Medicaid Managed Care Contract Matrix: Virginia

Programmatic Element	Standards	Source
Program Name	Commonwealth Coordinated Care (CCC) Plus	
Date of Transition	The state began transitioning individuals to CCC Plus in August 2017.	An Introduction to CCC Plus, VA DMAS
Total Enrollment	207,722 (includes all eligibility groups, not just individuals with I/DD)	Commonwealth Coordinated Care Plus Update – October 2018
Enrollment Type	Mandatory	Section 3.2
Plans Operating in the State	Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Health Community Care, UnitedHealthcare Community Plan, and Virginia Premier Health Plan	Virginia's Commonwealth Coordinated Care (CCC) Plus Medicaid Waiver
Authority for Managed Care	1915 (b)	Commonwealth Coordinated Care Plus 1915 (b) Waiver Application
Eligibility	Individuals eligible for CCC Plus include: • Dual eligibles with full Medicaid and any Medicare A and/or B coverage • Non-dual eligible individuals who receive long term services and supports (LTSS) through an institution or the state's four home and community based services (HCBS) waivers, including three Developmental Disability (DD) waivers: Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers. Individuals who are institutionalized in state or private ICF/ID and state ICF/MH facilities are excluded from managed care. • The aged, blind, and disabled (ABD) population (non-duals and those who do not receive LTSS) • The state's Medicaid expansion population, which includes adults ages 19-64, who are not already eligible for Medicare coverage, not already eligible for a mandatory coverage group (such as pregnant women or disabled), those whose income doesn't exceed 138% of FPL, and who have been identified as medically complex through a screening.	Section 3.1
Benefit Design	Individuals on the state's DD waivers are enrolled in the plan for medically necessary non-waiver services only, including physical, behavioral health, pharmacy, and non-LTSS waiver transportation services. MCOs are responsible for knowledge of the services within the DD waivers to ensure the overall health and well-being of all CCC Plus program members. Carved out services include DD waiver services, DD case management services, dental services, and transportation to and from DD waiver services.	Section 3.1 Section 4.7 Section 4.11

Plan Type	Traditional Managed Care Organization (MCO) model; MCOs operate statewide and enroll all eligible populations, the plans are not specific to individuals with I/DD.	Section 2.2
Integration with Medicare	Integrated; MCOs must have an approved Dual Eligible Special Needs Plan (D-SNP) contract in all localities in each region where the health plan provides services under the CCC Plus program contract or begin operating a D-SNP in all localities in each region where the health plan provides services under the contract within three years of being awarded a CCC Plus program contract. In any instance when the CMS approved D-SNP service areas do not match the state's approved CCC Plus service areas, the state may restrict the CCC Plus service area to align with the CMS approved D-SNP service areas. When appropriate, the state may work with the MCO to achieve fully aligned service areas prior to terminating the contract. Dual eligible members have the option of having their CCC Plus program and Medicare services coordinated by the same MCO. Therefore, the health plan must educate the member on benefits of alignment and encourage dual members that are enrolled with them for the CCC Plus program to also enroll in their companion D-SNP for the Medicare portion of their benefits. However, these members continue to have the option of receiving their Medicare benefits from fee-for-service Medicare or through another Medicare Advantage/D-SNP Plan. MCOs must work with the state to align, whenever possible, enrollment of dual eligible members in the same plan for both Medicare and Medicaid services. Plans remain responsible for coordinating care and services for members who do not participate their companion D-SNP. MCOs are responsible for coordinating Medicaid payments for dual eligible members and paying crossover claims. When a dual eligible member is enrolled either with the MCO's D-SNP or MA plan for his or her Medicare benefits, or with a D-SNP or MA plan, or another MCO not affiliated with the plan, the MCO is responsible for coordinating all benefits covered under the contract and the member's Medicare plan or other MCO. In this effort, the MCO must, at a minimum: • Provide the member's Medicare plan or other MCO with contact information of the person and division responsible for coordination of the member's Medicaid benefits; • Provide the member's Medicare plan or other MCO with contact information of the person or division responsible for coordination of cost sharing between Medicare or the member's primary MCO and Medicaid; • Request a representative from the member's Medicare plan or primary MCO carrier to participate in all needs assessments and person centered planning; • Provide the Medicare plan or primary MCO carrier with the results of all needs assessments and person centered planning; • At a minimum, provide the Medicare plan or member's primary MCO with timely (within 48 hours of becoming aware, of hospital, emergency department and nursing facility admissions and discharges and within 72 hours of the diagnoses of,	Section 2.6 Section 3.2.9 Section 5.13

or significant change in the treatment of, a chronic illness) inpatient hospital, emergency department and nursing facility admissions and discharges and the diagnosis of, or significant change in the treatment of, a chronic illness in order to facilitate the coordination of benefits and cost sharing between the Medicare and Medicaid plan;

