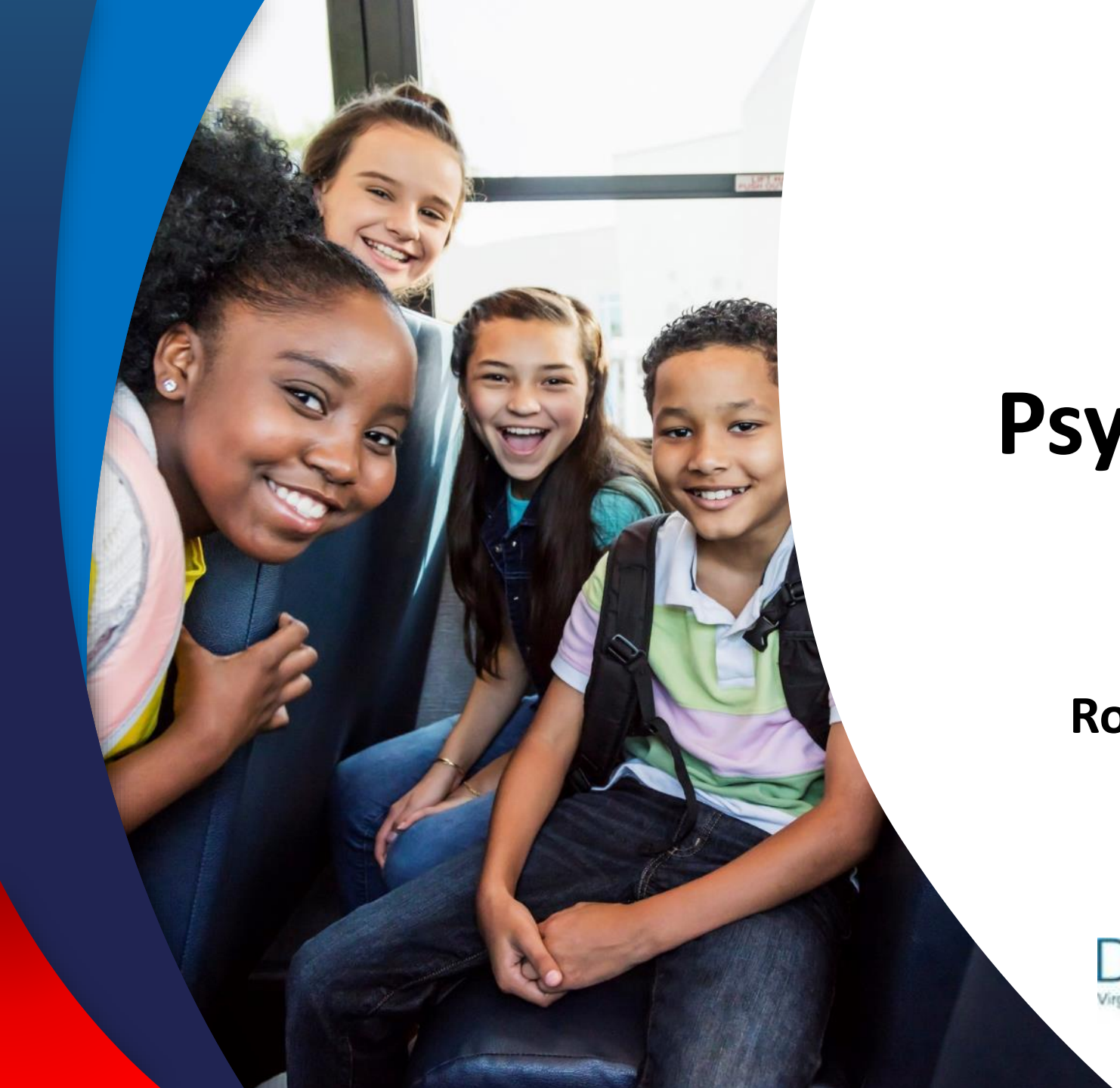

CardinalCare
Virginia's Medicaid Program

Psychiatric Residential Treatment Facility Service

Roles and Responsibilities for PRTFs, MCOs, and Acentra Health

DBHDS
Virginia Department of Behavioral Health and Developmental Services

RIGHT HELP. RIGHT NOW.
Transforming Behavioral Health Care for Virginians

DMAS

Overview of Care Management requirements for Members in Low, Moderate or High Intensity Care Management:

