COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

January 19, 2016

Ms. Victoria Wachino
Director
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

Dear Vikki,

Please find enclosed, Virginia's formal submission of a §1115 Demonstration Waiver. The waiver application is the product of months of dialogue among the Department of Medical Assistance Services (DMAS), stakeholders, and your staff at the Centers for Medicare and Medicaid Services (CMS). Governor McAuliffe is keenly interested in a successful application, and supports DMAS' desire to implement the initiatives outlined in the document. We understand that the submission of a §1115 waiver is the beginning of a dialogue and negotiation period, and we look forward to working with your team in the coming months.

Virginia's §1115 waiver demonstration application seeks authority to implement two strategic initiatives: (1) Medicaid Managed Long Term Services and Supports (MLTSS) and (2) the Delivery System Reform Incentive Payment (DSRIP) program. Alignment of MLTSS and DSRIP creates a powerful opportunity to strengthen and integrate Virginia Medicaid's community delivery structure and accelerate payment reforms toward value-based payments. As part of the MLTSS initiative, DMAS seeks to streamline administration of two waiver authorities by transitioning the administrative authority of these §1915(c) HCBS waivers to a §1115 waiver. The proposed migration of waiver authority will not alter eligibility or services under these waivers. The waivers included are the Elderly or Disabled with Consumer Direction (EDCD) and Technology Assisted Waiver (Tech).

DMAS recognizes that the Medicaid spending trajectory must change and the best opportunity to accomplish this is through delivery system transformation. To that end, the Department has committed to: "Think Big, Start Focused, and Scale Fast." You will find the proposal to be deliberate and scalable, ensuring broad impact across the Medicaid program.

The willingness of your staff to discuss elements of our proposal demonstrates your leadership and commitment in supporting states in their pursuit of stronger Medicaid programs. We understand the due diligence needed in reviewing the application and ask that you and your staff be in touch any time when you need clarity or more information. DMAS values the partnership we share and we are ready to work with you to achieve Medicaid system transformation in Virginia.

Sincerely,

[redacted]

Cynthia B. Jones
Director

INNOVATIVE, FOCUSED AND SCALABLE DELIVERY SYSTEM TRANSFORMATION: VIRGINIA'S SECTION 1115 WAIVER APPLICATION

A Demonstration Waiver Application for Medicaid Managed Long-Term Services and Supports (MLTSS), Delivery System Reform Incentive Payment (DSRIP), and transition of authority for existing HCBS Waivers: Technology Assisted and Elderly and Disabled with Consumer Direction

Contents

Executive Summary

The Department of Medical Assistance Services (DMAS) is submitting a §1115 waiver demonstration application seeking authority to implement two strategic initiatives: (1) Medicaid Managed Long-term Services and Supports (MLTSS) and (2) the Delivery System Reform Incentive Payment (DSRIP) programs. Alignment of the MLTSS and DSRIP programs creates a powerful opportunity to strengthen and integrate Virginia Medicaid's community delivery structure and accelerate payment reforms toward value-based purchasing.

This comprehensive innovation waiver gives the Centers for Medicare and Medicaid Services (CMS) the opportunity to invest in a waiver program that will accelerate transformation of how care is delivered and paid for in Virginia's Medicaid system. Through this application, DMAS seeks to ensure that high-value care is the norm and even the most medically complex enrollees with significant behavioral, physical, sensory, and developmental disabilities are supported to live safely and thrive in the community. DMAS has partnered with Department of Behavioral Health and Developmental Services (DBHDS), Virginia Department of Health (VDH), Department for Aging and Rehabilitative Services (DARS), and numerous other stakeholders to develop program ideas and will leverage their expertise to achieve sustainable transformation.

DMAS recognizes that the Medicaid spending trajectory must change and the best opportunity to accomplish this is through delivery system transformation. Historically, states could address increases in spending by cutting payment rates, services, and people covered. In the 1990's DMAS looked to managed care to achieve budget predictability and improve care delivery. Managed care has been extremely successfully in Virginia for close to two decades. During this time, however, Virginia had few opportunities to invest in how care is delivered at the provider-level. This demonstration waiver presents an exceptional opportunity for DMAS to further the goal of bending the cost curve through both expanding managed care's footprint in Virginia and investing in Medicaid providers. This includes improving coordination between providers and preparing them to be paid for the high-value care they provide- not just the volume of patients they see or procedures they do. To achieve transformation, the Department has committed to: "**Think Big, Start Focused, and Scale Fast**."

The plans outlined in the following proposal aims to transform the Virginia Medicaid system by transitioning to a coordinated MLTSS program and incenting high-quality and high-value care through the advancement of value-based purchasing models. The DSRIP program initially focuses on the portion of the Medicaid delivery system that is the most significant cost driver for the program and then scales to include the broader Medicaid population through inclusion of Affiliate Providers. If approved, DMAS will invest in provider infrastructure and supports in order for providers, payers, and the Department to succeed in the shift toward a new model of care and Medicaid payment models.

DMAS is confident in this approach and hopes CMS partners appreciate this waiver application that focuses on high-touch, coordinated care and the proliferation of value-based payment methodologies to sustain the model of care delivery. The two focus areas of this application include MLTSS and DSRIP.

1. **MLTSS**: MLTSS will build on the foundation of Virginia's Medicare-Medicaid enrollee financial alignment demonstration - Commonwealth Coordinated Care (CCC). CCC was Virginia's first opportunity to coordinate care for the high-risk dually eligible population and CCC activities in the areas of systems integration, contract and quality monitoring, outreach, and program

evaluation have been nationally recognized as best practices. Virginia seeks to strengthen this model through including additional populations and operating the program statewide. Virginia seeks authority to mandate the enrollment of eligible individuals into selected managed care plans. These plans will be competitively selected to ensure access to services and high-quality care. The populations enrolled and services included in two home and community-based service (HCBS) waivers will be included in the MLTSS program[1]. The MLTSS program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. MLTSS will operate with very few carved out services. Further, through person-centered care planning, MLTSS health plans will be expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice. DMAS seeks to streamline administration of multiple waiver authorities by transitioning the administrative authority of these §1915(c) HCBS waivers. The proposed migration of waiver authority will alter neither eligibility nor services under the included HCBS waivers: Elderly or Disabled with Consumer Direction (EDCD) and Technology Assisted Waiver (Tech).

2. **DSRIP:** A DSRIP Program in Virginia will provide funding to support provider readiness for value-based payments and optimally serve Virginia Medicaid's most complex enrollees through strengthening and better integrating the provider community. In order to achieve this, Virginia's Medicaid providers need to be better equipped to share information and integrate clinically to achieve better care, realize efficiencies, and be prepared for value-based payments. The DSRIP Program includes support for the establishment of groups of high-performing providers known as Virginia Integration Partners (VIPs). VIPs will share and integrate: care, data, processes, and communication. Initially, this will enable the Medicaid program to better offer high-touch, person-centered care for its highest utilizers and highest-risk enrollees. VIPs will partner with our managed care organizations to improve the coordination of care for the Commonwealth's high-cost enrollees and transition to new payment models. VIP partnerships will include medical, behavioral health, and long-term services and support (LTSS) providers, and also include care navigation and supports. Health systems focused on addressing enrollees' complex needs will coordinate the VIPs. Funds to support the establishment of VIPs and initial processes will be obtained through achievement of process and outcome measures. VIPs will achieve ongoing sustainability through transition to alternative payment models. In demonstration year three, DMAS will work with contracted health plans and additional providers to scale the DSRIP Program. This will include launching and supporting the transition of additional providers, known as Affiliate Providers[2], to alternative payment models for individuals who are not receiving care through a VIP. Payment models will be developed through a collaboration of contracted health plans, providers, and DMAS.

---

[1] Individuals enrolled in the Intellectual Disability, Developmental Disability, and Day Support waivers will continue to receive their HCBS through Medicaid fee-for-service until the Virginia Department of Behavioral Health and Developmental Services completes the redesign of these waivers. Individuals residing in ICF-ID facilities will be excluded from MLTSS until after the completion of the redesign.

[2] These providers will not be part of that coordinating entity's VIP, as they do not focus on providing services for a subset of the Medicaid population with the most complex care needs. However, they will leverage the infrastructure developed by the DSRIP Program to be ready for value-based payment arrangements with Medicaid health plans.

Program Description

Virginia is accelerating transformation of its Medicaid delivery system to ensure that high-value care is the norm and even the most medically complex enrollees with significant behavioral, physical, sensory, and developmental disabilities are supported to live safely and thrive in the community. To begin this process, the Virginia Department of Medical Assistance Services (DMAS) is seeking approval of a demonstration project under §1115 of the Social Security Act (Act) to implement two strategic initiatives. Alignment of the following initiatives creates a powerful opportunity to strengthen and integrate Virginia Medicaid's community delivery structure and accelerate a shift toward value-based payment.

1. Medicaid Managed Long-term Services and Supports (MLTSS); and,
2. Delivery System Reform Incentive Payment (DSRIP).

As part of the MLTSS initiative, DMAS seeks to streamline administration of multiple waiver authorities by transitioning the administrative authority of two §1915(c) home and community-based service (HCBS) waivers to a §1115 waiver. Transitioning the authority for these §1915(c) waivers is administrative. This application predominantly focuses on the MLTSS and DSRIP initiatives, therefore the specifics of the §1915(c) authority migrating to §1115 authority will only be referenced in select, applicable sections of this waiver application.

- **MLTSS:** MLTSS will leverage the successes of Virginia's Medicare-Medicaid enrollee financial alignment demonstration-Commonwealth Coordinated Care (CCC). Virginia seeks to strengthen this model, expand it to additional populations, and operate it statewide. Additionally, Virginia seeks authority to mandate enrollment of eligible individuals into competitively selected managed care plans.

  DMAS seeks to streamline administration of multiple waiver authorities by transitioning the administrative authority of these §1915(c) HCBS waivers to a §1115 waiver. The waivers included are the Elderly or Disabled with Consumer Direction (EDCD) and Technology Assisted Waiver (Tech). The proposed migration of waiver authority will alter neither eligibility nor services under these waivers. The populations enrolled and services included in these HCBS waivers will be included in the MLTSS program.

- **DSRIP:** The DSRIP Program will provide funding to support provider readiness for value-based payment and optimal service to Medicaid's most complex enrollees through strengthening and better connecting the provider community. DSRIP includes support for the establishment of groups of high-performing providers known as Virginia Integration Partners (VIPs). VIPs will share and integrate: care, data, processes, and communication. VIPs will partner with DMAS' managed care plans in order to improve the coordination of care and overall health of the Commonwealth's high-cost enrollees. This will enable the Medicaid program to better offer high-touch, person-centered care for its highest utilizers and highest risk enrollees. These partnerships will include medical, behavioral health, and long-term services and support (LTSS) providers, and also include care navigation and supports. Health systems focused on addressing enrollees' complex needs will coordinate the VIPs. Funds to support the establishment of VIPs and initial processes will be obtained through achievement of outcome measures. VIPs will achieve ongoing sustainability through transition to alternative payment models. In demonstration year 3, the DSRIP Program will launch and support the transition of additional providers, known as Affiliate Providers, to alternative payment models for individuals who are not already receiving care through a VIP. Alternative payment models will be developed in collaboration with contracted Medicaid health plans.

Rationale for the §1115 Demonstration Waiver

Background

The Virginia Medicaid program covers over 1,000,000 individuals as described in Figure 1. Seventy-five percent of enrollees receive care through contracted health plans and twenty-five percent of enrollees receive care through a fee-for-service arrangement. The majority of enrollees in the Virginia Medicaid program are children, pregnant women, and caretaker adults. These enrollees are relatively healthy. Virginia pays an average monthly capitated payment for each enrollee's services (a "per-member, per-month" (PMPM)) of $234, translating to an annual payment of $2,808.

Also included in Virginia's Medicaid population are over 200,000 individuals who are included in the Aged, Blind, and Disabled (ABD) coverage group. Out of the 200,000 individuals who are in the ABD group, 80,000 enrollees are in capitated health plans with an average monthly cost around $1,100 PMPM, an annual payment around $13,200. This spending amount for ABD enrollees, however, does not include costs for expensive long-term services and supports (LTSS) for this population and it does not include the costs for the subset of ABDs who are also enrolled in Medicare. Approximately 115,000 ABDs are Medicare-Medicaid enrollees where Medicare pays for the vast majority of their medical costs, and Medicaid pays for the majority of their long-term services and supports through fee-for-service.

Long-term Services and Supports (LTSS): A disproportionate share of Virginia's Medicaid spending is allocated toward enrollees who receive LTSS. This population is only 6% of enrollment, yet accounts for 30% of total Medicaid expenditures. The majority of LTSS recipients are also enrolled in Medicare, so the majority of this Medicaid spending is for LTSS and not medical services. In 2014, 56% of Virginia's LTSS expenditures were for

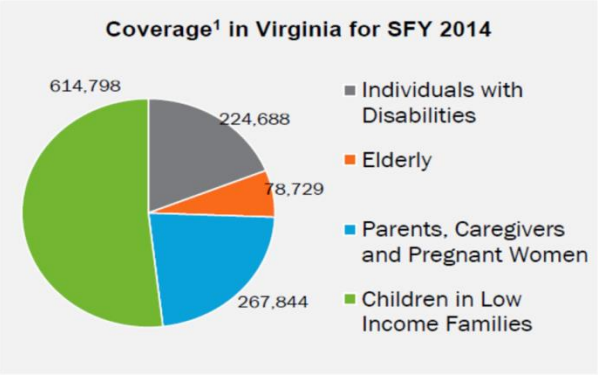

Figure 1 – Virginia Medicaid Enrollees

home and community based services (HCBS). Two-thirds of Virginians accessing LTSS, now do so in the community. Virginia, however, still has a significant opportunity to improve its LTSS delivery system. In 2014, Virginia spent close to $1.1 billion of its $7.8 billion total Medicaid spend on institutional care (public and private ICF/IDs and nursing homes).

In March 2014, Virginia launched the Commonwealth Coordinated Care (CCC) program. CCC is a Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Financial Alignment Demonstration. These demonstrations seek to test models to integrate Medicare and Medicaid services, rules, and payments under one delivery system for individuals who are eligible for both Medicare and Medicaid (dual eligible individuals). CCC operates as a managed care program with three health plans and includes a strong, person-centered service coordination/care management component, integration with an array of provider types for continuity of care, ongoing stakeholder participation, outreach and education, and the ability for innovation to meet the needs of the population.

CCC will operate through December 31, 2017, in five regions of the state (Tidewater, Central Virginia, Northern Virginia, and the Roanoke and Charlottesville areas). At of the end of November 2015, there were 67,327 Virginians eligible for CCC. Of those eligible, 29,429 have opted to participate in the voluntary program.