- Coordinate with the Medicare plan or member’s primary MCO regarding discharge planning from an inpatient setting, including hospital and nursing facility;
- Request a representative from the member’s Medicare plan or primary MCO to participate in all interdisciplinary team meetings;
- Receive, process and utilize in a timely manner (within 72 hours at a maximum or sooner if circumstances necessitate a faster response) information, including member-specific health data from the member’s Medicare plan or the member’s primary MCO, regarding the effective coordination of benefits and cost sharing;
- At the request of a Medicare plan or the member’s primary MCO, the plan must participate in training of the Medicare or member’s primary MCO plan’s staff regarding coordination of benefits and cost sharing between Medicare and Medicaid;
- Coordinate with a member’s Medicare or primary MCO plan to ensure timely access to medically necessary covered benefits needed by a member enrolled in the CCC Plus program;
- Submit to a member’s Medicare or primary MCO plan, as applicable and appropriate, referrals for care coordination and/or disease management; and,
- Receive and process from a member’s Medicare or primary MCO plan a referral for transition from a nursing facility to the community, and coordinate with the member’s Medicare or primary MCO plan to facilitate timely transition, as appropriate, including coordination of services covered by the plan and services covered by the Medicare or member’s primary MCO plan.

MCOs must utilize both Medicare and Medicaid health care data and data from the member’s primary MCO to coordinate all aspects of the member’s health care, including but not limited to: Medicare A, B, and D; data from the member’s primary MCO; historical data; Medicaid historical data; discharge planning; disease management; chronic conditions; and, care management. MCOs must coordinate behavioral health benefits with the state’s contracted behavioral health services administrator when appropriate.

MCOs must train staff working on services provided under the model contract on available Medicare benefits and coordination of Medicare and Medicaid benefits. Plans are required to develop, for review and approval by the state, policies, and procedures and training for the MCO’s staff, including care coordinators, regarding coordination with a member’s Medicare plan or primary MCO plan, which must include the following elements:

- Train network providers on available D-SNP and CCC Plus program benefits and services as requested by provider and/or provider associations.

	• Establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for CCC Plus members, that care coordinators are notified/engaged as appropriate. • Maintain daily reports for audit to determine appropriate and timely engagement in discharge planning. • Coordinate with a member's D-SNP or MA plan or other primary MCO regarding CCC Plus program services that may be needed by the member; however, the D-SNP or MA plan or primary MCO carrier remains responsible for ensuring access to all benefits covered by the member's primary payer, including nursing facilities and home health, and should not supplant such medically necessary covered services with services available only through the CCC Plus program. • Provide to D-SNPs and MA plans and any other MCO carrier with whom the member has coverage, training on the contractor's nursing home diversion program, including the referral process. • Accept and process from a member's D-SNP, MA plan, or other MCO carrier a referral for HCBS in order to delay or prevent nursing home placement.	
Residential Services	Individuals who are institutionalized in state or private ICF/ID and state ICF/MH facilities are excluded from managed care. Individuals enrolled in DD waivers can access shared living, supported living residential, and group home residential services through the DD waivers and remain eligible for CCC Plus.	Section 3.1.2 Services Available Under DD Waivers Chart
Care Coordination Model	MCOs are required to develop a model of care coordination that aligns with the state's goals to provide comprehensive care coordination that integrates the medical and social models of care through a person centered approach, promotes member choice and rights, and engages the member and family members throughout the process. In addition, the MCO's model of care must also include processes that prioritize continuity of care and seamless transitions for members and providers, across the full continuum of physical health, behavioral health, and LTSS benefits. The MCO's model of care design must have the capacity to effectively manage complex populations, including members enrolled in the DD waivers and members with I/DD. The model of care must include the following elements: • Provide the full scope of care coordination and related services for the CCC Plus populations; • Operate using person-centered care coordination for all members; • Include methods to identify, assess, and stratify vulnerable CCC Plus populations and populations with emerging high risks; • Include comprehensive health risk assessments, individualized care planning, and interdisciplinary care team involvement; • Integrate primary, acute, behavioral health, and LTSS; • Be responsive to the member's needs and preferences, and take into account the health, safety, and welfare of its members; • Include staff and provider training on the CCC Plus model of care to ensure members receive person-centered, culturally competent care through trained care coordinators and through a network of high-quality, credentialed providers who have attested to or demonstrated the required competencies required by the MCO; and	Section 5.1 Section 16.5 Section 4.2.4.1.7

