and people without disabilities in the workplace. These supports enable an individual to obt
job in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage
paid by the employer for the same or similar work performed by individuals without disabilities.

t apply to this service.

t 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

Available Under the DD Waivers (Carved out of this contract and covered through fee-for-service.)

Based Home Supports = A9279 (limited to \$5,000.00 per year)

e applies to all three (3) of the DD waiver

ow service designed to give individuals support to gain more independence and freedom at home by using electronic equipment. Electroni
chased and installed in the individual's home to help monitor and support greater autonomy. To qualify for reimbursement, purchases mu
or other Medicaid services, promote integration into the community and increase the individual's safety in the home. Providers that bill a
r this service are responsible for providing emergency assistance twenty-four (24) hours a day and three hundred and sixty-five (365) or t

OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES
of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

and sixty-six (366) days a year as well as furnishing, installing, maintaining, testing and providing user training of the services. Members receiving essential services will not qualify to receive this service.

do not apply to this service.

do not apply to this service.

Assistive Technology (AT) = T1999 (limited to per item with a set limit of \$5,000.00 per year)

Assistive Technology = T1999 U5 (limited to per item with a set limit of \$5,000.00 per year)

do not apply to all 3 of the DD waivers.

Assistive Technology maintenance costs cannot exceed the \$5,000.00 limit.

Specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available through Medicaid or Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with their environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

do not apply to this service.

do not apply to this service.

Environmental Modifications (EM) = S5165 limited to per item with a set limit of \$5,000.00 per year)

Environmental Modifications = 99199 U4 (limited to per item with a set limit of \$5,000.00 per year)

do not apply to all three (3) of the DD waiver.

Environmental Modifications maintenance costs cannot exceed the \$5,000.00 limit.

Physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable 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 benefit to individuals.

do not apply to this service.

do not apply to this service.

Emergency Response System (PERS)

do not apply to all three (3) of the DD waivers.

Installation = H2021 TD (RN)

Installation = H2021 TE (LPN)

Installation = S5160

Installation + Medication Monitoring = S5160 U1

Monitoring = S5161

OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Community Guide services: Utilizes an individual's existing assessment information regarding the individual's general interests in order to determine activities and venues that are available in the community (e.g., clubs, special interest groups, physical activities/sports teams, etc.) to promote independent participation in community life.

Independent Housing Guide services: Supports an individual's move to independent housing by helping with transition and tenancy sustaining activities. Community housing guide collaborates with the support coordinator, regional housing specialist, and others to enable the individual to achieve a goal of independent living.

Planning = T1023 (billed as hourly)

applies to all 3 of the DD waivers.

Planning is an individualized analysis and consultation service provided to assist individuals receiving waiver services and social security benefits (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. Includes education and analysis about current benefits status and implementation and management of state and federal work incentives as well as other options.

For more information on these services, refer to Medicaid Memo issued on 9/4/2018 located at <https://vamedicaid.dmas.virginia.gov/memo/three-new-services-added-for-mental-disabilities-dd-waivers>

Independent Living & 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, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities 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 independent 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 in addition to medical transportation required under 42 CFR § 431.53 and transportation services under the State plan, defined at 42 CFR § 431.53. It does not replace them.

Support Services = T2034 (billed as hourly)

applies to all 3 of the DD waivers.

The following components:

Emergency 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 for up to sixty (60) days per ISP year.

Respite Services: 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.

Behavioral Health Services: 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 sixty (60) days per ISP year.

may be authorized for an individual who has a history of at least one (1) of the following: (i) previous psychiatric hospitalization or hospitalization; (ii) previous incarceration; (iii) previous residential/day placement or placements were terminated; or (iv) behaviors that have significantly jeopardized the individual's safety.

OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES
of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

do not apply to this service.

do not apply to this service.