	Low Intensity CM	Moderate Intensity CM	High Intensity CM
Populations of Focus	**Mandatory Priority Populations + other individuals needing care management, as identified by the MCO**		**Mandatory High Priority**
Initial MMHS Screening Completion Timeline	**90 calendar days from enrollment** (***30 calendar days for Members who are ventilator dependent and receiving private duty nursing services***)		
Initial HRA Timeline	60 calendar days from MMHS completion/identification as requiring care management (*or sooner, as needed*)		
Initial ICP Timeline	60 calendar days from HRA completion (or enrollment if HRA was previously completed)	30 calendar days from HRA completion (or enrollment if HRA was previously completed)	7 calendar days from HRA completion (or enrollment if HRA was previously completed)
ICT Meeting/ Communications Timeframe	As needed or at Member request *NF and Waiver Members in Low/Moderate Intensity should receive ICT Meetings aligned with requirements for Members in High Intensity Care Management*		Initial: 30 calendar days from ICP completion Ongoing: Following HRA reassessment, triggering events, readmissions, upon member request
Minimum Contact Requirements/Format [2]	1 contact per 6 months **in-person, telephone or videoconference** *NF and Waiver Members: initial HRA and annual level of care review must be in-person; interim contacts may be via telephone or videoconference*	1 contact per 3 months **in-person, telephone or videoconference** *NF and Waiver Members: initial HRA and annual level of care review must be in-person; interim contacts may be via telephone or videoconference*	1 contact per month **Initial meeting and at least one contact every 6 months must be in-person** *NF and Waiver Members: Initial HRA and annual level of care review must be in-person; interim contacts may be via telephone or videoconference unless otherwise required to be in-person*
Caseload Ratios	1:500	1:175	1:70

1. Maintains face to face for certain LTSS populations; allows for interim / subsequent contacts to be in person, telephone, or video conference.
2. DMAS will allow for ICTs to move forward without every team member always being present. The Care Manager must provide a summary of the meeting to all ICT Members (including those who were unable to attend) within 30 calendar days of the meeting.
3. Care managers will be required to meet with members as expeditiously and frequently as their care conditions require but will be held to these minimum contact requirements. Minimum timeframes or contacts do not allay the MCO from its responsibility to make contacts as clinically necessary to ensure the health, safety and welfare of a member.

Budget Language

The Department of Medical Assistance Services shall amend the state plans under Titles XIX and XXI of the Social Security Act, and any waivers thereof, and make any changes to managed care contracts as necessary to enable children served in psychiatric residential treatment facilities (PRTF) to maintain their enrollment in managed care during their treatment. The payment for PRTF per diem payments and PRTF required services shall be carved out of managed care and paid as a fee-for-service benefit. Required services include assessment and diagnosis, physician medication management and supervision, urine testing and psychological professional services when delivered by facility staff or contractors. Any service eligible for reimbursement through the Children's Services Act shall not be included in managed care. The department shall have the authority to create a new capitation payment structure to reflect this change in managed care service delivery. Costs associated with any carved-out services shall be excluded from managed care payment methodologies. The department shall have the authority to implement this change effective July 1, 2025 and prior to the completion of any regulatory process.

General Updates

- Provider Bulletin was published on 10/17/25
  - https://vamedicaid.dmas.virginia.gov/bulletin/cardinal-care-managed-care-changes-youth-psychiatric-residential-treatment-facilities
- Go-Live is 11/1, on which date youth who enter PRTFs will no longer be removed from managed care
  - Members currently in the PRTFs will be transitioned later in the month by 12/1

What is Care Coordination?

- MCOs (vs. FFS Medicaid) paying for medical services and transportation during the PRTF stay likely would not have a direct impact on PRTF care
- But, the care coordination provided by MCOs will be a new support for youth in PRTFs and PRTFs need to be aware of what is offered and what the care manager brings to the system
- CardinalCare Model of care has multiple levels of care coordination/care management and youth in PRTFs are designated as a **mandatory high priority population,** which means there is a low care manager-member ratio and they are expected to hold or attend meetings to coordinate the care for the member
- The MCO care manager can serve as a single point of contact for the PRTF for all medical, transportation, referral, and other related needs of the youth

What is Care Coordination?