- Include processes and systems of care that engage members and family members in person centered, culturally competent care and ensures seamless transitions between levels of care and care settings

The care model stratifies enrolled plan populations by risk level, which drives the requirements for assessments and care coordination. The risk population classifications include members on the DD waivers and individuals with I/DD. MCOs must have policies and procedures in place to manage members that are enrolled in the DD waivers, in addition to all individuals with a diagnosis of a developmental disability. Plans must work with the member's DD waiver support coordinator/case manager and service provider to coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services, as applicable, to support the individual's health and well-being. Plans must be able to identify and access the appropriate community-based resources for these members.

Care Coordinators—At a minimum, the MCO's care coordinators must have at least a bachelor's degree in a health or human services field or be a registered nurse or a licensed practical nurse. All care coordinators must have at least one year of experience directly working with individuals who meet the MCO's target population criteria. Members are assigned a care coordinator on or before the member's enrollment effective date. MCOs must send a notice to the member within 14 days of enrollment providing the name and contact information for their assigned care coordinator. Upon request by the state, the plan must provide the name and contact number of the care coordinator assigned to a particular member. Care coordinators must:

- Act as the primary point of contact for members and the interdisciplinary care team (ICT)
- Ensure that members have access (e.g., a telephone number, e-mail address) to their care coordinator
- Engage members in care coordination activities
- Communicate with members about their ongoing or newly identified needs on at least a quarterly basis for the CCC Plus waiver, nursing facility and minimal risk populations, and at least every six months for the other high risk and emerging high risk populations (which includes members with I/DD), or as frequently as requested by the member, to include a phone call or face-to-face meeting, depending on the member's needs and preferences. For members in nursing facilities or receiving HCBS waiver services, contact with members must be at a frequency of at least every 90 calendar days, even if the member requests less frequent contact.
- Notify members if there is a change in their assigned care coordinators
- When possible, ensure continuity of care when care coordinator changes are made whether initiated by the member or by the plan.

MCOs are required to complete an MCO member health screening (MMHS) for all Medicaid expansion and any newly eligible individuals, which contains questions used to verify/determine if a member is medically complex and questions regarding social determinants of health. Plans must complete the MMHS within three months of each member's enrollment, unless the MCO is unable to screen the member after three good faith attempts.

Health Risk Assessment (HRA)—MCOs must use an HRA to develop the member's person-centered individualized care plan (ICP). At a minimum, the MCO's HRA must effectively identify the member's unmet needs, and encompass social factors (such as housing, informal supports, and employment), functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains, the member's strengths and goals, the need for any specialists, community resources used or available for the member, the member's desires related to their health care needs (as appropriate), and the person-centered ICP maintenance. MCOs must complete HRAs within 30 calendar days of completion of the MMHS for members classified as high risk (e.g., the member has had a combination of five or more emergency room visits or hospitalizations related to their chronic medical, physical, and/or behavioral health condition in the past 90 calendar days) and within 60 calendar days of completion of the MMHS for members classified as moderate risk (e.g., the member needs assistance with ADLs).

MCOs must use appropriate documentation to complete HRA elements in order to avoid unnecessary burden to the member, caregiver, or provider. The HRA must also document that during the initial health risk assessment, the member was informed of the program name, covered benefits, and the role of the care coordinator, and document the source of information for the HRA (i.e, the member, providers, facility staff, family/caregivers, etc. to include name and title) and location of completion (face-to-face or telephone and physical location). The state reserves the right, providing the MCO with at least 60 calendar days advance notice, to require the plan to add additional elements to its HRA.