Home Crisis Supports = H2019 UA and H2019 U1 (billed as hourly)

applies to the following waiver(s):

Building Independence Waiver formerly Day Support (DS) Waiver

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

includes crisis prevention and stabilization services in a residential setting (a crisis therapeutic home) using plan and emergency admission

is approved for those individuals who will need ongoing crisis supports for long-term. Services may be authorized for individuals who are a

(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.

do not apply to this service.

do not apply to this service.

Home-Based Crisis Supports = S9484 U1 (billed as hourly for up to six (6) months per year in thirty (30) day increments)

applies to the following waiver(s):

Building Independence Waiver formerly Day Support (DS) Waiver

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

to be approved to receive this service, the individual must:

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.

or 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.

or:

- 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.

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Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

provides ongoing supports to individuals in their homes and community settings or both.

do not apply to this service.

do not apply to this service.

Community Living Residential (formerly part of Congregate Residential Supports) = H0043 (billed as per diem with a maximum of three hundred and thirty (300) days per year)

applies to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

provides access to twenty-four (24) hour supports in an apartment setting operated by a DBHDS licensed provider. Services are provided 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, supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. The unit of service billed will be "hourly". New waivers take effect.

do not apply to this service and are stand-alone tiers.

do not apply to this service.

Community In-home Residential Supports (formerly In-home Residential Supports) = H2014 (billed as hourly)

applies to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

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 per 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".

do not apply to this service.

do not apply to this service. Size is defined as:

1 or Fewer Individuals/Staff = Size 1 = UA

2 TO 4 Individuals/Staff = Size 2 = U2

5 TO 10 Individuals/Staff = Size 3 = U3

including:

1 (TD)

4 (TE)

applies to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

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of services available here: https://drive.google.com/file/d/1LrbJAARPyynLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver
e billed as 15 minute increments.

Existing service that will not change as part of the waiver redesign; however, individuals receiving this service may be assessed to determine if nursing is now the appropriate service.

ing services: means both skilled and hands-on care, as rendered by either licensed RN or LPN, of either a supportive or health-related nature. Services ordered by a physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical services, monitoring of the health status and physical condition of the individual enrolled in the waiver.

do not apply to this service.

do not apply to this service.

Community Nursing:

(TD)

3 (TE)

do not apply to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

e billed as fifteen (15) minute increments.

new service that is designed to provide individual and continuous medically necessary care as certified by a physician, physician assistant or nurse to individuals with a serious medical condition and/or complex health care need. It allows individuals to remain at home to receive care in their facility, hospital or ICF-IID. This service is provided to an individual at his place of residence or other community setting.

do not apply to this service.

do not apply to this service.

Psychiatric Consultation - Therapists/Behavior Analysts/Rehab Engineer = 97139 (billed as hourly)

do not apply to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service is designed to create three (3) distinct therapeutic service rates according to the provider delivering the service.

do not apply to this service.

do not apply to this service.

Psychiatric Consultation - Psychologist/Psychiatrist = H2017* (billed as hourly)

do not apply to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

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of services available here: https://drive.google.com/file/d/1LrbJAArPyyLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service is intended to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Do not apply to this service.

Do not apply to this 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 exclusion for Members in one (1) of the DD Waivers with an appropriate service authorization for Psychosocial Rehabilitation H2017. Refer to Coverage

and Billing Manual for more information.

Therapeutic Consultation - Other Professionals = 97530 (billed as hourly)

Does not apply to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service is intended to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Do not apply to this service.

Do not apply to this service.

Assistance

(billed as hourly)

(billed as hourly)

Does not apply to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

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.

Do not apply to this service.

Do not apply to this service.

Services

(billed as hourly)

(billed as hourly)

Does not apply to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

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of services available here: https://drive.google.com/file/d/1LrbJAArPyyLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need of those unpaid persons normally providing the care. These services may be agency-directed or consumer-directed.

do not apply to this service.

do 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.

Workplace Assistance Services applies to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

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 (e.g., 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 services. The provider provides onsite habilitative supports related to behavior, health, time management or other skills that otherwise would be necessary for 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 primary purpose of Workplace Assistance services.