Behavioral Health: Similar to many other states, building the infrastructure to deliver the highest quality behavioral health services in the community continues to be a challenge for Virginia. Behavioral health services that are typically offered to a commercial population are currently offered through Virginia's contracted health plans. Community based behavioral health services, those services that are more typically accessed by the Medicaid population, are administered through a contracted behavioral health services administrator (BHSA) and offered through a variety of public and private providers. In the early 2000's states began a strong effort to strengthen their home and community-based service offerings. Coupled with this move were federal policy shifts that required that Virginia's behavioral health services be opened up to allow private providers the opportunity to administer services. Virginia implemented changes without substantially strengthening state regulatory, policy, and oversight requirements. This resulted in some providers taking advantage of the Medicaid program. Ultimately, Virginia's Medicaid funded behavioral health expenditures increased by 400% over 10 years. In a desire to ensure that individuals were receiving high-quality care, and providers were appropriately qualified, DMAS worked with the legislature and the Department of Behavioral Health and Developmental Services to overhaul licensing qualifications and processes for providers and implemented a pre-screening requirement for select mental health services to ensure a stronger program. Virginia also contracted with a BHSA to administer the community behavioral health services component of the Medicaid program. Virginia is now realizing improved outcomes as a result of the BHSA arrangement. DMAS has realized a decrease in psychiatric inpatient admissions and an increase in follow up care upon discharge. Spending on institutional mental health services has remained relatively steady over the past five years. In 2014, $136 million was spent on institutional services (state and private psychiatric hospitals and psychiatric residential treatment facilities) and in contrast spending for community-based mental health was just under $600 million. Virginia aspires to continue expanding the community-based behavioral health service delivery system and further reduce the costs of institutional psychiatric services.

The Case for a Unified Waiver Approach

Virginia is applying for a §1115 Waiver to operate its MLTSS and DSRIP Programs. Working in tandem, the authority granted through this §1115 Waiver will not only enable Virginia to create a better system of service provision for Medicaid beneficiaries, but also to strengthen the relationships among the providers and support networks that care for them.

Virginia has worked for decades to put policies in place that support community living and community choice for Medicaid beneficiaries. While significant progress has been achieved, opportunities to improve remain. This waiver program will enable providers, community support organizations, and Medicaid managed care organizations (MCOs) the opportunity to better coordinate and integrate member care. DMAS fully anticipates that if granted waiver authority, Virginia will be able to transform the current delivery system, support providers, MCOs, and DMAS in the design and implementation of value-based payment arrangements and drive innovation that yields better Medicaid beneficiary care and bends the Medicaid spending curve.

Managed Long-term Services and Supports (MLTSS) and the Need for Operational Authority

The 2013 *Virginia Acts of Assembly* directed DMAS to work toward the inclusion of all remaining Medicaid populations and services, including long-term care and home and community based waiver services into cost-effective, managed and

coordinated delivery systems.[3] The 2015 *Virginia Acts of Assembly*, (Item 301.TTT) again directed DMAS to further advance principles of care management to all geographic areas, populations, and services under programs administered by the Department. These legislative directives demonstrate strong state level support for better integrated and coordinated care. Building off of the successes of the CCC demonstration, DMAS is seeking authority through this §1115 waiver to meet the stated objectives of the Virginia legislature by creating a mandatory managed care program through the selection of qualified Managed Care plans who are also committed to being certified as a Dual Eligible Special Needs Plan (D-SNP) in Virginia. As a result, Virginians can continue leveraging the benefit of coordinating Medicare and Medicaid services for dually eligible beneficiaries.

Throughout this application, MLTSS refers to the delivery of long-term services and supports, including both HCBS and institutional-based services, and behavioral health through capitated Medicaid managed care plans. MLTSS programs provide an opportunity to create a seamless, integrated health services delivery program. Some of the goals of MLTSS include:

- Improved quality of life, satisfaction, and health outcomes for individuals who are enrolled;
- A seamless, one-stop system of services and supports;
- Service coordination that provides assistance in navigating the service environment, timely and effective transfer of information, and tracking of referrals and transitions to identify and overcome barriers;
- Care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and includes individuals and family members in decision making using a person-centered model;
- Support for transitions between service/treatment settings;
- Facilitation of communication among providers to improve the quality and cost effectiveness of care;
- Arrangement of services and supports to maximize opportunities for community living; and,
- System-wide quality improvement and monitoring.

Streamline HCBS Waiver Authority

As previously mentioned, DMAS proposes to transition the authority for two §1915(c) waivers (Elderly or Disabled with Consumer Direction (EDCD) and Technology Assisted Waiver (Tech). After much review and discussion of other state's experiences, streamlining the waiver authority for these waivers will simplify and reduce the administrative burden in preparing multiple waiver reports and cost neutrality/effectiveness calculations.

DMAS fully recognizes the requirements of home and community-based services and commits to adhering to all rules, including the Home and Community Based Services settings rule (fully, from day 1) with the transition to the §1115 authority. In accordance with 42 CFR §441.302, Virginia provides all assurances to CMS. Assurances for the EDCD and Tech Waivers include:

A. Health and Welfare
B. Financial Accountability
C. Evaluation of Need
D. Choice of Alternatives
E. Average Per Capita Expenditures
F. Actual Total Expenditures
G. Institutionalization Absent Waiver
H. Reporting
I. Habilitation Services; and,
J. Services for Individuals with Chronic Mental Illness

[3] (Item 307.RRRR.4. - http://lis.virginia.gov/131/bud/hb1500chap.pdf).

Additional requirements of the 1915(c) Waivers will be adhered to, as detailed in the 1915(c) applications. Those requirements include:

A. Service Plan
B. Inpatients
C. Room and Board
D. Access to Services
E. Free Choice of Provider
F. FFP Limitation
G. Fair Hearing
H. Quality Improvement
I. Public Input
J. Notice to Tribal Governments; and,
K. Limited English Proficient Persons

All requirements are adhered to in the same way with the exception of (I) Public Input. Depending on the targeted waiver population, the stakeholders engaged for public input differs. All details are currently accessible through the approved 1915(c) applications available on the CMS Demonstrations and Waivers website.

Delivery System Reform Incentive Payment (DSRIP) and the Need for Infrastructure

Over the past two decades, the Commonwealth of Virginia has been committed to a vision of community transformation. Together, with federal, state, and community partners, the Commonwealth has work to transform the community by investing a significant amount of time and effort to rebalance the cultural paradigm and funding from institutional living to *One Community,* where all individuals, regardless of ability, disability, or age, can live full lives. DSRIP will facilitate a final push to establish a system where quality and value are incented, member care is fully integrated, and coordination across the health, behavioral health, substance use, long-term services and supports, and other community support providers is the norm.

Virginia anticipates that implementation of MLTSS will move Virginia closer to more streamlined service delivery and higher quality of care for individuals with complex needs. However, a subset of Virginia's Medicaid population has needs so extensive that they will be better served when the MLTSS plans work with a partnership of providers (Virginia Integration Partners) that are fully integrated and share a financial incentive to provide optimal coordinated person-centered care. Virginia's DSRIP Program will support the development of these provider partnerships and the transition to payment models that incent the right care and create lasting culture change making *One Community* a reality for Virginians.

Virginia's Plan to Test the Demonstration Hypotheses: MLTSS and DSRIP

Through this §1115 Waiver, DMAS will test key hypotheses by supporting Medicaid providers and other partners, MCOs, and the Department; preparing Virginia for a shift away from paying for volume toward paying for better care and higher quality through value-based payments. Each effort below will work in parallel with the others listed, to yield a strong foundation upon which the tenants of quality care for Medicaid beneficiaries and value-based purchasing will be built.

Understanding the significant rigor expected in order to test the described hypotheses, DMAS intends to allocate DSRIP funding for the administration and evaluation oversight of this waiver.

Specifics of the evaluation and oversight process will be outlined in the Special Terms and Conditions document developed between DMAS and CMS. At this time, DMAS anticipates recommending a longitudinal mixed method research design to evaluate the MLTSS and DSRIP Programs. Using this design will allow DMAS to examine the MLTSS and DSRIP Programs from multiple perspectives over time.

DMAS and its designated agents will conduct periodic evaluations using both quantitative and qualitative methods. For DSRIP related activities, a

control group will be identified from the existing Medicaid population that could be eligible for VIP membership but are not included due to lack of access to services due to factors such as regional variance.

The evaluations conducted will be used to improve the program and to assess the program's overall impact on various outcomes including, but not limited to, enrollment patterns, beneficiary access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, home health, prescription drugs, nursing facility, and home and community based waiver), and program staff and provider experiences.

As such, the evaluations will include surveys, site visits, and analyses of claims and encounter data, focus groups, key informant interviews, observations, waiver assurance results, reporting records and document reviews. DMAS will work with pertinent stakeholders, including enrollees and their families, participating providers and managed care entities to ensure expectations are clear and reporting requirements are agreed upon.

MLTSS Program Design

To obtain federal authority for this program, including the ability to mandate enrollment into the program, DMAS seeks a waiver of select provisions of §1902(a) as outlined in the required section, "List of Proposed Waiver Authorities and Sections." To implement MLTSS, DMAS will solicit proposals from health plans to enter into fully capitated, risk-based contracts to administer the MLTSS program.

DMAS will test the hypothesis for MLTSS as described in Figure 2 by requiring that selected health plans: (1) employ a multi-disciplinary health care team approach to coordinating and facilitating care using health information technology which provides the necessary information to measure system and member-level outcomes; (2) implement a model of care that consists of health risk assessments, person-centered care planning, interdisciplinary care teams, and care management and ensures smooth transitions to and from hospitals, nursing facilities, and the community; (3) collaborate with community based organizations and other community partners; (4) develop and maintain a provider network that is adequate to meet the needs of the individuals covered within the scope of MLTSS; (5) collaborate with providers to develop innovative, value-based payment arrangements where reimbursement is based on high-quality outcomes; (6) measure and assess quality, outcomes, processes, and costs in partnership with the state and accept joint accountability for system performance; and (7)

Hypothesis for MLTSS	
Requiring a coordinated system of care that focuses on improving access, quality, and efficiency will:	Improve the quality of care and quality of life for Medicaid beneficiaries
	Reduce service gaps with focused attention on individuals with complex needs (such as individuals with disabilities, multiple chronic conditions, and/or serious mental illness)
	Provide coordination between physical health, behavioral health, and LTSS, as well as collaboration with social and community providers
	Facilitate the opportunity to build value based payment strategies where providers are incented and rewarded for providing high-quality care

Figure 2 – MLTSS Hypothesis

provide services and supports that are culturally competent and sensitive to the needs of Virginia's Medicaid population.

Additionally, DMAS will require that selected plans achieve status as a Dual Eligible Special Needs Plan (D-SNP) in the localities in which the plan is selected to provide services. It will be expected that the plans work with DMAS to align, whenever possible and within Medicare rules, the enrollment of the dual eligible members in the same plan for both Medicare and Medicaid services. Selected plans will contract with DSRIP integrated provider partnerships (VIPs), where geographically available, to provide an even greater level of coordinated services to individuals who are most complex or high risk.

Initially, MLTSS will include approximately 50,000 dual eligible members. In addition, approximately 20,000 non-duals who receive long-term services and supports will be enrolled in MLTSS. Individuals currently eligible for CCC (approximately 67,000) will be enrolled in MLTSS upon CCC's end date in December of 2017.

Understanding the complexities of this population, the Department is proposing to utilize strategies reflected in the hypothesis, through an integrated benefit design where services will include primary and acute services, long-term services and supports, and behavioral health (including substance use disorder) services. Care coordination is critical and will be a cornerstone of the program. Health plans will be selected through a competitive procurement process. Finally, the program will be phased in to assure diligence and focused attention on the Medicaid members.

DMAS will utilize data sources including Medicare and Medicaid claims and encounter data. Data specifications will be outlined in contracts between DMAS contracted managed care entities and providers where applicable.

For the Medicaid population in scope for the MLTSS demonstration, DMAS proposes a phased in approach to enrollment that is expected to begin in March 2017 as discussed in later sections of this application. Once enrolled, individuals will be assigned to a health plan at which time initial assessments will be conducted and care plans determined. MLTSS will focus on improving access, quality and efficiency. It is believed that the MLTSS demonstration will reduce service gaps through focused attention on individuals' needs. Ultimately, the Department's goal is to develop a managed care model that is designed to provide individuals with enhanced opportunities to improve their lives by:

- Promoting long-term care options in community settings;
- Promoting community capacity and supports designed to better enable individuals to thrive in the community; and,
- Providing flexible and innovative benefit plans to serve individuals in their setting of choice.

MLTSS will operate under a fully integrated, person-centered model of care (Figure 3) that enables quality, access, efficiency, and value-based payments. DMAS will expect participating health plans to secure a provider network of both

Model of Care Components
Description of the MLTSS Target Populations – including those that will be attributed to the VIP
Measurable Goals
Staff Structure
Training
Provider Network with Specialized Expertise in the MLTSS Population and Use of Clinical Practice Guidelines and Protocols
Assessments
Interdisciplinary Care Team
Individualized Care Plan
Communication Network
Care Management
Transition Programs

Figure 3 – MLTSS Model of Care

traditional Medicaid providers as well as LTSS providers to enable an integrated and coordinated system of care. The model of care for this population is a significant component of the demonstration. LTSS members have unique and often individualized needs. These are frequently combined with and compounded by other health and social issues. For Medicaid beneficiaries who are eligible for both Medicare and Medicaid, there is great value in being able to coordinate the two programs. MLTSS plans will be required to also offer D-SNP enrollment for Medicare-covered services. Once operational, Medicaid beneficiaries will have the option to choose the same plan for their Medicare and Medicaid coverage achieving care coordination across the full continuum of care. The MLTSS program utilizes a robust benefit package. The benefits include Medical, Behavioral Health, Substance Use Disorder, and Long-term Services and Supports. The full detail of benefits can be found in Appendix A.