Person-Centered Individualized Care Plan (ICP)—Following completion of the HRA, the plan's care coordinator must develop an initial ICP prior to the interdisciplinary care team (ICT) meeting. The ICP is considered complete upon member signature. The care coordinator can develop the initial ICP during the HRA process and obtain the member's signature at that time. MCOs must develop a person-centered, culturally competent ICP for each of its enrolled members. The plan's care coordinators must:

- Engage each member in the ICP process;
- Ensure that the member receives any necessary assistance and accommodations to prepare for and fully participates in the care planning process that includes ICT participation and person-centered ICP development;
- Develop and maintain the ICP and make the ICP or information related to the ICP accessible to providers and members as needed and upon request;
- Revise the ICP based on triggering events, such as hospitalizations or a decline or improvement in health or functional status;
- Ensure information is secured for privacy and confidentiality in accordance with all applicable state and federal requirements;
- Obtain member's or their representative's signature on the initial ICP and all subsequent revisions. Where the ICP is conducted telephonically, if the audio is recorded, the plans must have the member's consent for the audio recording. Also document all efforts when members or their representatives refuse to sign, including a clear explanation of the reason for the member's refusal;

- Communicate any ICP revisions to the member, ICT, and other pertinent providers;
- Develop and implement the ICP no later than the end date of any existing service authorization. Services must be continued until the HRA has been completed and the ICP has been developed.

The ICP must include the following elements:

- ICP completion date; ICP attainable goals and objectives with start date; target end dates; completion dates; and outcome measures-based assessments;
- Strategies and actions, including interventions and specific services to be implemented to meet the member's needs and preferences (including community-based resources, service provider information, quantity, frequency, and duration of the services or the person(s) responsible for the specific interventions/services (including peer supports);
- Documentation within the ICP regarding progress towards goal completion noting success; rationale for extending target end goal dates; updating of ICP with new goals; any barriers or obstacles;
- Identification of the member's primary care provider and specialists, including plans for follow-up care;
- Member's informal support network and services;
- Addressing all needs of the member (functional, medical, behavioral, cognitive, social, LTSS, wellness and preventive) as well as any preferences as identified by the individualized care team (ICT) and agreed upon by the member. Social needs include but are not limited to: housing, food, security, economic security, community and informational supports, and personal goals (e.g. go to school, have a job, be at granddaughter's wedding);
- Prioritized list of concerns, preferences, needs, goals, and strengths, as identified with the member;
- Advance directive information; including education needs of the member about advance directives, and obtaining any advance directive documentation and filing them in the member's file. The status of advance directives must be reviewed at annual assessments and with a significant change in health or functional status and must be included in the ICP. Also included is documentation of information regarding the inability to provide information regarding advance directives and the reasons why the advanced directives may not have been obtained;
- Plans for transition coordination and services for members in nursing facilities who wish to move to the community;
- Addressing health, safety (including minimizing risk), and welfare of the member.
- Crisis plans for members with behavioral health needs. For crisis plans, the plan must describe how the MCO will assist the member to identify and select individuals or agencies that will provide support, crisis intervention, crisis stabilization or other services (including peer supports) to assist the member in managing the crisis and to minimize emergency room or inpatient needs;
- Plan to access needed and desired community resources and non-covered services;
- Member's choice of services (including model of service delivery for personal care and respite);
- MMHS responses;

- Elements included in the home health plan of care for members receiving private duty nursing.

Interdisciplinary Care Team (ICT)—The MCO must arrange for each member, in a manner that respects the needs and preferences of the member, the formation and operation of an interdisciplinary care team (ICT). The plan must ensure that each member's care (e.g., medical, behavioral health, substance use, LTSS, early intervention, and social needs) is integrated and coordinated within the framework of an ICT and that each ICT member has a defined role appropriate to his or her licensure and relationship with the member. The member is encouraged to identify individuals that he or she would like to participate on the ICT. The ICT must be person-centered, built on the member's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The care coordinator leads the ICT. At a minimum, the MCO conducts initial ICT meetings within 30 calendar days of completion of the HRA or no later than the next scheduled ICT in conjunction with the service provider, whichever is later.

MCOs must ensure that the ICT includes the member and/or their authorized representative(s) and at least the staff listed below. The plan must ensure that advance notice is provided to the member and other required attendees in order to maximize participation for planned ICT meetings; such advance notice must be provided at least one week in advance. MCOs must ensure that input is requested for inclusion in the ICT discussion from ICT members who are unable to attend the ICT in-person or telephonically. At a minimum, the following staff must be invited to participate in the ICT:

- Care coordinator
- PCP
- Behavioral health clinician, if indicated
- LTSS provider(s) when the member is receiving LTSS
- Targeted case manager, if applicable (if the member is receiving targeted case management (TCM) services (e.g., a member with I/DD through a waiver), the plan must include the targeted case manager on the member's ICT
- Pharmacist, if indicated