To qualify for an activity to qualify under Workplace Assistance services it must include all three (3) of the following:

The activity must not be work skill training related which would normally be provided by a job coach

Services are delivered in their natural setting (where and when they are needed)

Services must facilitate the maintenance of and inclusion in an employment situation

The ratio is 1:1

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.

do not apply to this service.

do not apply to this service.

Family Caregiver Training = S5111 (billed as hourly). Limited to eighty (80) hours per ISP year.

Family Caregiver Training applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Family Caregiver Training: service that provides training and counseling services to individuals, families, or caregivers of individuals receiving services. All individual and family/caregiver training must be included in the individual's written person-centered plan. "Family" does not include individuals employed to care for the individual.

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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 impairment, his/her self-determination / self-advocacy abilities.
3. Travel expenses and room and board expenses are not covered.

do not apply to this service.

do not apply to this service.

Services:

Code = S5135 (billed as hourly)

Code = S5136 (billed as hourly)

applies to the following waiver(s):

Family and Individual Support (FIS) Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living (CL) Waiver formerly the Intellectual Disabilities (ID) Waiver

Companion care means non-medical care, or support and socialization provided to an adult (ages eighteen (18) years and over). The provision of companion care 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 custodial in nature. Companions may assist or support the individual (enrolled in the waiver) with such tasks as meal preparation, community access, transportation, laundry, and shopping but companions do not perform these activities as discrete services. Companions may also perform light housekeeping (e.g., bed-making, dusting, and vacuuming, laundry, grocery shopping, etc.) which such services are specified in the individual's Plan for Supports and Services. Companion care is provided to enhance 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.

do not apply to this service.

do not apply to this service.

Services Facilitation (SF)

applies to the following waiver(s):

Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Comprehensive Visit = H2000 (billed as visit).

Consumer Training Visit = S5109 (billed as visit).

Assessment Training Visit = S5116 (billed as visit).

Home Visit = 99509 (billed as visit).

Assessment Visit = T1028 (billed as a visit).

Definition – Services Facilitation

When working with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate to ensure the adequacy and appropriateness of the consumer-directed services with regards to the individual's current functioning and cognitive status.

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of services available here: https://drive.google.com/file/d/1LrbJAArPyyLT40Wq8hfclIEB1uUHAR_/view

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and social needs, and the established Plan of Care. The individual's satisfaction with the type and amount of service must be discussed. The
if the Plan of Care continues to meet the individual's needs, and document the review of the plan.

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

do not apply to this service.

do not apply to this service.

Community Residential (formerly part of Congregate Residential Supports) = H2022 (billed as per diem with a maximum of three hundred and forty

Community Residential applies to the following waiver(s):

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

services in a home in which an individual lives with other individuals with developmental disabilities receiving supports from paid staff. These
include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports
mandated by DBHDS and follow state and federal guidelines to participate in the service. The unit of service billed will be "daily" when the new

do not apply to this service and are stand-alone tiers.

do not apply to this service. Size is defined as:

Four (4) or Fewer Individuals/Staff = Size one (1) = UA

Five (5) individuals/staff = Size two (2) = U2

Six (6) individuals/staff = Size three (3) = U3

Seven (7) individuals/staff = Size four (4) = U4

Eight (8) individuals/staff = Size five (5) = U5

Nine (9) individuals/staff = Size six (6) = U6

Ten (10) individuals/staff = Size seven (7) = U7

Eleven (11) individuals/staff = Size eight (8) = U8

Twelve (12) individuals/staff = Size nine (9) = U9

Community Residential (formerly part of Congregate Residential Supports) = T2033 (billed as per diem)

Community Residential applies to the following waiver(s):

Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

January 1, 2017:

OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES

of services available here: https://drive.google.com/file/d/1LrbJAArPyyLT40Wq8hfclIEB1uUHAR_/view

Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

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. Services provided by the sponsor may include skill building, supports with ADLs and IADLs, community access and recreation/social supports, as well as transportation. Sponsors are generally not related to the individual unless all other alternatives were investigated and found not to be appropriate for the individual. The sponsor must be affiliated with a DBHDS licensed agency.