Considering the vulnerability of this population and the importance of coordination between Medicaid and Medicare, DMAS will take a stringent approach to the administration of health plan licensure, certification, and accreditation requirements. This strategy as described in Figure 4 will help ensure the highest standard of quality in MCOs. In short, DMAS will require MLTSS MCOs to have appropriate licensure from the Virginia Bureau of Insurance (BOI), Certification of Quality Assurance for Managed Care Health Insurance Plans (MCHIP) Licensees from the Virginia Department of Health, and to obtain health plan accreditation through the National Committee for Quality Assurance (NCQA)

MLTSS will require that health plans work with providers to negotiate value-based payment strategies that financially incent high-quality interdisciplinary care in the right setting, accelerate innovation to create value, and control spending. The value-based payment focus of the MLTSS design will be supported by DSRIP projects, which will prepare providers for the transition to alternative payment models. Initial steps will be taken to evaluate readiness, identify infrastructure needs, and give providers support as they modify business practices and protocols. Final steps will then be taken to implement payment strategies that benefit Medicaid members, providers,

Health Plan Licensure, Certification, and Accreditation	
Dual Special Needs Plan (D-SNP)	MLTSS contracted health plans will be required to operate as a dual special needs plan (D-SNP), through the Center for Medicare and Medicaid Services (CMS) for all localities in which the plan intends to operate within two (2) years of being awarded an MLTSS contract.
Virginia State Corporation Commission's Bureau of Insurance (BOI) Licensure	MLTSS contracted health plans will need to be licensed by the Virginia State Corporation Commission's Bureau of Insurance (BOI), as set forth in the Code of Virginia §38.2-4300 through 38.2-4323, 14 VAC5-211-10 et. Seq. prior to MLTSS contract signing (if selected).
Certification of Quality Assurance	MLTSS contracted health plans will need to have in place an approved Certificate of Quality Assurance from the Center for Quality Health Care Services and Consumer Protection, Office of Licensure and Certification, Virginia Department of Health, pursuant to §32.1-137.1 through §32.137.7 Code of Virginia, and 12VAC5-408-10 et. seq. for all region(s) in which the health plan intends to operate prior to MLTSS contract signing (if selected).
National Committee for Quality Assurance (NCQA) Health Plan Accreditation	Each MLTSS contracted health plan selected will be required to obtain NCQA accreditation for its Virginia Medicaid line of business. Plans who are not NCQA accredited would be required to adhere to DMAS' timeline of milestones for achieving NCQA accreditation. Further, all contracted plans would be required to comply with NCQA guidelines at contract signing, based on the most current version of NCQA Standards and Guidelines for the Accreditation of MCOs. Plans would also be required to comply with and participate in comprehensive onsite reviews at dates to be determined by the Department and must attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to MLTSS members), and obtain NCQA accreditation status of at least "Accredited" within 36 months of MLTSS start date.

Figure 4 – MLTSS Health Plan Licensure, Certification, Accreditation

participating MCOs and the state. DMAS' MLTSS contract with the MCOs will include requirements that MCOs collaborate with providers to meet expectations and benchmarks for value-based purchasing set by DMAS and CMS through the DSRIP waiver.

DSRIP Program Design

DSRIP is a strategic opportunity for Virginia to partner with the federal government to ready providers for value-based payment and improve care delivery while reducing waste and inefficiency. By facilitating shared learning across Virginia, DSRIP initiatives will create a sustainable and robust community-based delivery system. Virginia will leverage DSRIP funding to transform the current system so that Medicaid providers are financially incented to organize and deliver care in a way that results in healthier person-centered outcomes and experience. As a result, Virginia's rate of Medicaid spending will slow down.

Virginia believes the time is now to partner with CMS to transform the Commonwealth's Medicaid delivery system. Providers in Virginia are responding to CMS transformation of Medicare payments and DMAS seeks to capitalize on this momentum. Through stakeholder engagement and departmental expertise, DMAS has identified the following goals included in Figure 5 for DSRIP.

Throughout this application, DMAS utilizes the terms 'High-utilizer' and 'High Risk.' DMAS defines these as stated below:

High-Utilizer: High-Utilizer is the term used to refer to Medicaid beneficiaries who have significant expenses due to above average use emergency departments and inpatient care (hospital, institutional) which may be prevented by less expensive early interventions, social supports, and primary care.

High-Risk: There are two categories of high risk Medicaid beneficiaries.

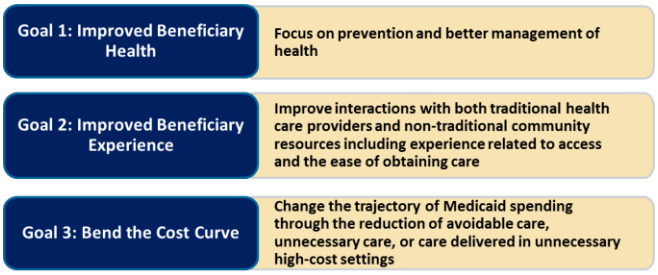

Figure 5 – DSRIP High-level Goals

- Medicaid beneficiaries, who do not engage in the provider community as needed, often do not follow medicine regimens as prescribed, do not follow up with physicians or specialty referrals and often refuse treatment if offered. These individuals often experience an acute episode, that is potentially preventable, and end up in costly inpatient settings. They can also be described as emerging high-utilizers.
- Medicaid beneficiaries who frequently engage the provider community, often unnecessarily, and in high-cost inappropriate places such as the Emergency Department. It is often this subset of high-risk beneficiaries that become high-utilizers

Virginia Integration Partners (VIPs)

The first phase of Virginia's DSRIP proposal will support the creation of high-performing, integrated partnerships known as Virginia Integration Partners. The VIPs will partner with managed care organizations to improve care for the Commonwealth's high-cost enrollees. In coordination with the beneficiaries' managed care plan[4], VIPs will share and integrate: care, data, processes, and communication and provide high-touch, person-centered care for Medicaid's highest utilizers and highest-risk enrollees, as well as emerging high-utilizers (individuals who have the proclivity to become high-utilizers). VIPs will partner with DMAS' managed care plans in order to strengthen the coordination of care and improve overall health for the Commonwealth's high-cost enrollees. These partnerships will include medical, behavioral health, and long-term services and support providers, and will be anchored by strong care navigation and community supports. Health Systems will coordinate the VIPs. Transformational DSRIP goals will be initially achieved by the VIPs.

These partnerships, as shown in Figure 6, will be established through contractual arrangements between high performing public and private providers and include other community supports that are focused on high-touch care coordination. Community supports will essentially be Interdisciplinary Teams (IDTs) inclusive of but not limited to: Health Systems, primary and specialty care providers, Community Services Boards (CSBs,) Federally Qualified Health Centers (FQHCs), Area Agencies on Aging (AAA), Centers for Independent Living (CILS), and schools, where appropriate. The partnerships will also include care navigators, community health workers (CHWs), and other

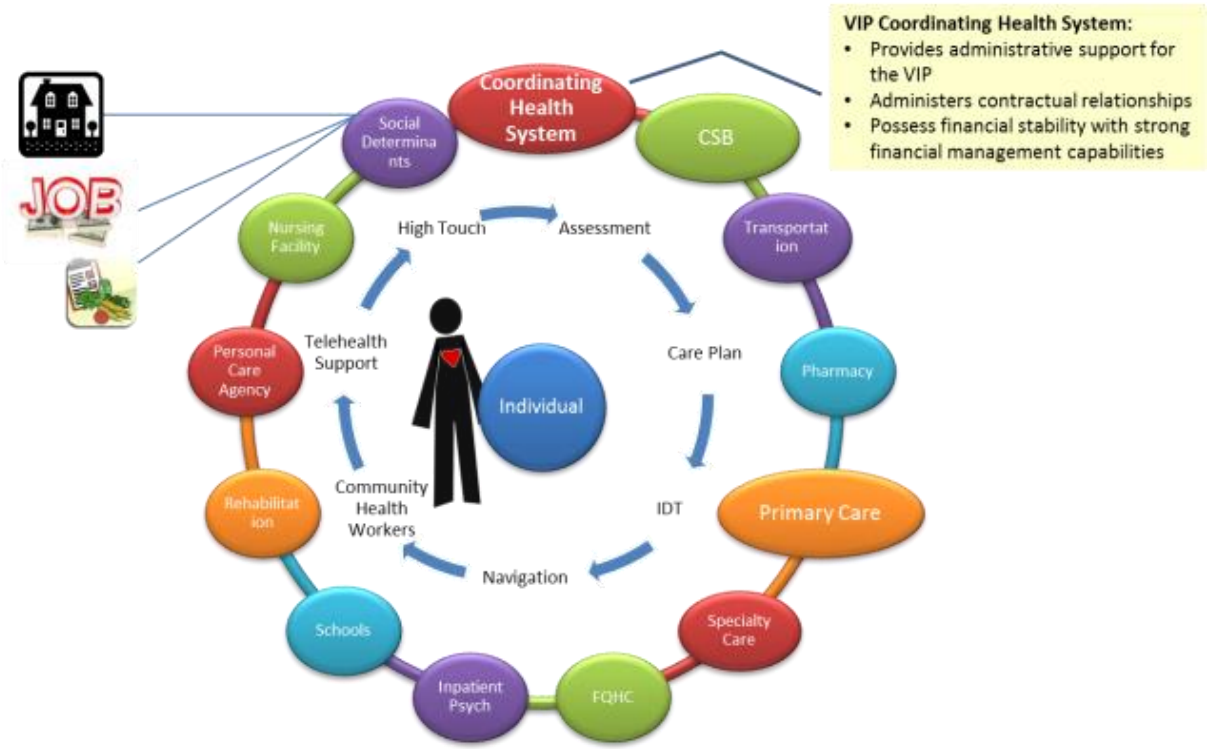

Figure 6 – VIP Partnership Design

[4] The Department fully understands the importance around anti-trust issues as it pertains to the participating health organizations/plans. DMAS will work with plans, providers, and other stakeholders to ensure that contracts respect anti-trust principles while expecting cooperation and partnership.

resources in the community who will help connect the VIP beneficiaries to housing, employment, and nutrition supports. This work will be supported through a robust data driven care management system. These entities will work together to integrate the care and services needed to optimally support individuals with the most complex needs.

DSRIP funding (Figure 7) will be used to support the transition of Medicaid payment methodologies to value-based payment and reimbursement. To achieve this, VIPs will be developed based on seven core components:

1. VIPs will be supported to move to value-based payment arrangements;
2. All VIPs will establish a contractual relationship among VIP partners;
3. All VIPs will participate in data integration;
4. VIPs will select projects and outcome targets from the determined project menu to achieve the DSRIP goals;
5. The number of VIPs in Virginia will be determined by available funding, interest level and commitment;
6. Initially, provider partners will maintain individual provider contracts with the MCOs; and,
7. Ultimately, the VIPs will operate in an alternative payment arrangement with the MCOs such as total cost of care or other sustaining alternative.
8. Each VIP will have a single coordinating entity, a health system that serves in this leadership role. The VIP, however, will be a separate entity from the coordinating health system. Understanding the responsibility of coordination is significant. The coordinating entity will have a contract with DMAS for DSRIP funding, and therefore the entity will be expected to have significant financial management capabilities.

Affiliate Providers

Affiliate Providers will work with the coordinating entity of a VIP to access DSRIP resources. These providers will not be part of that coordinating entity's VIP, but will use DSRIP resources to be positioned to enter into other value-based payment arrangements with Medicaid health plans. These providers will be seeking support for their transition to value-based payment, but are not in the position to take on risk-based payments within the next several years. They will be able to access resources to enhance their data infrastructure and participate in shared learning and educational resources that will enable their transition to value-based payment.
Affiliate Providers will be supported to transition to value-based payment arrangements with health plans and will contribute to the fundamental goal of bending the cost curve.

Think Big, Start Focused, and Scale Fast: Strategy for Implementing Virginia's VIPs and Affiliate Providers

Virginia is committed to "Think Big, Start Focused, and Scale Fast." DSRIP will be implemented through a two pronged approach over the five year period (Figure 8). First, Virginia will facilitate development of VIPs. This prong will be self-sustaining by the end of the demonstration period through transition to a total cost of care payment or similar alternative payment model with the enrollee's health plan.

Second, beginning in year three "Affiliate Providers" can leverage DSRIP data infrastructure

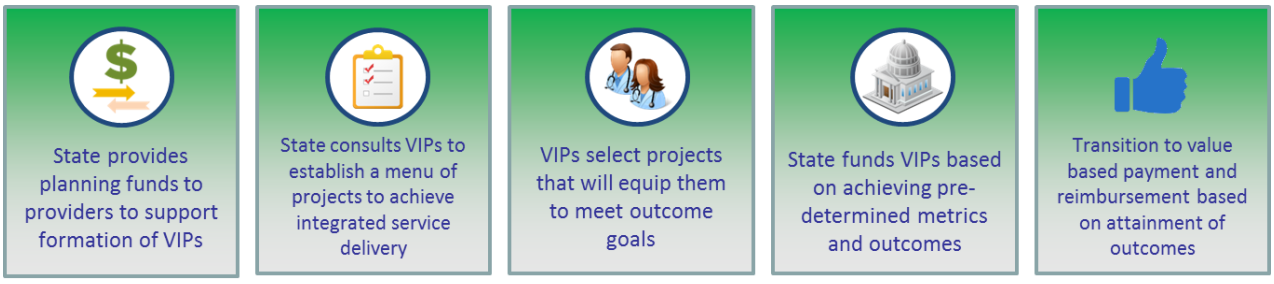

Figure 7 – Proposed VIP Development

and learning resources to enable their transition to value-based payment. Affiliate Providers will contract with health plans to engage in value-based payment strategies such as episodes of care.

DMAS is planning this two pronged approach: **Start focused** on the population where the greatest costs and greatest opportunities to improve care exist. **Scale fast** the program to benefit a greater number of enrollees. Roughly 1% of enrollees drive 22% of program costs and 5% of enrollees drive over 50% of costs. Preliminary data indicate that 72% of these enrollees were high cost in the preceding year. This means that they can be identified and supported to receive enhanced care. In addition, 72% of the highest-utilizers had a behavioral health diagnosis. This provides further evidence for Virginia to develop a program that focuses on addressing behavioral health and complex needs first.

The goals of the VIPs align with the goals for MLTSS. A significant portion of the MLTSS population (Medicare-Medicaid enrollees and individuals accessing LTSS) are high-risk or high-utilizers. Contracted health plans in MLTSS will provide population health services, assessment, and care coordination – the subset of the MLTSS population made up of high-risk, high-utilizers, and emerging high-utilizers will receive even more focused high-touch coordination and navigation through a VIP and managed care organization partnership, where geographically available. The individual will remain enrolled in the MLTSS plan, but receive enhanced care delivery through the VIP and the managed care organization.