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

- A representative from the Medicare plan, if applicable
- Registered nurse
- Specialist clinician
- Other professional and support disciplines, including social workers, community health workers, and qualified peers
- Family members
- Other informal caregivers or supports
- Advocates

- State agency or other case managers

MCOs must ensure that there is document evidence in the member record to support all of the following:

- The names, titles, and roles of each ICT participant in attendance
- The names, titles, and roles of invitees but not in attendance
- Solicited input from required participants who are unable to participate in the ICT meeting and information provided through alternate means
- Informing of the ICT participants (present or not) of information discussed; outcomes of the ICT meeting and any additional information obtained through alternate means
- When applicable, the member's active refusal to participate in the ICT. The member or his/her authorized representative must be included in the ICT; alternate forms of soliciting input from the member are not acceptable unless there is clear documentation of the member's refusal to participate with the stated reason
- Review and discussion of the initial ICP developed by the care coordinator with the member. The ICP must be revised/updated as deemed necessary based on the needs and goals developed through the ICT process.

The ICT must be convened, subsequent to all reassessments, within 30 calendar days and in the following circumstances: subsequent to triggering events requiring significant changes to the member's ICP (e.g., initiation of LTSS, behavioral health crisis services, etc.); upon readmissions to acute or psychiatric hospitals or nursing facility within 30 calendar days of discharge; and, upon member request.

As the leader of the ICT, care coordinators must execute the following responsibilities:

- Participate in HRAs for care planning
- Ensure that ICT meetings and conference calls are held periodically;
- Monitor the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the member
- Ensure the ICP is developed updated as necessary
- Ensure that appropriate mechanisms are in place to receive member input, complaints and grievances, and secure communication among relevant parties
- Incorporate but not duplicate TCM for applicable members
- Solicit and comply with the member's wishes (e.g., advance directive about wishes for future treatment and health care decisions, prioritization of needs and implementation of strategies, etc.)

State approval—MCOs must submit to the state for approval prior to implementation, upon revision, or upon request, the care coordination staffing structure, including staff positions that will be involved in care coordination operations for the CCC Plus

	program, including but not limited to, care coordinator supervisors, care coordinators, care coordination support staff, and administrative staff support. Plans must also identify the role/function(s) of each care coordination staff as well as the required educational requirements, clinical licensure standards certification, and relevant experience with care coordination standards and/or activities. The state reserves the right to train to the MCO's care coordination staff in relation to the CCC Program requirements. MCOs must also include a description of their assignment process for care coordinators, which must take into consideration the care coordinator's experience working with populations with physical disabilities, developmental disabilities, serious mental illness, traumatic brain injury, the elderly, etc. *Transition care coordinator*—MCOs must have at least one dedicated transition care coordinator in each region without a caseload (other than individuals in transition) to assist individuals with care transitions. Care transitions include transitioning individuals from NFs, hospitals, inpatient rehabilitation, or other institutional settings into the community, and assisting individuals who desire to remain in their community setting. *Care Coordination Partnerships*—MCOs may subcontract with community-based organizations (CBOs) for the provision of care coordination as long as the plan ensures that CBO care coordination staff and supervisors meet all standards in the model contract and federal conflict of interest requirements, particularly in the area of functional eligibility assessments. Partnering organizations may include, but are not limited to, Centers for Independent Living (CILs), Community Services Boards (CSBs), Area Agencies on Aging (AAA), adult day health care centers, health systems, and nursing facilities.[1] Plans must submit to the state prior to implementation, upon revision, or upon request, a detailed description of any innovative partnership(s), the type and scope of the partnership(s), specific services and/or functions to be carried out through or in tandem with the partnership, geographic area(s) served, the number of members expected to be served and related value based payment incentives. The report must further explain the extent of the partnership(s) (e.g., contract signed, in negotiations, etc.). *Electronic care coordination system*—MCOs must utilize an electronic care coordination system that maximizes the opportunity to share and integrate data and information among the plan its multiple service areas, helplines, providers, members, and care coordinators quickly and efficiently. The system should allow staff (e.g., customer service, nurse helpline, medical management) who may be contacted by a member regarding care coordination to have immediate access to the most recent case-specific information within the MCO's electronic system. MCOs must focus on the PCP relationship as the member's provider "health home." This strategy will promote one provider having knowledge of the member's health care needs, whether disease specific or preventive care in nature. MCOs must ensure that PCPs	