Do not apply to this service and are stand-alone tiers.

Do not apply to this service.

Shared Living = T2032 (full month)

Partial month)

Does not apply to the following waiver(s):

Residential Independence Waiver formerly Day Support (DS) Waiver

Day Support service provided to adults (eighteen (18) and older) that offers skill building and supports necessary to secure a self-sustaining, independent life in the community and/or may provide the support necessary to maintain those skills. Individuals typically live alone or with a roommate in shared apartments. The roommate may be paid (see Shared Living above) or unpaid. The unit of service billed is “monthly” or “partial month.”

Day Support services = no modifier

Day Support with services = U1 modifier

Do not apply to this services

Only two (2) Tiers for this service.

(stand-alone)

(not combined together)

Do not apply to this service.

COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS

	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Applicable
ns	<p>CMS Bulletin 1/28/17</p> <p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>US Preventive Services Task Force</p> <p>https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>42 U.S.C. § 300gg–13</p>	No	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/tions</p> <p>CPT Codes and Limitations*:</p> <ol style="list-style-type: none"> 1. 99385 (New patient, eighteen to thirty-nine (18-39 years)); six (6) units per calendar year 2. 99386 (New patient, forty to sixty-four (40-64 years)); six (6) units per calendar year 3. 99387 (New patient, sixty-five years and older (65+)); six (6) units per calendar year 4. 99395 (Established patient, eighteen to thirty-nine (18-39 years)); one (1) per calendar year 5. 99396 (Established patient, forty to sixty-four (40-64 years)); one (1) per calendar year 6. 99397 (Established patient, forty to sixty-five (> 65 years)); one (1) per calendar year <p>*CPT Code descriptions above subject to change</p>
g	<p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>42 U.S.C. § 300gg–13</p>	Limited	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/tions</p> <p>CPT Codes and Limitations*:</p> <ol style="list-style-type: none"> 1. 99406 (Individual counseling visit, three through ten (3-10 minutes)); six (6) units per calendar year; no preauthorization 2. 99407 (Individual counseling visit, > ten (10) minutes); six (6) units per calendar year; no preauthorization <p>S9446 (Group patient education, not otherwise classified, non-physician provider); six (6) units per calendar year; no preauthorization</p> <p>*CPT Code descriptions above subject to change</p>
r th se	<p>CMS Bulletin 1/28/17</p> <p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>US Preventive Services Task Force</p>	Limited	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/tions</p> <p>CPT Codes and Limitations*:</p> <ol style="list-style-type: none"> 1. 97802 (Medical Nutrition Therapy, Initial Assessment and Intervention, Individ., Face-to-Face with the patient, each fifteen (15) minutes; twelve (12) units per calendar year; no preauthorization) 2. 97803 (Medical Nutrition Therapy Reassessment and Intervention, Individ., Face-to-Face with the patient, each fifteen (15) minutes; twelve (12) units per calendar year; no preauthorization)

COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS

	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Applicable
	https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations 42 U.S.C. § 300gg-13			3. 97804 (Medical Nutrition Therapy, Group (two (2) or more individual(s), each thirty (30) minutes; four (4) units per year; no preauthorization 4. G0270 (Medical Nutrition Therapy; Reassessment and intervention(s) following second referral in same year diagnosis, medical condition or treatment regimen (in additional hours needed for renal disease), individual, with the patient, each fifteen (15) minutes; eight (8) units per calendar year; no prior authorization 5. G0271 (Medical nutrition therapy, reassessment and intervention(s) following second referral in same year diagnosis, medical condition, or treatment regimen (in additional hours needed for renal disease), group (two individuals), each thirty (30) minutes; four (4) units per 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
d s	2023 Appropriations Act, Chapter 1, Item 304. EEEE. CMS Bulletin 1/28/16 CDC Adult Immunization Schedule 42 U.S.C. § 300gg-13	Yes	Yes	Coverage in accordance with Centers for Disease Control and Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

9 VIRGINIA MEDICAID AID CATEGORY LIST

Also known as Recipient Program Designation or Scope of Coverage code. This is the program category under which a recipient is eligible for Medicaid or DMAS- administered programs. It is also used to identify an enrollee's eligibility for certain Benefit Plans. Aid categories highlighted in green are dually eligible for Medicare and full Medicaid coverage; aid categories highlighted in yellow eligible for Medicare, but not full Medicaid coverage.