Individuals who are high-risk, high-utilizers in the Medallion 3.0 program will also be attributed by their health plan to the VIP, where geographically available. The VIP will work with the Medallion 3.0 health plans to provide enhanced services and coordination for the enrollees. At the end of the five year waiver demonstration period:

- Enrollees will benefit from an enhanced

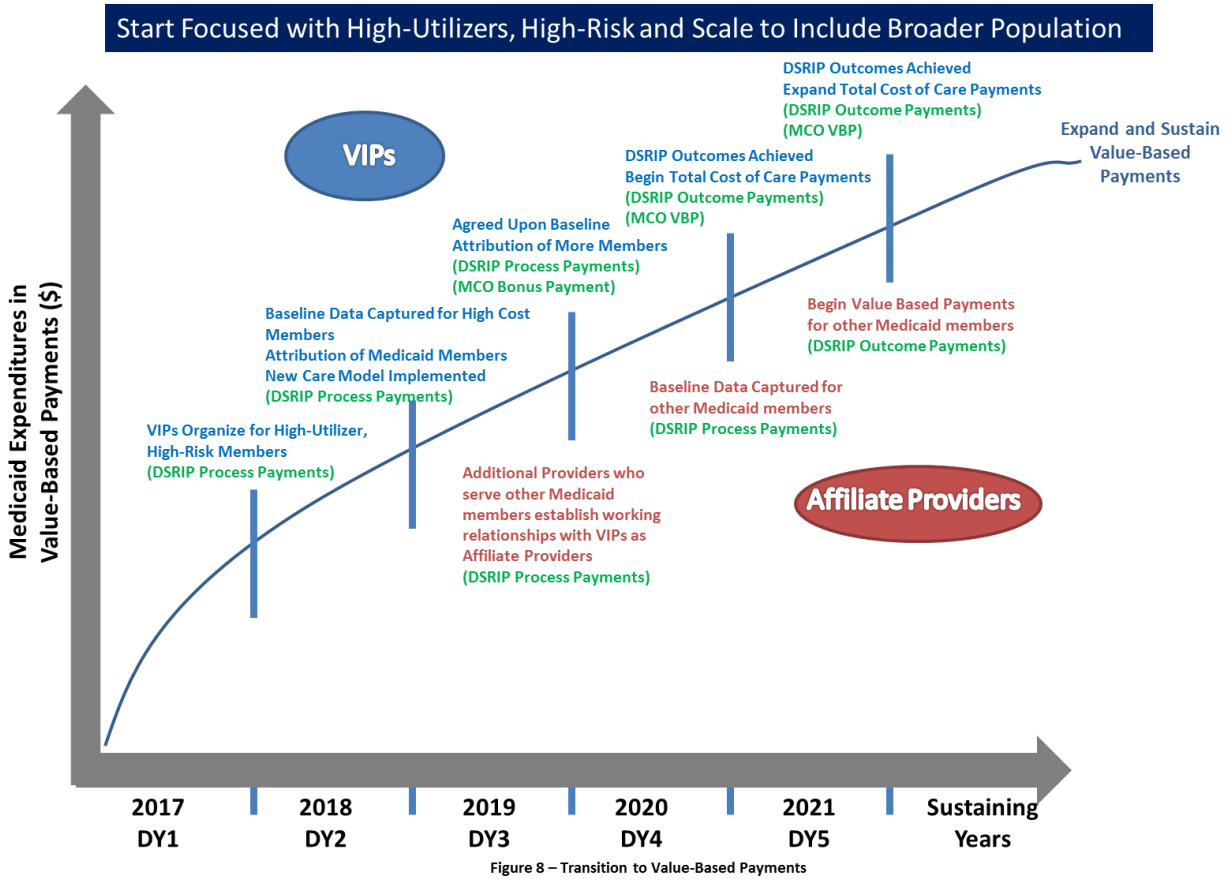

Figure 8 – Transition to Value-Based Payments

level of high-touch, person-centered care and navigation across the complex landscape of medical, behavioral health, social, and long-term services and supports.
- The health plan will benefit from having its highest utilizers receive a heightened level of data-driven complex care management and in-person navigation across a focused spectrum of high-performing providers.
- The VIP will benefit from having additional resources to address the often extremely complex needs of the Medicaid population they already serve and support transition to a data-driven, well organized care delivery system.

There are many communities throughout Virginia that have already considered a similar concept and some are already participating in similar arrangements through Medicare Accountable Care Organizations (ACOs). While this proposed model will not duplicate what is already in place, DMAS intends to build upon lessons learned and best practices of the ACOs in an aim to build and deploy strong VIPs that are ready to work together to serve Virginia Medicaid's most complex enrollees.

DMAS recognizes that currently providers do not have time to deviate from the traditional fifteen minute patient visit. This makes adequately caring for patients who have complex conditions difficult. DSRIP will help develop care models that incent providers to modify care delivery so that they can appropriately allocate time and resources to each Medicaid beneficiary and develop a plan to care for members and be reimbursed appropriately.

Through the support of DSRIP, the Commonwealth plans to invest in the provider community and intends to ensure that the impact is lasting and meaningful. During the first year of the demonstration, DMAS and its partners will spend a significant amount of time working with participating providers, health plans, and stakeholders to develop a governance structure and refine all necessary policies, protocols, contracts, metrics, and expectations to ensure successful implementation of VIPs throughout the Commonwealth. Additionally, participating VIPs must put a sustainability plan in place to ensure that contractual arrangements with proven partners (public and private entities) will last when the 5 year DSRIP waiver demonstration ends.

Testing the Hypothesis for DSRIP

To support the proposed DSRIP Program design, DMAS has identified the following hypotheses and potential measures (Figures 9 – 11). Program design is predicated on a number of the hypotheses. As a demonstration waiver, DMAS has the opportunity to test these hypotheses to help define this program and refine the development of programs in the future.

Goal 1: Improved Beneficiary Health – Focus on prevention and better management of primary behavioral and medical care.		
	Hypothesis	**Potential Measures**
1	If high-touch coordinated interventions are provided to high-risk and high-utilizers, then quality and health outcomes will improve	Medicaid population rate of all-cause ED visits and inpatient admissions among high-risk beneficiaries (↓)
2	If DSRIP invests in enhanced linkages to social determinants (employment, housing support, etc), then beneficiaries will have improved health outcomes	Medicaid population rate of all-cause ED visits and inpatient admissions among high-risk beneficiaries (↓)

Figure 9 – DSRIP Hypothesis: Improve Beneficiary Health

Goal 2: Improved Beneficiary Experience – Improve Interactions with both traditional health care providers and non-traditional community resources including experience related to access and the ease of obtaining care		
	Hypothesis	**Potential Measures**
1	If DSRIP invests in integrated bi-directional medical and behavioral primary care, then access to care will improve	Adherence to scheduled appointments (↑) Wait times to access primary care and behavioral health visits such as psychiatry (↓) Outpatient behavioral health encounter in the last 12 months for Medicaid population with behavioral health condition (↑)
2	If DSRIP formalizes processes between medical, behavioral health and LTSS providers, then beneficiaries will have a better experience of care	Patient Satisfaction (↑)
3	If DSRIP invests in formalizing interdisciplinary care and comprehensive care planning and implementation, then beneficiaries will experience better care	Patient Satisfaction (↑)

Figure 10 – DSRIP Hypothesis: Improve Beneficiary Experience

Goal 3: Bend the Cost Curve – Change the trajectory of Medicaid spending through the reduction of preventable care, unnecessary care, or care delivered in avoidable high-cost settings		
	Hypothesis	**Potential Measures**
1	If DSRIP supports additional community investments, then care delivered in avoidable high-cost settings will decrease	Number of Medicaid beneficiaries in an institutional setting (↓) Inpatient psychiatric hospital utilization (↓)
2	If DSRIP invests in a high-touch, person-centered system of care, then the trajectory of spending on high-utilizers will decrease	Potentially Preventable ED visits (↓) Potentially Preventable Readmissions (↓) Utilization of High-Cost Settings (↓) Potentially Preventable Admissions (↓)
3	If DSRIP supports expanded use of standard care transitions, then care delivered in avoidable high-cost settings will decrease	Potentially Preventable Readmissions (↓) Utilization of High-Cost Settings (↓) Potentially Preventable Admissions (↓) Potentially Preventable ED Visits (↓)
4	If contracted MCOs optimize the strength of the VIP networks, then the spending on high cost Medicaid beneficiaries will decrease	Total Annualized Per-Beneficiary Medicaid Spending (↓)
5	If payment is based on outcomes as opposed to volume, then a higher performing health system with less waste will result	Rate of increase of Medicaid costs (↓)
6	If DSRIP invests in a robust data platform to facilitate information sharing and communication, then health outcomes will improve, experience of beneficiaries will improve, and the cost curve will bend	Cost Curve (↓) Beneficiary Experience (↑) Provider Experience (↑)

Figure 11 – DSRIP Hypothesis: Bend the Cost Curve

Preliminary DSRIP System Transformation Projects

DSRIP system transformation projects (Figure 12) are focused on the establishment of VIPs, development of the VIP model of care and ensuring that the provider capacity exists to support the care model, and data integration and utilization. The Department will further refine and develop the DSRIP project list during the negotiation and finalization of the Special Terms and Conditions. The projects described below are representative of the types of projects Virginia seeks to implement.

A.1 and A.2 - Establish VIP delivery partnerships in select geographic regions across the Commonwealth, where there is an adequate volume of MLTSS and Medallion 3.0 enrollees who meet the criteria to support the transformation of the regional delivery system, and establish VIP

A	System Transformation Projects
1	Establish VIP delivery networks in select geographic regions across the Commonwealth
2	Establish VIP model of care and preferred care pathways between VIP providers
3	Identify and address training and workforce development needs – especially for working with individuals with behavioral health needs and developmental disabilities
4	Establish attribution methodology between VIP networks and contracted health plans
5	Establish data pathways between providers in the VIP networks
6	Establish data pathways between VIP networks, contacted health plans, and statewide system
7	Emergency department information system

Figure 12 – Representative System Transformation Projects

model of care and preferred care pathways between VIP providers

The preceding section detailing the "Proposed VIP Development" outlines the establishment of VIP partnerships and care model and addresses System Transformation Projects A.1 and A.2.

A.3 - Identify and address training and workforce development gaps and needs – especially for working with individuals with behavioral health needs, and developmental and physical/sensory disabilities. An additional area of focus will include treating and supporting individuals with substance use disorders. DMAS recognizes that training of Virginia's workforce and caregivers/peers/health workers is critical for Virginia's communities to have the breadth of expertise to care for the entire Virginia Medicaid population. DSRIP will support workforce training for health care and support services professionals, including school based providers where appropriate, to help meet this need. Training will be developed so that behavioral health can be more fully integrated with primary care. Additionally, resources will be focused to ensure medical professionals are trained so they are competent and confident to work with individuals of all ability levels, as appropriate.

Not only will a focus be on training the existing workforce, but there will also be efforts to address workforce capacity gaps to improve care access where needed across the Commonwealth. Virginia envisions expanded investment into disciplines such as: nurse practitioners (including psychiatric NPs), EMS workers, addiction specialist, caregivers, peers (individual and family), behavioral care managers, and community health workers.

DMAS recognizes that schools are often a central point of care for many children with complex needs (diabetes, asthma, behavioral health, etc.) who receive Medicaid. DMAS will seek to use DSRIP funding to develop continuing education models that ensure that school nurses are trained to meet the most demanding needs of these children and are able to more appropriately partner with other community providers when caring for Medicaid members in the school setting.

A.4 – Establish attribution methodology between VIP partnership and contracted health plans

DMAS will work with VIPs and contracted health plans to determine how to best attribute beneficiaries to VIPs; including the consideration of prospective vs. retrospective attribution models. The model chosen will respect the MCO/beneficiary relationship while leveraging the strength of the VIPs to enhance care delivery to the most complex MLTSS and Medallion 3.0 Medicaid enrollees.

A.5 – Establish protocols and supports for Affiliate Providers

DMAS will work with VIP coordinating entities and contracted health plans to identify protocols and expectations for providers seeking to obtain status as an Affiliate Provider. This will include contract terms, process and outcome goals, and expectations for value-based payments.

A.6- Establish data pathways between providers in the VIP partnership and data pathways between VIP partnerships, contacted health plans, and statewide system

A shared technology platform is critical when engaging in a team based care approach and model. Further, shared information facilitates better patient experience, and decreases waste within care development and assessment processes. Relying on claims data to facilitate care is not efficient or sustainable. DSRIP will allow DMAS to work with participating VIP partners, including community providers, to leverage and build upon existing systems and resources and develop an optimal data system that will:

- Establish data-readiness for providers to conduct team-based care;
- Establish data-readiness for providers to be reimbursed for outcomes;
- Develop close to real-time data sharing between Medicaid providers;
- Develop capacity for business intelligence; and,
- Develop capacity for data analytics.

In order to successfully achieve all of the proposed DSRIP strategies, Virginia's Medicaid providers need to be better supported in their ability to capture, report, and analyze their Medicaid member data and information. Virginia will use DSRIP to help VIPs build an integrated clinical, behavioral, social, and support data platform to accelerate provider integration and enable value-based payment models (later explained). Strategic focus areas for information technology and data strategies will be identified during the early phase of DSRIP implementation. DMAS plans to support a needs assessment of the Medicaid provider community as it pertains to needed data support from DMAS. DSRIP Program will enable DMAS to achieve its goals for strengthened data analytics capabilities, beneficiary information exchange, and revised payment structure.

Virginia's proposal aligns succinctly with the recently published Federal Health I.T. strategic plan. Specifically, Federal Health IT Plan Goal 1 (Advance Person-centered and Self-Managed Health) and Goal 2 (Transform health Care Delivery and Community Health) and the associated objectives can be leveraged to support the need for a single statewide support structure that will connect providers, payers, members, and DMAS.

DMAS will use DSRIP funding to design the data requirements that will enable providers to share usable information with each other and payers while tracking Medicaid member outcomes to be utilized for reimbursement strategies of value-based care.

In addition to the data sharing capabilities, DSRIP will be used to connect providers to DMAS' Medicaid Enterprise System (MES) – Care Management Module that will serve as a backbone for sharing relevant data related to Virginia's Medicaid members. Today, if a Medicaid member exercises his or her choice to change MCOs, the care management data is not transferred to the new MCO resulting in a significant duplication of

effort and testing for the member. This is cumbersome and wasteful for the Medicaid agency but, most importantly, time consuming for Medicaid providers and beneficiaries. The proposed connection to DMAS' MES – Care Management Module will provide the transparency and data needed to move Virginia towards value-based payment arrangements within the Medicaid program.

DMAS understands that significant information technology investments have been made by providers across the Commonwealth. DSRIP will afford the opportunity to facilitate connectivity of these individual provider systems, without duplicating, replicating, or making insignificant the investments of providers, to date.

Further, all information technology efforts will build upon key investments previously made in Virginia. Virginia leveraged federal funding available under the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Patient Protection and Affordable Care Act (PPACA) to comply with federal mandates and to align with the Medicaid Information Technology Architecture (MITA) vision. In 2011 the eHHR Program was initiated to transform Virginia's IT infrastructure into an integrated system based upon Service Oriented Architecture (SOA). Implementing SOA technology and the MITA framework has enabled initial steps in the collection, aggregation, and sharing of data among agencies and localities thereby eliminating redundant efforts, streamlining work flows, and ensuring cleaner data for all participating agencies. DSRIP will leverage this work.