[1] Centers for Independent Living (CILs) are non-residential centers operated by people with disabilities that provide advocacy, peer counseling, independent living skills training, information and referral, and transition services for youth, people living in institutions, and services that prevent institutionalization for people with disabilities. Community Service Boards (CSBs) provide supports to individuals with mental health challenges, substance use disorders and I/DD. CSBs provide support coordination/case management for individuals who wish to transition from an institution to the community with the state's I/DD waivers. Area Agencies on Aging (AAA) provide advocacy and training and education services for older adults, individuals with disabilities, caregivers and communities in need of supports and services.

	are educated regarding their responsibilities.	
Network Adequacy	MCOs must ensure that they develop and maintain an adequate network of qualified providers to meet the non-waiver integrated care needs of I/DD members through a person-centered delivery model. Plans must provide members with at least two providers for each type of service listed below: • Primary care provider (PCP) • Pediatrician • Specialist • Outpatient behavioral health • Psychosocial rehabilitation, day treatment/intensive outpatient, and therapeutic day treatment • Nursing facility • Pharmacy • Ob/Gyn Plans must also provide members with at least one provider for adult day health care and hospital services. The state has set member time and distance standards for PCPs and other providers, including specialists, for urban and rural counties throughout Virginia. For members in urban counties, time distance standards range from 15-30 miles/30-45 minutes for PCPs and 30-60 miles/45-75 minutes for other providers, including specialists. For members in rural counties, the time and distance standards are 30 miles/45 minutes for PCPs and 60 miles/75 minutes for other providers, including specialists. Plans must report any network deficiencies as soon as possible and no later than within five business days and request an exemption to the state network standards for any circumstance whereby the plan is unable to meet the state's network time and distance standards. Such a request may be granted only in circumstances where there exists a shortage of the number of providers in a specialty practicing in the region (i.e., provider shortage area). MCOs must establish a system to monitor their provider network to ensure that the state's access standards are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must provide a quarterly report by provider type that demonstrates to the state that these access standards are being continuously monitored by the MCO.	Section 8.2 Section 9.17 Section 9.2
Dental Services	Dental services are carved out of CCC Plus.	Section 4.11
Optical Services	MCOs must cover vision services, including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Plans must also cover eyeglasses for children under age 21. The MCO's benefit limit	Summary of Covered Services – Part 1 – Medical Benefits

	for routine refractions must not be less than once every 24 months.	
Workforce	Many CCC Plus program services are provided in the member's home. Plans must ensure that CCC Plus providers who are not located in the city/county of the member's residence are willing and able to service residents of that city/county. The state acknowledges that recruiting and retaining agency- and community-based LTSS providers may be challenging due to low pay, limited benefits, and transportation costs. Urban areas generally have the advantage of public transportation systems. However, the distances workers have to travel, variable gas prices, other costs associated with automobile ownership, seasonal road and weather conditions, and serving fewer individuals per day due to travel time can present challenges in rural areas. Therefore, the state encourages MCOs to consider implementing creative solutions such as: carpooling, scheduling based on geography, reimbursing workers for mileage expenses, arranging with rental companies to rent fuel-efficient cars for workers to use, etc., in rural areas.	Section 9.14
Plan Rates	MCOs are reimbursed by the state on a capitated basis for all covered services all associated administrative costs, pending any final recoupments, reconciliation, or sanctions. The state utilizes either FFS claims data or MCO encounter data to calculate PMPM costs from a two-year base period, and then adjusts for any policy and program changes between the base period and the rate year and apply a trend to the base data to accurately reflect any increase in costs expected to be incurred during the rate year. *MLR*—As required by federal regulations, Virginia has imposed an MLR of 85%. MCOs that fail to meet the MLR are required to repay funds to the state. The MLR is determined as the ratio of incurred claims plus expenditures for activities that improve health care quality, plus expenditures on activities to comply with certain program integrity requirements, divided by adjusted premium revenue.	Section 19.8 Section 19.10
Value-Based Payment Arrangements	Beginning in 2021, MCOs will be required to meet state-set VBP targets for the total portion of medical spending.	Section 13
Employment	Individuals on one of the DD waivers can access the following employment services available through the waiver: • *Individual supported employment* is provided to an individual in work settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment. • *Group supported employment* provides continuous staff support in a naturally occurring place of employment to groups of two to eight individuals with disabilities and involves interactions with the public and coworkers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group supported employment must be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace.	Services Available Under the DD Waivers