005	FAMIS Moms Pregnant Woman, Income > 133% FPL & <= 166% FPL
006	FAMIS Child under age 6, income >150% poverty and <=200% poverty.
007	FAMIS Child 6-19 years old, income >150% poverty and <=200% poverty.
008	FAMIS Child under age 6, income>133% poverty and <=150% poverty.
009	FAMIS Child 6-19 years old, income>133% poverty and <=150% poverty
010	FAMIS Deemed Newborn <1 year old
011	Aged SSI Recipient - Includes Dually Eligible QMB
012	Aged AG Recipient - Includes Dually Eligible QMB
014	FAMIS DEEMED NEWBORN ABOVE 150% FPL
018	MN Aged; December 1973 Individual ; Not Also QMB
020	Aged - Individual in Medical Institution or receiving Wavered Services with income <=300% SSI; Hospice Recipient; Not also QMB.
021	Aged - Protected Covered individual; Former Money Payment Recipient - August 1972; Former SSI/AG Recipient; Protected Widow(er); Qualified Severely Disabled Individual; Protected Adult Disabled Child.
022	Aged - Individuals in Medical Institution or receiving Wavered Services with Income <=300% SSI; Hospice Recipient. Includes Dually Eligible QMB.
023	Aged - QMB Only
024	M/N-Aged SLMB Plus
025	300% SSI Aged SLMB Plus
028	MN Aged Individual - December 1973 Individual; Dually Eligible QMB
029	Aged, 80% FPL Group. Includes Dually Eligible QMB.
031	Blind SSI Recipient - Includes Dually Eligible QMB
032	Blind AG Recipient - Includes Dily Eligible QMB.
035	Presumptive Eligibility Adult (Pregnant). Age range 19 but less than 57
038	MN Blind Individual; December 1873 Individual; Not also QMB.
039	Blind, 80% FPL Group. Includes Dually Eligible QMB
040	Blind - Individual in Medical Institution or WS with income <=300% SSI; Hospice Recipient; Not also QMB
041	Blind - Protected Covered Individual; Former Money Pymt Recipient - August 1972; Former SSI/AG recipient; Protected Widow(er); Qualified Severely Disabled Individual; Protected Adult Disabled Child.
042	Blind - Individual in Medical Institution or receiving Wavered Services with Income <=300% SSI; Hospice Recipient in Medical Facility. Includes Dually Eligible QMB.
043	Blind - QMB only.
044	M/N-Blind/Disabled SLMB Plus
045	300% SSI Blind/Disabled SLMB Plus
048	MN Blind - Blind Individual; December 1973 Individual; Dually Eligible QMB.
049	Disabled, 80% FPL Group. Includes Dually Eligible QMB
051	Disabled SSI Recipient. Includes Dually Eligible QMB.