The SOA tools are currently being used by Virginia's Eligibility and Enrollment System, and system interfaces with the Federal Data Services Hub and the Medicaid Management Information System.

Federal funding was also used to create Virginia's Electronic Health Records Provider Incentive Program. Additionally, a grant from the Office of the National Coordinator for Health Information Technology (ONC) was used to establish Virginia's Health Information Exchange (HIE), which will be a key component to achieve the Triple Aim principles of better care, improved health, and lower costs.

In addition to the above stated efforts, DMAS is replacing its existing monolithic mainframe based Medicaid Management Information System (MMIS) and transforming to a modular Medicaid Enterprise System (MES). This future procurement is designed to align Medicaid with CMS's required movement toward complying with Medicaid Information Technology Architecture 3.0 and Seven Standards and Conditions. DMAS is currently in development of Requests for Proposals (RFP) for a Medicaid Enterprise System (MES). Details pertaining to the scale and scope of the procurements will be available upon the release of the RFPs in the first quarter of 2016.

Recognizing the robust expectation and request for providers to capture and report numerous data points, Virginia seeks to develop a statewide set of minimum data standards. Across the healthcare continuum, to include the partnership with the MCOs, there are hundreds of data elements measured and reported by Medicaid providers and MCOs. While these data sets are all valuable in their own catchment, there is significant duplication of effort due to gaps in taxonomy and uniformity in reporting requirements. DMAS proposes using DSRIP support to bring together key partners across Medicaid and the commercial sectors in order to undertake a statewide effort to establish a uniform set of minimum data standards (MDS). Standardization is a cornerstone of meaningful data analysis. Virginia aims to utilize data analytics to improve care and institute value-based payments which reward providers for the delivery of quality care to Medicaid members.

A.7 – Emergency Department Information System

DSRIP investment will flow through the VIP partnership; however, a significant component to

improved care and financial savings is the ability to quickly share information between emergency departments including those outside of the VIP partnership. Virginia seeks to identify a VIP that will lead the implementation of a statewide (or near statewide) electronic health record platform for emergency departments. A shared emergency department information system will reduce medical errors, expedite care, reduce redundant testing, and improve care.

Preliminary DSRIP Financial Incentive Alignment Projects

DSRIP financial incentive alignment projects (Figure 13) are focused on transitioning the Medicaid system to value-based and alternative payment models. DMAS does not believe that it is responsible to expect the magnitude of change anticipated in the payment structure without supporting Virginia's Medicaid providers through the transition.

Funding to support provider transition to alternative payment models will flow through the VIPs. Providers participating in VIPs will receive support to transition to alternative payment models in two ways: (i) As a streamlined VIP delivery partnership for high risk, high-utilizers with the goal of moving to a self-sustaining global sub-capitation or similar alternative payment arrangement at the end of the five year waiver period; and (ii) as an Affiliate Provider. Affiliate Providers are Medicaid health plan-contracted providers that will receive support to implement additional alternative-payment models. Value-based payment will be incorporated into the MLTSS and Medallion 3.0 contracts over the demonstration period.

Virginia intends to use DSRIP to develop and test payment methodologies through the VIPs and with VIP providers which are a subset of the Medicaid provider network. Through DSRIP, DMAS will identify strategies with the highest return on investment and likelihood of self-sustainability. At the end of the waiver period, DMAS will work with additional providers and health plans to replicate and scale best practices throughout the provider network.

B.1 – Transition to alternative payment model for the integrated VIP delivery partnership

DSRIP funding will support the development of the integrated VIP partnership and care model for high-risk, high-utilizers. This high-performing partnership of providers will transition over a five year period to a sub-capitation arrangement or other alternative payment arrangement with contracted health plans. VIPs will be designed to meet the complex behavioral, social, and medical needs of this population and will need to invest in supports and services that are not historically paid for by the Medicaid program. Payment models will be developed to reflect this and in a way that best meets enrollees' needs and decreases utilization of expensive avoidable medical services. DMAS is designing its DSRIP VIP program to meet the needs of Virginia's most complex enrollees – those that will be enrolled in MLTSS- but also plans to use its VIP system and alternative payment methods for complex enrollees in its Medallion 3.0 health plans.

To the extent possible, when developing alternative payment models, health plans, VIPs,

B	Financial Incentive Alignment Projects
❶	Transition to alternative payment model for the integrated VIP delivery network
❷	Transition to alternative payment models with VIP providers for enrollees not attributed to the integrated VIP delivery network

Figure 13 – Representative Financial Alignment Projects

and DMAS will seek models that: 1) encourage the willing participation of key providers needed to support the population's needs, 2) preserve existing, effective provider relationships to support patient-centered and coordinated care, 3) introduce reimbursement policies that support the integration of clinical services with community social supports; and, 4) provide funding support for interdisciplinary teams that can address the needs of the targeted complex patient populations.

DMAS anticipates that any value-based purchasing methodology will be based on quality and outcome performance measures. Measures will initially be more process oriented. Payments for enrollees attributed to the VIPs will evolve to progressively higher risk, total cost of care models.

B.2 - Transition to alternative payment models with VIP providers for enrollees not attributed to the integrated VIP delivery partnership and Affiliate Providers

Only individuals designated as high-risk (to include emerging high-risk) and high cost will be attributed to the formal VIP partnership. The majority of enrollees a VIP Medicaid provider sees will be outside of the VIP arrangement, yet still may experience significant episodes of care or have chronic conditions to manage. Further, Affiliate Providers will not be part of the formal VIP but will still be moving to value-based payment. DMAS will leverage DSRIP to work with the VIP providers, Affiliate Providers, and health plans to develop alternative payment arrangements, such as episodes of care and bundled payments, to improve care for these enrollees, for example, a bundled payment for all maternity care and delivery. These payment models will be developed in collaboration with providers and health plans and tied to the clinical improvement projects included in DSRIP.

Preliminary DSRIP Clinical Improvement Project List

The information below contains highlights of select DSRIP Clinical Improvement projects (Figure 14). The projects listed will be formalized, and related measures established, during the Special Terms

C	Clinical Improvement Projects
1	Bi-directional, integrated primary care (behavioral health and medical)
2	Expanded points of access and hours to primary care
3	Emergency department diversion
4	Enrollee engagement incentives
5	Home visit and mobile care
6	Expanded focus on social determinants of health: supportive housing, employment supports, and nutrition
7	Care transitions (e.g., Naylor and Coleman models)
8	REACH and Health Support Networks for individuals with developmental disabilities
9	Expanded telehealth
10	Condition-focused initiative (up to 2 per VIP, developed in collaboration with health plan, e.g., healthy pregnancy or diabetes care)

Figure 14 – Representative Clinical Improvement Projects

and Conditions development process. DMAS will do this in consultation with VIP coordinating entities, providers interested in partnering with a VIP, contracted health plans, SIM workgroups, self-advocates, and CMS.

C.1- Bi-directional, integrated behavioral health and primary care (High-touch coordinated interventions),

Team-based, integrated behavioral health and primary care aims to increase interdisciplinary care teams (including public and private providers) so that holistic, person-centered care becomes the standard practice for Medicaid enrollees. Additionally, there will be a focus on integrating primary behavioral health and medical care so that behavioral health is a natural extension of primary care and primary care is a natural extension of behavioral health. This will be a bidirectional approach, understanding that individuals will initiate care where they are most comfortable, be it a center or practice whose main focus is behavioral health or physical health.

DMAS recognizes that in many practices, the availability of a clinical social worker, or other expert such as a psychiatric nurse practitioner, integrated into the care practice, will dramatically enhance the ability of the practice to follow up and wrap behavioral health and social supports around individuals in need of behavioral health care. Behavioral health practices will greatly benefit from the infusion of primary care practitioners into their practice model. This team based approach will facilitate a stronger, bidirectional care model no matter where Medicaid beneficiaries choose to access care.

This high touch approach to care recognizes the importance of face to face interactions with by providers in the community. Depending on the expressed needs of the Medicaid beneficiary, high touch support could be either a social worker or other social support professional, or a medical professional. The flexibility of the VIP partnership will allow for the person-centered planning approach to determine what the best fit is for the individual, facilitating positive interactions and appropriate engagement of the Medicaid provider community. It is expected that, where appropriate, beneficiaries will be engaged in their health care and the VIP providers and participating MCOs will work together to determine the best engagement strategies and incentives to ensure beneficiaries are actively engaged in their health and health outcomes.

Formalized processes between medical health, behavioral health, and LTSS providers will translate into beneficiaries being able to access better care, which translates into a better experience of care, yielding better health outcomes for Virginia's Medicaid beneficiaries.

C.2- Expanded hours and access to primary medical and behavioral health care

The care model proposed through DSRIP recognizes the importance of access to care especially for individuals supported by family caregivers and those with behavioral health needs. There is strong evidence that expanding access to primary medical and behavioral health care will ultimately reduce the overreliance on emergency department use and preempt acute episodes that result in hospitalization. DMAS will likely require VIPs to provide extended office hours. The Department understands the need to support providers in the development of extended hours, due to overhead costs, and staff turnover risk, and will encourage VIP providers to work together to determine the best model to ensure equity in time spent and cost incurred as a result of this project.

DMAS also recognizes the latest Substance Abuse and Mental Health Services Administration (SAMHSA) work with states in the development of Certified Community Behavioral Health Centers (CCBHCs). As a planning grantee, the Commonwealth is actively working to develop the certification process with selected partners and

identify payment strategies for this model. DMAS will partner with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) in its development and certification of CCBHCs as a viable service delivery model within the Medicaid delivery system. DMAS will work with DBHDS and key stakeholders to determine the best avenue in which DSRIP can support this effort to ensure timely, consistent access to behavioral health services in the community.

C.3- Emergency Department Diversion

Throughout Virginia, individuals often rely on emergency departments (ED) to receive non-emergency care. This occurrence is often compounded by individuals who experience Serious Mental Illness (SMI) and other behavioral health conditions. This reality is often the result of a lack of access to primary and behavioral health care. Additionally, there are individuals who are high-utilizers of inpatient hospital care. DMAS proposes to utilize DSRIP funding to support the VIPs' implementation of protocols that increase access to patient navigation tools, strengthen hospital coordination efforts, and extend office hours through partnering primary care practices. This could also include working with local Fire and Rescue and Emergency Medical Technicians to develop innovative ways to build upon their skill sets.

C.4- Enrollee Engagement Incentives

Virginia supports the concept of patient engagement, or in this domain beneficiary engagement, yielding better health outcomes and more efficient use of the health system. DMAS recognizes that strategies developed in this domain must be effective, not only for the motivation of engagement but also for the entity responsible for tracking engagement. Tracking minimal copayments or other penalties previously explored with Medicaid populations often yields significant administrative burden with little to no ultimate behavior change. To that end, DMAS will work with VIPs to identify incentives to motivate Medicaid beneficiaries to engage the health care system in more appropriate ways.

C.5- Home Visit and Mobile Care

DMAS, along with sister state agencies and community partners, has been working diligently over the past decade to strengthen the connection of individuals who live in the community to the providers and support services that care for them. In many communities this connection is best served by a mobile care team and there is a need to further support and multiply the number of mobile care teams throughout the Commonwealth. Through DSRIP, Virginia intends to increase access to primary and behavioral health care in all geographic regions by increasing mobile clinics and/or providers. Another targeted approach will be to increase access to primary and behavioral health care to adults and children with limited mobility, or who are otherwise difficult to reach, through home visits. DMAS will look to the VIPs to put their resources on wheels and engage and provide care throughout Virginia's communities.

DMAS is aware of the current use of community health workers and believe a resource such as this could help ease the constraints on providers who would need to dedicate staff and time to a mobile unit. DMAS will work with the VIP partnerships to establish standards and protocols that meet both the expectation of federal partners and feasibility of the provider community.

C.6- Expanded Focus on Social Determinants of Health: Supportive Housing, Employment Supports, and Nutrition

DMAS acknowledges that there are social determinants that directly influence the overall health and wellbeing of Medicaid beneficiaries. To that end, housing, workforce/employment, and nutrition projects will be developed through VIPs, utilizing partnerships with managed care plans and community and regional resources.

Supportive Housing: The Department believes that housing is healthcare. While Medicaid is not allowed to pay for housing, Virginia desires a clear statewide process for identifying and disseminating appropriate and available safe housing options for Medicaid enrollees. DMAS is committed to working with statewide experts and partners to ensure Virginia's policies are appropriate and person-centered. Through DSRIP, Virginia intends on identifying a preferred solution, to make this information available to providers, care managers, and the individuals who are in need of housing, or better housing options.

Expanded Employment Supports: In addition to housing, employment is desired by many Medicaid beneficiaries and considered to be an important piece of meaningful community living. DMAS intends to build off of the existing Medicaid Works program and use DSRIP to enable investment in the development of partnerships with representatives from the business community as well as workforce training experts such as the Virginia Disability, Aging, and Rehabilitation Services (DARS) agency, in order to make sure that the Commonwealth has an established process for recruiting and connecting Medicaid members to employers committed to employing individuals with Serious and Persistent Mental Illness (SPMI) and other varying abilities.

In October, 2015, Virginia received a $4.3 million federal grant from the U.S. Department of Education to help nearly 500 Virginians with disabilities gain new skills and credentials to seek employment in competitive, high-demand, high-quality occupations. The five-year grant will allow (DARS) and the Department for the Blind and Vision Impaired (DBVI) to develop and implement a demonstration project to enhance Virginia's existing regional career pathways systems to serve individuals with disabilities. This may overlap with demonstration beneficiaries; however, lessons learned and strategies developed will translate well into the objectives of this DSRIP strategy. Mirroring the process for housing, DSRIP funding will also be used to make developed employment strategies and information available to providers, care managers, individuals, and family members.

Nutrition: The Medicaid beneficiaries included in the demonstration often have co-occurring and often times co-morbid conditions. Without specific guidance and follow-up from trusted sources, these beneficiaries often fall back into poor eating, exercise, and lifestyle habits. Through DSRIP, VIPs will work to develop the best nutritional support options for members who would benefit from closer monitoring, and more frequent nutritional support. DMAS, like CMS, acknowledges that promoting healthy behaviors can reduce the occurrence of chronic conditions. Through DSRIP, Virginia intends on strengthening the focus of nutritional supports and will work with VIPs, managed care plans, and community resources to develop specific support models for use in this demonstration.

C.7- Care Transitions and Diversions from Institutional Care

Institutional care is valuable to the Medicaid program for individuals who are truly in need of highly monitored, comprehensive care in a residential facility. Virginia, however, is not unlike other states in the country where there is a legacy and history of institutional bias. Despite decades of efforts to strengthen the community options for individuals who have a level of care need that formerly would have triggered institutional care, care transitions often default to relying on institutions as a hospital discharge alternative.