	• *A benefit planning service* is an individualized analysis and consultation service provided to assist individuals receiving waiver services and social security benefits (SSI, SSDI, SSI/SSDI) to understand their benefits and explore the possibility of work, to start work, and the effect of work on local, state, and federal benefits. • *Employment & community transportation* enables individuals to gain access to an individual's place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available. • *Workplace assistance services* are supports provided to someone who has completed job development and completed or nearly completed and job placement training (i.e., supported employment) but requires more than typical job coach services to maintain stabilization in their employment.	
Assistive Technology	Individuals on the DD waivers can access the assistive technology benefit through the waivers. The benefit is limited to $5,000 per year. Assistive technology is defined as specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the Medicaid state plan that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.	Services Available Under the DD Waivers
Utilization Management	The MCO's UM program must reflect the UM standards from the most current NCQA accreditation standards. The UM program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles. The MCO may subcontract for UM responsibilities. At initial contract, annually, upon revision (if any) and upon request, MCOs must submit all applicable policies and procedures to the state for review regarding their UM program. The policies and procedures must include procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of services. Plans must use the state's service authorization criteria or other national standard(s) approved by the state in making medical necessity determinations. The plan's authorization process for LTSS must be based on a member's current needs assessment and consistent with the member's ICP. Coverage decisions for LTSS must be provided in a manner that supports a participant in their ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). MCOs must cover appropriate LTSS based on needs identified through the uniform assessment instrument (UAI), other comprehensive assessments, and subsequent level of care reviews. Plans have the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope, if the ICP determines that such authorization would provide sufficient value to the member's care. Value will be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the member in the least restrictive setting with reduced reliance on emergency department use, acute inpatient care and institutional LTSS. MCOs must report LTSS service reductions, suspensions, or terminations to the state on a monthly basis. The state reviews a sample of the MCO's LTSS plans of care that include a reduction, suspension, or termination in	Section 6.0 Section 10.10

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<td>personal care and/or private duty nursing services to ensure that reductions, suspensions and terminations were done appropriately.

An MCO must utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations. The QI activities for the UM program must include:

• Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue medically necessary services;
• At least one designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one designated behavioral health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of LTSS representative of the plan or subcontractor, with substantial involvement in the UM program; and
• A written document that delineates the structure, goals, and objectives of the UM program and that describes how the plan utilizes QI processes to support its UM program. Such a document may be included in the QI description, or in a separate document, and must address how the UM program fits within the QI structure, including how the plan collects UM information and uses it for QI activities.</td>
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<tr>
<td>Enrollee Protections</td>
<td>Failure to pay—MCOs, and their participating providers, are prohibited from denying any covered service to a member for failure or inability to pay any applicable charge or where the member, who, prior to becoming CCC Plus program eligible, incurred a bill that has not been paid.

At the time of the MCO's contract implementation, at revision, or upon request, plans must provide written policies and procedures to assure that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all covered services from the MCO. Plans must accommodate all members and ensure that the programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities.

Provider access—MCOs must establish a system to monitor its provider network to ensure that the access standards are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must provide a quarterly report by provider type that demonstrates to the state that access standards are being continuously monitored by the MCO and that standards have been met.