- Today's discussion begins the relationship between Virginia PRTFs and Medicaid MCOs to ensure that youth in PRTFs are able to access the benefits of care coordination
- **No detailed policy changes** are being put forth right now for PRTFs, and only a minor change will move forward with Acentra Health. Majority of new responsibilities are on MCOs, as they are the new support coming to the system
- If there are issues that cannot be resolved through collaboration and suggested actions, we can consider policy changes in the future
  - MCO care coordination will yield/merge to PRTF existing meetings, assessments, etc. Whenever possible, versus doing additional meetings to meet their contractual requirements
  - Onus is on MCO to establish communication protocols, share information, bring the care coordination model to the PRTFs. However, they can't do it alone! Ultimately, they will need to be "invited in"

Acentra Health's Responsibility in the Process

- Acentra Health will inform MCOs when a member is referred to an IACCT assessment. MCOs must use this notification to become engaged with the care, beginning with the IACCT process.

MCO Responsibilities During Assessment, Referral, and PRTF Stay

- MCOs should use the notification regarding the IACCT to become engaged with the process, including sharing information as allowable for the purpose of the assessment
- MCOs should, whenever feasible, work to provide alternative community referrals early in the assessment process. For example, if IOP, PHP, MST, and FFT have not been considered, barriers to these alternatives should be addressed by the MCO.
- If a youth is found to need PRTF level of care, MCOs should provide bed/provider finding care coordination
- MCOs remain (or become, for youth currently in PRTFs) responsible for coordinating and facilitating non-PRTF healthcare
- MCO should establish communication and explain the supports that can be provided as early in the process as possible, requesting to be added to the treatment team

MCO Responsibility for Discharge Planning

- If MCO encounters barriers with a PRTF to be included on the treatment team, can reach out to DMAS BH for assistance and support
  - Reach out via enhancedbh@dmas.virginia.gov
- MCO care managers should contribute to identify providers and schedule/arrange for appointments for all needed services included in the discharge plan, including transportation, ensuring that follow up occurs in a timely manner following discharge.
- All high priority care coordination responsibilities continue for three months minimally.

PRTFs Responsibility to Include MCOs in Discharge Planning

- PRTFs are highly encouraged to include MCO care managers on treatment teams and should take every effort to be responsive when MCO care coordinators reach out. PRTF leadership will need to lead this change for all staff until it becomes part of the general culture.
- PRTFs should reach out to MCO care managers when there are other health needs or NEMT needs
- PRTFs are encouraged to include MCO care managers in discharge planning activities, particularly during the last 30 days prior to planned discharge, and can make specific requests of MCO care managers regarding need for referrals and appointments post-discharge
- Submit the discharge summary to Acentra Health timely to avoid any delays with post discharge services
    - DMAS Recommendation-PRTF should also send the discharge summary to the MCO (discussion)

Critical Incident Reporting Discussion

- Currently who do the PRTFs send this information to?
- Does Acentra Health receive this information?
- How does information get filtered to the MCOs?
- Is there a form that needs to be completed?

Next Steps

Communicate and Collaborate 😊

A follow up meeting will be scheduled- TBD

CCMC MCO	PRTF Contacts
Aetna Better Health of Virginia	Lauren Bayes, BH Clinical Director, BayesL@aetna.com Corey Pleasants, COO, PleasantsC@aetna.com Alexa Pfaffenberger, Care Management Director, PfaffenbergerA@aetna.com
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Humana Healthy Horizons in Virginia	Jessica Vermont, Director of BH and ARTS Care Management, jvermont@humana.com
Sentara Community Plan	Lavinia Smith, Sr. Director of Strategy and Innovation, lysmith3@sentara.com Felicia Graves, Sr. Director, Operations and Program Integration, facampbe@sentara.com
United Healthcare	Pamela Andrews, Executive Director of Medicaid Programs, pamela_andrews@uhc.com

PRTF Contact List

- We are compiling a list for the MCOs with a single point of contact for each PRTF. If you would like to be added to the list, please put your name and contact information in the chat. Thank you!