052	Disabled AG Recipient. Includes Dually Eligible QMB.
053	Special Low Income Medicare Beneficiary (SLMB).
054	Hospice Individual.
055	Qualified Disabled Working Individual (QDWI).
056	Qualified Individual (QI1).
058	MN Disabled Individual; December 1973 Individual; Not also QMB.
059	AC 059 - MEDICAID WORKS, Disabled, 80% FPL Group. Includes Dually Eligible QMB.
060	Disabled - Individual in Medical Institution or receiving Waiver Services with income <= 300% SSI; Hospice recipient in Medical Facility. Not also QMB.
061	Disabled - protected Covered Individual; Former Money Payment Recipient--August 1972; Protected Widow(er); Qualified Severely Disabled Individual; Protected Adult Disabled Child. Includes Dually Eligible QMB.
062	Disabled - Individual in Medical Institution or receiving Waiver Services with Income <=300% SSI; Hospice Recipient. Includes Dually Eligible QMB.
063	Disabled - QMB Only
064	Presumptive Eligibility (PE) Child. Age less than 19
065	Presumptive Eligibility (PE) Parent/Caretaker Relative
066	Breast or Cervical Cancer Group
067	PE Breast or Cervical Cancer Group
068	MN Disabled Individual; December 1973 Individual; Dually Eligible QMB.
070	Former Foster Care. Age 19<26
072	Non-IVE Adoption-assistance Child; special Medical Needs Adoption-assistance Individual. Includes Dually-eligible QMB.
074	IVE Foster-care or IVE Adoption-assistance Recipient. Includes Dually eligible QMB. Note: Enrollment in this group was discontinued effective 01-31-2013.
075	Juvenile Justice Department Child. Includes Dually Eligible QMB.
076	Non-IVE Foster Care Child. Includes Dually Eligible QMB.
077	PE FORMER FOSTER CARE.
078	Refugee Other or Refugee Medicaid Other.
079	Refugee Medicaid Unaccompanied Minor
080	Plan First. [family planning services only]
081	Protected Covered Individual: Former Money payment Recipient--August 1972; Low-income Family with Child(ren) (LIFC) Individual; 4-month or 12 month-extended Medicaid Recipient. Includes Dually Eligible QMB.
082	Individual Under Age 21 in ICF or ICF-MR. Includes Dually-eligible QMB.
083	Former Money Payment Recipient--August 1972; Low-Income Family with Child(ren)-Unemployed Parent (LIFC-UP) Individual; 4-month or 12-month extended Medicaid Recipient
084	PE PLAN FIRST [time-limited family planning services only]
085	MN Individual Under age 21; Juvenile Justice Department Child. Includes Dually-Eligible QMB.
086	MN Individual under age 21; Non-IVE Foster-care Child or Non-IVE Adoption-assistance Child; Special Needs Adoption Assistance Child. Includes Dually-Eligible QMB.
087	GOVERNOR'S ACCESS PLAN (GAP)
088	MN Child Under Age 18. Includes Dually-Eligible QMB
090	Child Under Age 6 with income between 100% and 133% of poverty. Includes Dually-Eligible QMB.
091	Pregnant Woman; Child under age 6 with income <=100% of poverty. Includes Dually-Eligible QMB.
092	Child Age 6 to 19 with income <= 100% poverty (insured or uninsured); Child age 6 to 19 with income > 100% and <=133% poverty (insured). Includes Dually-Eligible QMB.
093	Newborn Child Under Age 1. Includes Dually Eligible QMB.
094	Child Age 6 to 19. Income > 100% poverty and <= 133% poverty (uninsured).

097	MN Pregnant Woman. Includes Dually Eligible QMB.
098	MN Individual Under Age 21 in a Nursing Facility. Includes Dually-Eligible QMB.
099	MN Newborn Child UNDER Age 1. Includes Dually-Eligible QMB.
100	Caretaker Adult, age 19 to 65 , LE 100% FPL
101	Caretaker Adult, age 19 to 65 , GT 100% FPL
102	Adults, age 19 to 65 , LE 100% FPL
103	Adults, age 19 to 65 , GT 100% FPL
106	PE Adults, age 19 to 65, LE 133% FPL
107	Pregnant Women, age 19 to 65
108	DOC Adults, age 19 to 65 [hospitalization only]
109	DOC FC/ABD [hospitalization only]
214	TDO - General District Court
215	TDO - Juvenile and Domestic Court
216	TDO - Combined District Court
401	Premium Payment - COBRA
402	Premium Payment - Conversion
404	Premium Payment - Individual
501	ACR
601	HIDP
801	ASSM Level 1
802	ASSM Level 2
803	ASSM ACR