Provider terminations—In all cases of termination of the MCO's contract with the state, the plan is responsible for notifying its network providers about the termination of its contract and about the reassigning of its members by the state to other MCOs and for covering the costs associated with such notification. The MCO must conduct these notification activities within a time frame established by the state.</td>
<td>Section 9.16
Section 9.17
Section 11.7
Section 11.8
Section 21.4.6</td>
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	Member Advisory Committee—MCOs must establish a Member Advisory Committee to provide regular feedback to the plan on issues related to the CCC Plus program management and member care. Plans must ensure that the Member Advisory Committee meets at least quarterly and is comprised of a reasonably representative sample of the LTSS members, or other individuals representing members including family members, independent advocates and other caregivers that reflect the diversity of the CCC Plus program population, including individuals with disabilities and individuals residing in NFs. MCOs must advise all members of this Committee and provide a procedure for interested members, family members, independent advocates, and other caregivers to participate. The state reserves the right to review and approve Committee membership. Plans must include Ombudsman reports in quarterly updates to the Member Advisory Committee and participate in all statewide stakeholder and oversight meetings as requested by the state.	
Plan Selection	CCC Plus has an enrollment lock in, which limits the ability of members to change MCOs to once annually. Members are permitted to change MCOs without cause during the initial 90 days following enrollment in a health plan. However, this 90-day time frame applies only to the individual's initial enrollment and does not reset or apply to any subsequent enrollment periods with a different MCO. After the initial 90-day period, members are only permitted to disenroll for cause. Members can also disenroll without cause during the annual open enrollment period.	Section 3.2.15
Provider Protections	*Timely filing*—The plan's timely filing requirements for all providers (in and out-of-network) cannot be less than three months and not more than 12 months from the date of service. If the member has other coverage, the timeframe for submission would begin on the date of payment from the primary payer. *Benchmark rates*—Plans must ensure LTSS services are reimbursed at no less than the current Medicaid FFS rate. In the absence of an agreement between the MCO and the provider, the MCO must pay out-of-network providers, including out-of-state providers, at the prevailing state rate in existence on the date of service. *Provider relations*—MCOs must provide adequate resources to support a provider relations function to effectively communicate with existing and potential network providers. Plans are also required to establish and conduct ongoing provider education and trainings to assist in contracting with qualified providers that meet the MCO's requirements and with whom mutually acceptable provider contract terms, including rates, are reached. MCOs must offer technical assistance to all CCC Plus program providers (in and out-of-network) related to their members' care. Technical assistance includes activities such as: needs assessments; trainings (e.g., billing, credentialing, service authorizations, etc.); direct one-on-one support/assistance; and, facilitating sharing of best practices.	Section 12.1.1 Section 12.2 Section 12.4 Section 12.4.14 Section 21.4.5
Telehealth	MCOs are required to encourage the use of telehealth and provide coverage for telemedicine and telehealth services as medically necessary, at minimum equal to the amount, duration, and scope that is available through the Medicaid fee-for-service program, as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in	Section 4.9 State Telehealth Laws & Reimbursement Policies, Center for

	care, increase access to and/or enhance existing services, and increase timely interventions.[2]	Connected Health Policy, 2019
Self-Direction	Individuals on two of the state's three DD waivers have the option to choose self-direction for their respite services, personal assistance services, and companion services (companions assist or support the individual with such tasks as meal preparation, community access and activities, light housekeeping, laundry, and shopping). The case manager for waiver services is responsible for explaining the consumer-directed program and informing the individual and family/caregiver that self-direction involves the hiring, training, supervision, and termination, if necessary, of consumer-directed assistants. Individuals selecting services through the consumer-directed model may choose a Medicaid-enrolled services facilitator (SF) to provide the training and guidance needed to be an employer. The SF completes an assessment for consumer-directed services, a plan for supports, and maintains documentation of services provided as outlined, including documentation of face-to-face visits with the individual at least every six months to ensure appropriateness of consumer-directed services. Specific duties of the individual (or individual's employer of record) as the employer of the care-directed employee include: checking references, determining that the employee meets basic qualifications, training, supervising performance, and submitting time sheets to the state's contracted fiscal intermediary (FI) on a consistent and timely basis. The FI conducts all payroll functions on behalf of the individual, including the requesting and processing of criminal background investigations, payment of assistants, and filing of IRS wage withholdings.	Section 2.1.5 VA Family and Individual Support Waiver
Additional Information	Plans must develop programs and establish partnerships to address social factors that affect social determinants of health (SDOH), which contribute significantly to the cost of care and the member's health care experience. Effective July 1, 2019, the state encourages MCOs to focus SDOH programs and partnerships on addressing the following priority populations: • Transitions of care – members transitioning from the hospital to the community, from the nursing facility/ICF/IID to the community, and from incarceration to the community • High risk populations – members who are considered high emergency department (ED) utilizers; • Children with asthma • Substance use/opioid use disorders – members with SUD and/or OUD especially pregnant mothers with SUD and/or OUD	Section 10.14

[2] The state's Medicaid fee-for-service program covers the following telehealth services: evaluation and management, psychiatric care, specialty medical procedures such as echocardiography and obstetric ultrasound, speech therapy, and radiology service and procedures. A service specific provider intake meeting may be conducted via telemedicine for psychosocial rehabilitation, partial hospitalization, intensive community treatment, and crisis intervention. Psychotherapy and counseling may be provided via telemedicine in rural areas if the nearest licensed credentialed addiction treatment professional is located more than 60 miles away from the buprenorphine waivered practitioner, or members are having to travel more than 60 miles to the licensed credentialed addiction treatment professional. The state also reimburses for diabetic retinopathy screening through telemedicine for Medicaid members with Type 1 or 2 diabetes. Radiology related procedures are also included under telemedicine coverage, as well as certain codes for teledermatology. Face-to-face encounters for home health services may occur through telehealth.