In addition, transitions from an institution back into the community are often difficult to manage and Medicaid members are at risk of confusion about care plans and the arrangement of home services, leading to readmission to the institution.

DSRIP will be used to facilitate better relationships and communications between community partners

supporting Medicaid members in the community. Virginia will seek to implement best practices and principles such as, but not limited to, the Coleman Model or the Transitional Care (Naylor) Model to increase success when transitioning Medicaid members between care settings (e.g. hospital discharge, nursing facility to home/community, Psychiatric Residential Treatment Facility (PRTF) or Institute for Mental Disease (IMD) to home/community). DMAS will also work with partners to determine the value of remote patient monitoring, where appropriate, in order to support individuals who are transitioning. Protocols will be refined and pathways will be developed to ensure that home and community based services and supports are easy to both establish and maintain. DMAS will work with VIPs and other community partners to develop these processes.

C.8- Expanded REACH

REACH is a program to support adults with intellectual and/or developmental disabilities, as well as a mental health condition or challenging behavior that is negatively affecting their quality of life. REACH programs, offered across Virginia provide consultation, mobile support, and therapeutic home services to individuals ages 18 and above with documented evidence of an intellectual or developmental disability and mental health or behavioral needs. REACH emphasizes the prevention of crises before they occur. This prevention is done through early identification of individuals in need of service, development of crisis response plans, trainings, and technical assistance. REACH programs are under development in these regions for children.

C.9- Telehealth

Virginia is one of the leading states in the country when it comes to utilization of telehealth as a mode of Medicaid care delivery. While we celebrate the successes of this accomplishment, there are significant opportunities to strengthen the use of telehealth in order to better support Virginia's Medicaid members and the providers that care for them. Through DSRIP, Virginia seeks to strengthen home monitoring for chronic condition management, long-term services and supports, and intends to deploy resources and tools to aid in crisis prevention and beneficiary safety. Telehealth has the ability to make preventive health screenings more timely and accessible, both incredibly valuable when focusing on sustaining health and wellness. With the extended focus towards integration of care, telehealth has the ability to enhance access to providers, especially for behavioral health treatment. Further, Virginia seeks to expand the ability of providers to consult with expert and specialty care providers.

DMAS recognizes that DMAS needs to work with CMS to ensure flexibility around payment for telemedicine, and telehealth services. The Department will work with CMS to develop appropriate flexibilities that will be reflected the negotiated Special Terms and Conditions document.

C.10- Condition-focused Initiative (up to 2 per VIP developed in collaboration with health plan, e.g., healthy pregnancy or diabetes care)

As described previously, at its core the VIP model relies on a high-touch, person-centered system of care. As exemplified in the project highlights, DSRIP intends to invest in this high-touch model, supporting the provider community in its efforts to expand existing care models, and strengthen the existing care transition efforts. This care approach will translate into more engaged Medicaid beneficiaries and more accountable providers.

Unified Waiver Approach

DMAS is proposing to utilize this opportunity to retool the Medicaid program in order to better integrate care provided to Medicaid members while substantiating a data system that will ultimately support the successful movement to value-based payment models. While the MLTSS

and DSRIP efforts are unique in some project components, the opportunity to combine these efforts will result in a strong, robust, Medicaid delivery system. Integrating the efforts of all Medicaid providers, the MCOs that facilitate payment of services, and the Department will allow for better care delivery and better member experience for Virginia's Medicaid beneficiaries. DMAS begins these strategic efforts with the member's health and wellness at the forefront of all decision making.

Other Required Application Elements by Centers for Medicare and Medicaid Services

Describe where the demonstration will operate.

MLTSS: The MLTSS effort will be statewide, though the rollout will be phased in by geographic region. The regional approach will ensure that the participating health plans, along with DMAS, have the appropriate resources needed to in order to achieve a successful implementation and most importantly a safe implementation for the Medicaid members. Figure 15 below highlights the timeline and regional implementation approach.

§1915(c) Home and Community Based Services Waivers: The proposed migration of the Elderly or Disabled with Consumer Direction (EDCD) and Technology Assisted Waiver (Tech) waiver authorities to a §1115 waiver will alter neither eligibility nor services under these existing three waivers. Additionally, the waivers will operate statewide, as they do under the§1915(c) authority.

DSRIP: The implementation of the DSRIP demonstration will be in a number of geographic areas around the state. Affiliated Providers will likely be based in the same geographic area as the VIP; however, Affiliated Providers may also be used to expand the geographic reach of Virginia's DSRIP. The Department will negotiate specifics of this strategy in the agreed upon Special Terms and Conditions and use these standards to finalize arrangements with VIP provider partnerships. To date, DMAS has issued a request for non-binding letters of interest to all Virginia health systems. So far nine health systems have expressed interest in engaging as a VIP coordinating entity. DMAS will continue to engage interested health systems as the Special Terms and Conditions are developed.

Demonstration Eligibility

Demonstration eligibility will not affect or modify other components of Virginia's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems. Eligibility for individuals who qualify for the program demonstrations will not be altered from eligibility determination processes and protocols that currently exist. Additionally, there are no proposed enrollment limits. Individuals who receive improved care through a DSRIP initiative include a subset of those currently enrolled or eligible for MLTSS and Medallion 3.0. The chart identifying populations whose eligibility will be affected can be

MLTSS Implementation Phases

Year	Date	Regions	Total Population*
2017	March 1, 2017	Tidewater	8,000
	May 1, 2017	Central	11,000
	July 1, 2017	Charlottesville/Western	13,000
	September 1, 2017	Roanoke/Alleghany	4,500
	September 1, 2017	Southwest	12,500
	November 1, 2017	Northern/Winchester	13,500
2018	Starting in January 2018	CCC Demonstration (Transition plan is to be determined with CMS)	67,000
Total		**All Regions**	**129,500**

*Source – VAMMIS Data; *Approximate totals based upon MLTSS targeted population as of June 2015*

Figure 15 – MLTSS Rollout

found in Appendix B.

Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs

MLTSS: The projected number of individuals eligible for the MLTSS portion of the demonstration is 129,500. These projections are based on current state enrollment of both state plan and six 1915(c) waivers. Broadly, the populations included in the MLTSS demonstration are shown in Figure 16.

§1915(c) Home and Community Based Services Waivers: The projected number of individuals eligible based on waiver enrollment as of December 31, 2015 for the following waivers total 33,392 individuals:

- Technology Assisted
  - Enrolled: 282
- Elderly or Disabled with Consumer Direction
  - Enrolled: 33,110

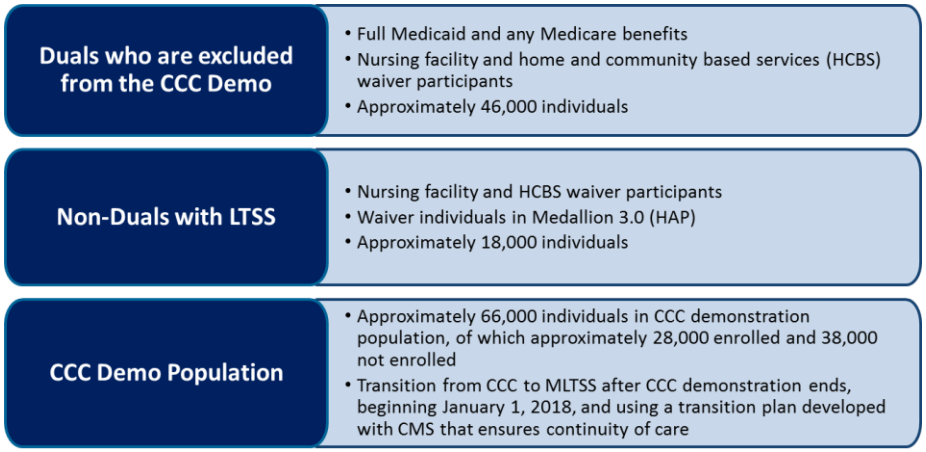

Figure 16 – MLTSS Rollout

DSRIP: DSRIP Program will include a subset of both the MLTSS population and the Medallion 3.0 population. This subset will include high risk, high-utilizers who will be attributed by the health plans to the VIP partnership. This population will make up an estimated 1-5% of Medicaid enrollees. Individuals who experience a chronic condition or episodic care event and receive care from a provider who participates in a VIP partnership may also be included in an alternative payment methodology through DSRIP. The number of individuals impacted will vary depending on the number of VIP partnerships and their geographic availability, the finalized VIP partnership attribution model outlined in the Special Terms and Conditions, and the alternative payment models developed with VIP providers and health plans outside of the formal VIP partnership.

To the extent long-term services and supports are furnished (either in institutions or the community); describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.735 (209b State).

Virginia utilizes the spousal impoverishment rules under section 1924 for married institutionalized individuals who receive home and community based care services and have a spouse residing in the community (outside of a nursing facility). If in a nursing facility, there is only one basic difference, realized in the deduction explanation below.

From the individual's gross income, deductions are made in the following order: 1) HCBS: personal maintenance[5] (165% of SSI by state option), Institution: Personal

[5] The personal maintenance deduction may also include a guardian fee (actual fee up to 5% of income) if there is a guardian who charges a fee and a special earnings deduction depending on the number of hours of employment per week. The total personal maintenance deduction cannot exceed 300% of SSI.

needs allowance $40 (higher the federally minimum of $30 at state option). If the stay in the facility is expected to be less than 6 months, there can also be a final deduction for a home maintenance allowance. 2) community spouse monthly income allowance, 3) dependent family member's allowance if the dependent lives with the community spouse, and 4) non-covered medical expenses. The remainder after all allowable deductions is the individual's contribution to his cost of care (patient pay) and Medicaid pays the balance, up to the Medicaid rate for the authorized services.

If there is no community spouse, then from the individual's gross income, deductions are made in the following order: 1) personal maintenance* (165% of SSI by state option), 2) dependent family member's allowance, and 3) non-covered medical expenses. The remainder after all allowable deductions is the individual's contribution to his cost of care (patient pay) and Medicaid pays the balance, up to the Medicaid rate for the authorized services.

Demonstration Benefits and Cost Sharing Requirements

Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

MLTSS:

Yes (No) (if no, please skip questions 3 – 7)

DSRIP:

Yes (No) (if no, please skip questions 3 – 7)

§1915(c) Home and Community Based Services Waivers:

Yes (No) (if no, please skip questions 3 – 7)

While differing from the Medicaid/CHIP state plan, benefits will not be altered as currently available under the existing 1915 (c) authority. While the answer reflects the divergence from the state plan, all details for questions 3-7 are currently accessible through the approved 1915(c) applications available on the CMS Demonstrations and Waivers website.

Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

MLTSS:

Yes (No) (if no, please skip questions 8 - 10)

MLTSS enrolled individuals will be exempt from cost sharing other than for the patient pay towards long term services and supports. This does not differ from the process under the Medicaid State Plan.

DSRIP:

Yes (No) (if no, please skip questions 8-10)

The DSRIP portion of this demonstration will exercise the opportunity to explore and subsequently implement a patient engagement strategy that requires Medicaid members to be active in their health care. DMAS will work with VIP partnerships and MCO partners to determine the best incentive strategies to encourage positive member engagement.

§1915(c) Home and Community Based Services Waivers:

Cost sharing requirements for this portion of the demonstration will not alter from those currently recognized under existing 1915(c) authority.

Yes (No) (if no, please skip questions 8-10)

Delivery System and Payment Rates for Services

Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

MLTSS: The delivery system used to provide benefits to the Demonstration participants in the MLTSS portion of the waiver will transition the majority of remaining fee-for-service services into a mandatory managed care environment. A detailed explanation of the proposed delivery system is identified in earlier sections of this document. As described, DMAS anticipates that the proposal will drive increases in quality, and access to care while driving down total cost of care. Most importantly, it is expected that this demonstration, will positively improve the health status of those participating.

DSRIP: The delivery system used to provide benefits to the Demonstration participants in the DSRIP portion of the waiver is described in detail in earlier sections of this document. As described, DMAS anticipates that the proposal will drive increases in quality, and access to care while driving down total cost of care. Most importantly, it is expected that this demonstration, will positively improve the health status of those participating.

§1915(c) Home and Community Based Services Waivers: The operational authority sought through the migration of administrative authority from an existing 1915(c) to 1115 waiver authority does not alter how benefits are provided to these traditional 1915(c) waiver beneficiaries.

Describe the delivery system reform that will occur as a result of the Demonstration. Specifically include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

The program description section of this application describes in full all answers to the above question.

Indicate the delivery system that will be used in the Demonstration

Managed Care Organization –As described in the opening section of the application, 75 percent of the Medicaid program enrollees receive care through contracted health plans. MLTSS (including the three HCBS waivers discussed in this application), will require an additional 129,500 individuals be covered through mandatory managed care organizations. The DSRIP demonstration, will utilize the MLTSS managed care plans, as well as the existing Medallion 3.0 managed care plans.

Other: DSRIP will not only leverage the existing managed care plans, but it will also create Virginia Integration Partners (VIP) as fully described in this application. VIPs will contract with managed care plans as a part of the Commonwealth's managed care delivery system.

If multiple delivery systems are used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration. Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b), or section 1932 option)

All eligible individuals will have access to MLTSS managed care plans. For DSRIP, the only variance in the delivery system accessible for beneficiaries will be the result of regional availability of VIPs, which has not yet been determined. DMAS will work with CMS during the negotiation phase to determine, if needed, where there will be a variance in the access to a VIP. Delivery System specifics, as it

pertains to VIPs, will be included in the agreed upon Special Terms and Conditions document.

If the Demonstration will utilize a managed care delivery system:

a) ***Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?***
MLTSS: Enrollment into the demonstration will be mandatory, as reflected in the application and in the requested waiver section of the document.
DSRIP: Enrollment will be mandatory by virtue of the authority granted through this waiver for MLTSS, or through existing 1932 authority for the existing Medallion 3.0 program.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);
Managed Care will be statewide, as described in previous sections of the document.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);
MLTSS: Managed Care will have a phased in roll out as depicted in Figure 15.
DSRIP: Managed Care will have a phased in roll out for MLTSS related beneficiaries. Medallion 3.0 currently operates in all regions of the state.

d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and
MLTSS: DMAS anticipates at least two MCOs will operate in each region, providing the assurance of choice. DMAS will require MLTSS MCOs to have appropriate networks as well as licensure and certifications from the Virginia Bureau of Insurance (BOI) and the Virginia Department of Health, and MCOs will be required to obtain National Committee for Quality Assurance (NCQA) accreditation.

e) Describe how the managed care providers will be selected/procured
MLTSS: For the MLTSS portion of the demonstration, Managed Care Organizations (MCOs) will be selected through a competitive procurement process. The Request for Proposal will be released in spring of 2016 with an anticipated rollout of the demonstration, upon CMS demonstration approval, beginning in January of 2017.

DSRIP: The DSRIP demonstration will utilize the MLTSS procured plans as well as those currently participating as Medallion 3.0 MCOs. MCOs will have a role in the DSRIP demonstration as partners in the integrated care partnerships (Virginia Integration Partners).

Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment);

Not Applicable

If the Demonstration will provide personal care and/or long-term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).

The Demonstration will continue the long history in the Commonwealth of provision of opportunities

for individuals to self-direct their respite, companion and personal care services. The Commonwealth utilizes a Fiscal/Employer Agent and currently supports 16,000 individuals who self-direct and 22,000 attendants who are employed by those individuals. The Demonstration will include this model of self-direction.

If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates.

Any fee-for-service payment will be made according to existing state plan provider payment rates.

If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates and any deviations from the payment and contracting requirements under 42 CFR Part 438.

Capitation rates for managed care (MLTSS) will be consistent with payment and contracting requirements under 42 CFR Part 438. Since most of the population to be included in MLTSS is currently in FFS, DMAS will use FFS data to calculate PMPM costs from a two year base period, adjust for any policy and program changes between the base period and the rate year and trend to the rate year. DMAS will include adjustments for managed care and administrative costs. If encounter data is available, DMAS will use encounter data.

If quality based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including quality markers that will be measured and the data that will be collected.

The VIP model will allow for value-based payments to be rendered. DMAS intends to work with the VIPs and health plans in tandem with CMS to determine the best methodologies to deploy in order to realize quality based payments. DMAS anticipates the methodology being agreed to and provided to CMS as outlines in the Special Terms and Conditions document. Quality indicators will be identified, measured, and data collected in order to determine if the VIP was successful in securing any supplemental payment.

Implementation of Demonstration

Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone

The MLTSS, 1915(c) to 1115 Waiver Authority, and DSRIP proposals will all adhere to a 5 year timeline, beginning January 2017 and ending December 2021 (Figure 17). The MLTSS and 1915(c) to 1115 Waiver Authority will recognize the need to be renewed and specifics regarding renewal will be agreed upon by DMAS and CMS in the STCs. DMAS anticipates the DSRIP portion of the waiver to not be renewed after the 5 year demonstration.

MLTSS: The MLTSS implementation schedule can be found in Figure 15, MLTSS Implementation Phases.
DSRIP: The anticipated DSRIP implementation schedule can be found in Figure 17.

Describe how potential Demonstration participants will be notified/enrolled into the Demonstration

MLTSS: Enrollment in MLTSS will be mandatory for eligible individuals. The Department shall have sole authority and responsibility for the enrollment of individuals into the MLTSS program and for excluding members from MLTSS. There shall be no retroactive enrollment in MLTSS. Upon determination of eligibility the individual will be assigned to a participating MLTSS MCO using intelligent assignment methodology. The intelligent assignment method will seek to preserve existing MCO-beneficiary relationships as well as provider-beneficiary relationships in which the provider is the main source of Medicaid services for the beneficiary during the previous year. Approximately 30 days prior to the MCO enrollment effective date, enrollees will be sent information regarding the MLTSS program. This

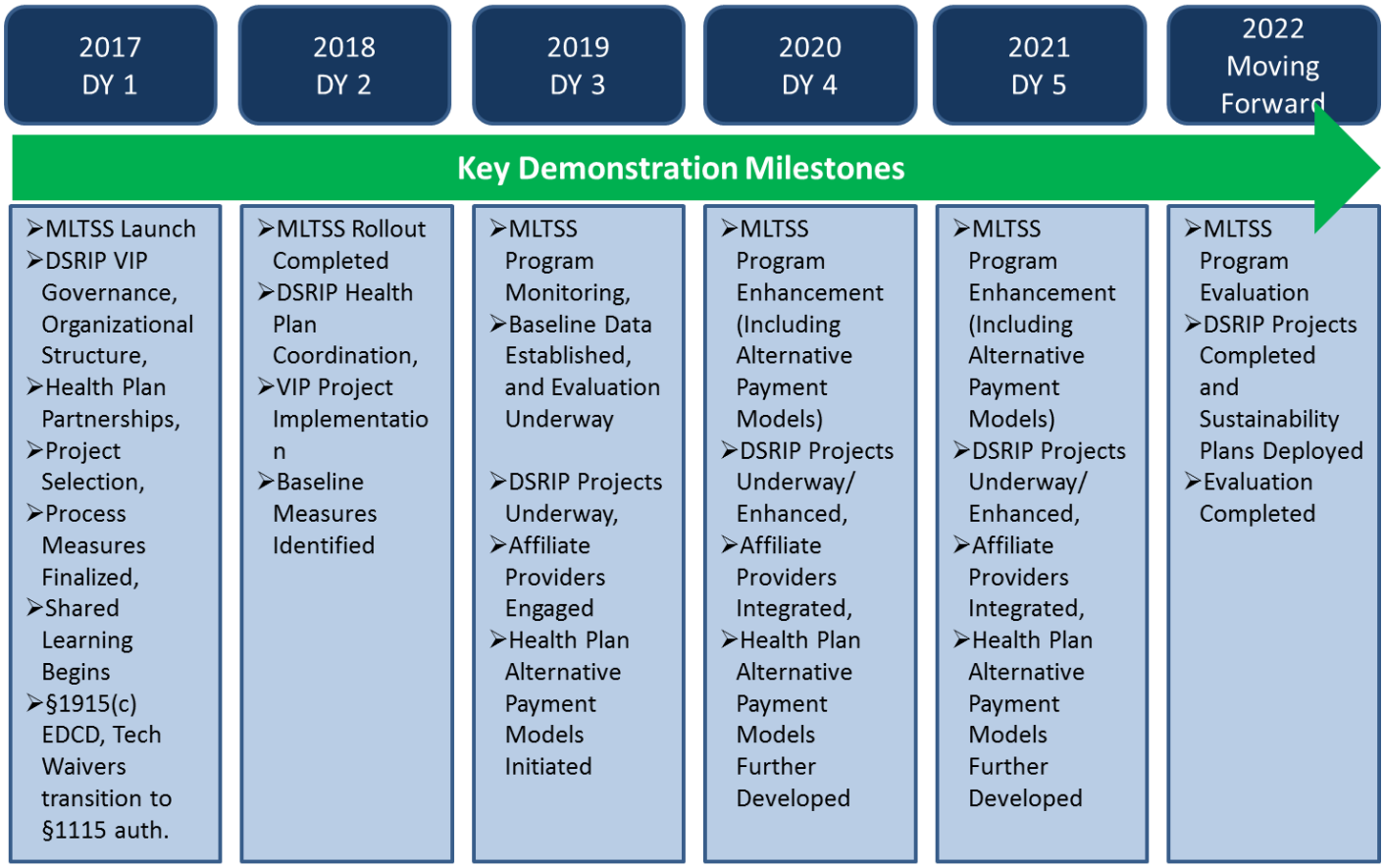

Figure 17 – Demonstration Timeline

information will include the enrollee's default MCO assignment, an MCO comparison chart, information regarding the enrollee's right to choose between at least 2 plans in that region, and information about the Department's enrollment broker, including how to contact the enrollment broker for choice counseling, plan selection and additional information about the MLTSS program. Individuals will also be sent a confirmation letter that confirms their managed care plan assignment and clearly explains their right to change from one MCO to another within the first 90 days of enrollment without cause. Prior to the initial date of enrollment, the enrollee's MCO will notify the member of his or her enrollment in health plan through a letter submitted simultaneously with the member handbook, provider directory, member identification card and information on how to contact the member's care manager (e.g., a telephone number, e-mail address).

DSRIP: DMAS will work closely with VIPs and selected MCOs to determine the protocol and process for notifying Medicaid beneficiaries of their opportunity to participate with the VIP. It will be important for members to understand that they remain enrolled with their MCO and will benefit further from participating in the VIP structure. The notification will include all pertinent contacts and information to ensure that beneficiaries and necessary caregivers are aware of the VIP opportunity and have the appropriate contact information to ensure seamless integration with their existing care.

If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action

MLTSS: As explained, DMAS is currently in development of a Request for Proposal (RFP) for Managed Long-term Services and Supports (MLTSS) managed care plans. Details pertaining to the scale and scope of the procurement will be available upon the release of the RFP in spring of 2016. DMAS will make the RFP available to CMS upon its release. DMAS anticipates awarding this procurement and securing contracts with the chosen plans well in advance of January 2017.

DSRIP: In addition to the MLTSS explanation above, DMAS currently contracts with six managed care organizations for Medallion 3.0, DMAS will leverage these contracts for DSRIP related involvement.

Demonstration Financing and Budget Neutrality

Virginia recognizes that Section 1115 waivers are generally approved for a 5-year period and must be budget neutral to the federal government—meaning that, over the course of the waiver, federal Medicaid expenditures will not be greater than they would have been without the waiver. To build its DSRIP investment pool, Virginia is proposing to leverage a portion of savings accrued to the federal government as a result of state strategies previously employed to constrain the rate of Medicaid spending. Through providing managed care choices for a percentage of Virginia Medicaid enrollees through Medallion 3.0, and rebalancing the long-term care system from institutional to community based settings, Virginia has achieved savings of $4.2 billion from 2004 through 2014.

The Medallion 3.0 savings assumes that managed care has saved at least 5% from what would have been spent under FFS. Savings from Long-term Services and Supports (LTSS) have been achieved via a rebalancing of care toward more community based settings. Between 2004 and 2014, the percent of individuals receiving LTSS through home and community based services rather than institutions, have shifted from 39 percent to 62 percent at an average annual savings per unduplicated beneficiary of $9,467 in 2014.

The MLTSS initiative will continue the rebalancing of care toward more community based setting. Virginia expects the percent of individuals receiving LTSS through home and community based services to increase to 76% by 2022. From 2018 through 2022, Virginia will achieve an additional $5.5 billion in savings through MLTSS. These achievable savings will also result in better care for members through managed care.

Virginia proposes a total investment of $1 billion over five years to support delivery system reforms that will transform Medicaid to a value-based payer with the goal of achieving better care at lower cost for Medicaid individuals. Initial efforts will be focused on preparing providers to more effectively serve the high risk, high-utilizers and subsequent high cost populations. These beneficiaries represent 20% of the Medicaid enrollment but 80% of the cost. Virginia expects to see additional tangible and sustainable savings in Medallion 3.0 and MLTSS during the latter part of the five-year DSRIP waiver.

Financing of the Non-Federal Share for DSRIP

To access federal funding for delivery system transformation, Virginia recognizes the responsibility to fund the non-federal share, meaning it must match any federal investment with an equal state or local share. This is significant because it determines the amount of funding the Commonwealth can receive to finance transformational activities.

In order to satisfy this requirement, Virginia is proposing to leverage designated state health programs (DSHPs) and intergovernmental transfers (IGTs). Virginia understands that for all funding sources, the dollars leveraged for the non-federal share cannot already be used for federal claiming. DMAS has identified eligible DSHPs and IGTs to support the DSRIP effort. DMAS will work with CMS and financing partners to ensure attestation of DSHP funds and IGT processes and protocols are agreed to and have as minimal administrative burden as possible.

The demonstration financing and budget neutrality forms can be found in Appendix C.

List of Proposed Waivers and Expenditure Authorities

Provide a list of proposed waivers and expenditure authorities; and describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Title XIX Waivers

MLTSS:

- Statewideness – Section 1902(a)(1): To enable the State to operate the Demonstration on a less-than-statewide basis. Rationale for Authority: To enable Virginia to use a phased approach to implement the MLTSS model statewide. The Commonwealth anticipates that MLTSS will roll out, regionally, as described in the body of the waiver application.

- Reasonable Promptness – Section 1902(a)(8): To enable the State to limit enrollment Rationale for Authority: DMAS will seek the use of an enrollment broker and to allow changes within period of time, e.g., during initial and open enrollment, and during specified exceptions identified by the state in accordance with federal requirements.

- Amount, Duration and Scope of Services – Section 1902(a)(10)(B): To enable the State to provide benefit packages to Demonstration populations that differ from the State plan benefit package. Rationale for Authority: The proposal seeks to waive the state plan benefit package for the described populations

- Rate-Setting/Payment Methodologies – Section 1902(a)(13) and (a)(30) Rationale for Authority: to permit the State to implement a value-based purchasing strategy based on the use of withholds and incentives.

- Comparability – Section 1902(a)(17) Rationale for Authority: To permit the Commonwealth to exclude from the Demonstration:
  Beneficiaries in the following categories: limited coverage groups, Medallion 3.0, FAMIS, ICF-ID and MH Facilities, Veterans Nursing Facilities, Residential Treatment Level C, Medicaid Works, PACE, Certain Out of State Placements, Hospice and ESRD.

- Freedom of Choice – Section 1902(a)(23)(A): To enable the State to mandatorily enroll Demonstration participants to receive benefits through certain providers and MCOs. Rationale for Authority: to enable the State to mandate enrollment of certain beneficiaries in the Demonstration Populations in risk-based contracted health plans. Beneficiaries will retain the right to choose between MCOs.

- Virginia seeks CMS guidance to determine which, if any additional waivers of State Plan requirements under the authority of section 1115(a)(1) of the Social Security Act are necessary to enable the state to carry out the demonstration.

Title XIX Waivers

DSRIP:

- Statewideness – Section 1902(a)(1): To enable the State to operate the Demonstration on a less-than-statewide basis. Rationale for Authority: To enable Virginia to pilot DSRIP strategies in certain areas of the state.

  Amount, Duration and Scope of Services – Section 1902(a)(10)(B): Rationale for Authority: To enable the state to offer cost-effective alternative benefit packages to different populations or regions of the state under the demonstration.

- Rate-Setting/Payment Methodologies – Section 1902(a)(13) and (a)(30) Rationale for Authority: to permit the State to implement a value-based purchasing strategy that may be based on the use of withholds and incentives.

- Comparability – Section 1902(a)(17) Rationale for Authority: To permit the Commonwealth to allow VIPs to target transformation projects in different regions and to different sub-populations.

- Freedom of Choice – Section 1902(a)(23)(A): To enable the State to mandatorily enroll Demonstration participants to receive benefits through certain providers. Rationale for Authority: to enable the State to mandate enrollment of certain beneficiaries in the Demonstration Populations in risk-based contracted health plans. Beneficiaries will retain the right to choose between MCOs.

- Limit payment to providers 42 CFR §438.60. Rationale for Authority: to allow direct payments to managed care providers or supportive housing and supported employment services.

- Utilization Review Requirement of Hospital or SNF §1903. Rationale for Authority: to allow for reimbursement for specific managed care plan, provider, behavioral health organization and system payments that support performance, quality, system alignment and whole-person care coordination to the extent not otherwise allowed. This may include fee-for-service and managed care-based incentive payments, and expenditures that support value-based payment evolution.

- DMAS anticipates the need to waive elements of §1903 as it pertains to the design of the DSRIP program. DMAS will work with CMS to ensure the appropriate provisions are waived to ensure:
    - The State may receive federal matching dollars for specified designated state health programs to allow the State to fund the non-federal share of payments and transition payments.
    - The State may receive federal matching dollars for payments made under the Demonstration to allow the State to make payments to IDNs for achieving specific milestones and metrics for specific projects undertaken to support the Demonstration vision.
    - The State may receive federal matching dollars for transition payments to providers to allow the State to strengthen and to support providers to enable them to participate in delivery system reform.

- Virginia seeks CMS guidance to determine which, if any additional waivers of State plan requirements under the authority of section 1115(a)(1) of the Social Security Act are necessary to enable the state to carry out the demonstration.

§1915(c) Home and Community Based Services Waivers: The waiver descriptions for the waivers currently operating under §1915(c) authority describe the specific waiver authorities requested. As this 1115 application seeks to grant administrative simplification only, there are no modifications to what can be found here: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html

(Search 1915(c) Virginia, Approved, Application)

Public Notice

The Department has a strong history of working with stakeholders. The public notice and public facing process of this demonstration waiver has required a significant amount of dedicated staff time and effort. To that end, stakeholders shall be able to attest to the incorporation of ideas, suggestions, and concepts. Due to the complex nature of this waiver, the initial public facing strategies were targeted based on demonstration concept, though all elements provided for in 42 CFR 431.408 have been addressed.

Appendix D contains all the documents from the public notice process.

Start and end dates of the state's public comment period:

MLTSS: General Approach Proposal: May 18th – June 16, 2015

Model of Care: September 1 – September 30, 2015

DSRIP: September 11 – October 19, 2015

Unified Waiver (MLTSS, DSRIP, §1915(c) waiver authority): December 1 – 31, 2015

Comments received by the state during the 30 day public comment period and a summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

A summary of comments received and DMAS' responses can be viewed in Appendix D.

Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS

MLTSS:

General Approach Proposal: May 18th – June 16, 2015
http://www.dmas.virginia.gov/Content_atchs/ltc/MLTSS%20Public%20Comment%20AMENDED%20052615.pdf

Discussion of Proposal: June 2, 2015:
http://www.dmas.virginia.gov/Content_atchs/ltc/Notice%20announcing%20all%20plans%20meeting%20final.pdf

DSRIP:

September 11, 2015 http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23344
1:00 PM to 3:00 PM (EDT)
Meeting location: VCU - Community Memorial Hospital, 125 Buena Vista Circle, South Hill, VA 23970

September 14, 2015
1:00 PM to 3:00 PM (EDT)
Meeting location: Southwest Higher Education Center, One Partnership Cir, Abingdon, VA 24210

September 16, 2015
1:00 PM to 3:00 PM (EDT)
Meeting location: Mary Washington Hospital - John F. Fick Conference Center, 1301 Sam Perry Blvd, Fredericksburg, VA 22401

September 25, 2015 http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23396
1:00 PM to 3:00 PM (EDT)
Meeting location: 920 Corporate Lane, Chesapeake, VA 23320

September 29, 2015 http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23397
10:00 AM to 12:00 PM (EDT)
Meeting location: Kaiser Permanente Center for Total Health, 700 2nd Street Northeast, Washington, DC 20002

October 15, 2015 http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23571
Webinar: Provider Organization Models for Integrated Care Delivery – Models for Other States
DSRIP Focus Groups

Community Capacity http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23522
Wednesday, October 7, 2015
10:00am - 4:00pm (EDT)
Meeting location: 3831 Westerre Parkway, Henrico, VA 23233

Virginia Integration Partners (VIPs) http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23523
Thursday, October 22, 2015
10:00am - 4:00pm (EDT)
Meeting location: 3831 Westerre Parkway, Henrico, VA 23233

Data Integration and Infrastructure http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23524
Friday, November 6, 2015
10:00am - 1:00pm (EDT)
Meeting location: Perimeter Center, 9960 Mayland Drive, Suite 201, Board Room 1, Henrico, VA 23233

MLTSS + DSRIP:

November 18, 2015: http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23693 (phone call capability)

Unified Waiver (MLTSS, DSRIP, §1915(c) waiver authority):

December 1, 2015: http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23735 (phone call capability)

December 2: 2015: http://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=23736

Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.

1)	Virginia Town Hall – State Administrative Register – web links intermittent throughout the explanations above
2)	DMAS webpage – highly visible off of main page: MLTSS: State webpage with all related information: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx DSRIP: State webpage with all related information: http://www.dmas.virginia.gov/Content_pgs/dsrip.aspx
3)	Agency Electronic Mailing: Distribution to Network Providers 3,700 and approximately 290 Stakeholders and additional contacts
4)	Distribution by Virginia Center for Health Innovation – SIM lead and strong supporting partner

1115 Waiver concept continues to be developed through extensive stakeholder engagement with a broad public audience

Engagement Meeting	Stakeholders Engaged							
	All Public	Health Systems	Health Plans	Medicaid Service Providers (including Behavioral Health Providers)	Community Based Organizations	Community Advocates	Board for Medical Assistance Services (BMAS)	State Agencies (VDH, DBHDS, DARS, DHP, VBPD DPB)
SIM Workgroups		✓	✓		✓		✓	✓
Public Roadshow (5 across the state)	✓	✓	✓	✓	✓	✓	✓	
MLTSS and DSRIP Website, Email Communications, and Request for Written Public Comments	✓	✓	✓	✓	✓	✓	✓	✓
One-off Meetings		✓	✓	✓	✓	✓	✓	✓
Focus Groups	✓	✓	✓	✓	✓	✓	✓	✓
Value Based Purchasing Request for Information	✓		✓					

Over 500 people have been engaged through the process to date

Demonstration Administration

The contact information for DMAS' point of contact for the Demonstration application is below:

Name and Title: Seon Rockwell, Senior Programs Advisor, Administration

Virginia Department of Medical Assistance Services

Telephone Number: (804) 298-3851

Email Address: seon.rockwell@dmas.virginia.gov

Application Appendix Documents

A. MLTSS Covered Services
B. MLTSS and Medallion 3.0 Eligibility Chart(s)
C. Budget Neutrality and Financing Forms
D. Public Comment Aggregated Themes and DMAS Summary Responses

Appendix A – MLTSS Covered Services

The MLTSS health plans shall provide benefits as defined in the future released Request for Proposal (RFP) within at least equal amount, duration, and scope as available under the State Plan for Medical Assistance Services, and as further defined in the Virginia Administrative Code, Title 12 VAC 30-50, and the appropriate DMAS Provider Program Manuals. The chart below describes the full range of services that are available to MLTSS enrolled individuals. The "MLTSS Contract Covered" column explains whether or not the service is covered under the MLTSS contract. Services that are not covered under the State Plan would need to be covered when medically necessary for children under age 21, in accordance with Federal EPSDT guidelines. There are a few services that are carved-out of the MLTSS contract that will continue to be covered for MLTSS members under fee-for-service.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Abortions, induced	12 VAC 30-50-100 and 12 VAC 30-50-40	Yes; limited to those cases where there would be substantial danger to life of mother	Yes; limited to those cases where there would be substantial danger to life of mother	The Contractor shall provide coverage for abortion in limited cases where there would be a substantial danger to life of the mother as referenced in Public Law 111-8, as written at the time of the execution of this contract, shall be reviewed to ensure compliance with State and federal law. The Contractor shall be responsible for payment of abortion services meeting state and federal requirements under the fee-for-service program.
Behavioral Health	See Part 2 of this Attachment			
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service except as medically necessary in accordance with EPSDT criteria.
Christian Science Sanatoria	12 VAC 30-50-300	Yes	No	Individuals will be excluded from MLTSS participation upon entry into a Christian Science Sanatoria. Services will be covered through the DMAS fee-for-service program in accordance with 12 VAC 30-50-300.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor shall cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor shall 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 referenced in such recommendations.
Court Ordered Services	Code of Virginia Section 37.1-67.4	Yes	Yes	The Contractor shall cover all medically necessary court ordered services included as a part of this Contract.
Dental Services	12 VAC 30-50-190	Yes	Yes for certain circumstances.	Under MLTSS, DMAS' contracted dental benefits administrator (DBA) will continue to cover routine dental services for children under 21 and for adult pregnant women, so these services will be carved out of MLTSS. However, the Contractor shall be responsible for transportation and medication related to covered dental services. Specifically, the Contractor shall cover CPT codes billed by an MD as a result of an accident, and CPT and "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor shall also cover medically necessary anesthesia and hospitalization services for its members when determined to be medically necessary by the DMAS Dental Benefits Administrator.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover EPSDT screenings according to the American Academy of Pediatrics periodicity schedule, diagnostic services as well as any and all services identified as necessary to correct, maintain or ameliorate any identified defects or conditions. The Contractor shall screen and assess all children; cover immunizations; educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Early Intervention Services	20U.S.C. § 1471 34 C.F.R.§ 303.12 Code of Virginia § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415	Yes	Yes	The Contractor is required to provide coverage for Early Intervention services as defined by 12 VAC 30-50-131 and 12 VAC 30-50-415 within the Department's coverage criteria and guidelines. Early Intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. The Contractor shall also cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.
Emergency Services	12 VAC 30-50-110 12 VAC 30-50- 12 VAC 30-50-300 12 VAC 30-120-395	Yes	Yes	The Contractor shall cover all emergency services without service authorization. The Contractor shall also cover services needed to ascertain whether an emergency exists. The Contractor shall not restrict a member's choice of provider for emergency services.
Post Stabilization Care following Emergency Services	42 C.F.R. § 422.100(b)(1)(iv)	Yes	Yes	The Contractor shall cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency condition has been stabilized.
Experimental and Investigational Procedures	12 VAC 30-50-140	No	No	Experimental and investigational procedures as defined in the MLTSS Contract are not Medicaid covered. See Section 1, Definitions.
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover all family planning services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor shall not restrict a member's choice of provider or method for family planning services or supplies, and the Contractor shall cover all family planning services and supplies provided to its members by network providers and by out-of-network providers.
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01	Yes	Yes	The Contractor shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Home Health Services	12 VAC 30-50-160; and 12 VAC 30-10-220; Additional information can be found in the Home Health provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits shall be allowed. Skilled home health visits are limited based upon medical necessity. The Contractor shall manage conditions, where medically necessary and regardless of whether the need is long or short-term, including in instances where the member cannot perform the services; where there is no responsible party willing and able to perform the services, and where the service cannot be performed in the PCP office/outpatient clinic, etc. The Contractor may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option.
Hospice Services	See Part 3 (LTSS) of this Attachment.			
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover immunizations. The Contractor shall educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.
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 shall cover inpatient stays in general acute care and rehabilitation hospitals for all members; shall comply with maternity length of stay requirements; shall comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements; and shall cover an early discharge follow-up visit in maternity cases where the member is discharged earlier than 48 hours after the day of delivery.
Laboratory and X-ray Services	12 VAC 30-50-120	Yes	Yes	The Contractor shall cover all laboratory and x-ray services directed and performed within the scope of the license of the practitioner.
Lead Investigations	12 VAC 30-50-227	Yes	Yes	The Contractor shall cover environmental investigations by local health departments and shall be limited to no more than two visits per residence.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor shall cover low-dose screening mammograms for determining presence of occult breast cancer.
Medical Supplies and Equipment	12 VAC 30-50-165; 12 VAC 30-60-75; and 12 VAC 30-80-30 Additional information can be found in the DME and Supplies provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall cover medical supplies and equipment at least to the extent covered by DMAS. The Contractor shall cover nutritional supplements and supplies. The Contractor shall cover specially manufactured DME equipment that was prior authorized by the Contractor per requirements specified in the DME supplies manual. The Contractor's benefits shall be limited based upon medical necessity.
Mental Health Services	See Part 2 of this Attachment			
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor shall cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.
Organ Transplantation	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	The Contractor shall cover organ transplants for children and adults in accordance with 12 VAC 30-50-540 through 12 VAC 30-50-580. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. Contractor shall cover necessary procurement/donor related services. Transplant services for medically necessary transplantation procedures that are determined to not be experimental or investigational, as experimental is defined in the MLTSS contract, shall be covered for children (under 21 years of age) per EPSDT guidelines.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Outpatient Hospital Services	12 VAC 30-50-110 -	Yes	Yes	The Contractor shall cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The Contractor shall cover limited oral surgery as defined under Medicare.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor shall cover annual pap smears.
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 and 12 VAC 30-50-225 12 VAC 30-60-150	Yes	Yes	The Contractor shall cover physical therapy, occupational therapy, and speech pathology and Audiology services that are provided as an inpatient, outpatient hospital service, outpatient rehabilitation agencies, or home health service. The Contractor's benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity.
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130	Yes	Yes	The Contractor shall cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT.
Podiatry	12 VAC 30-50-150	Yes	Yes	The Contractor shall cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot.
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410 12 VAC 30-50-280 12 VAC 30-50-290	Yes	Yes	The Contractor shall cover case management services for its high risk pregnant women and children (up to age two). The Contractor shall provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The Contractor shall cover pregnancy-related and post-partum services for sixty (60) days after pregnancy ends for the Contractor's enrolled members.
Prescription Drugs	12 VAC 30-50-210	Yes	Yes	The Contractor shall cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Private Duty Nursing (PDN)	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 C.F.R. § 441.50 1905(a) of Social Security Act	Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. Coverage is also available for PDN under the Technology Assisted Waiver.	Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. Coverage is also available for PDN under the Technology Assisted Waiver.	The Contractor shall cover medically necessary private duty nursing services for children under age 21 consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal (Also see Technology Assisted Waiver in Section 3 of this Attachment)
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male members for prostate cancer.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120	Yes	Yes	The Contractor shall cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	The Contractor shall cover reconstructive breast surgery.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
School-Health Services	12 VAC 30-50-130	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department's criteria will continue to be covered as a carve-out service through the DMAS fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Local Education Agency school provider manual. The Contractor shall cover EPSDT screenings for the general Medicaid student population. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school.
Skilled Nursing Facility Care	See Part 3 (LTSS) of this Attachment			
Substance Use Disorder Treatment	See Part 2 of this Attachment			

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MLTSS Contract Covered	Highlights Regarding Contractor Responsibilities
Transportation	12 VAC 30-50-530 12 VAC 30-50-300	Yes	Yes	The Contractor shall provide urgent and emergency transportation as well as non-emergency transportation to all Medicaid covered services, including those Medicaid services covered by Medicare or another third party payer and to services provided by subcontractors. These modes shall include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The Contractor shall cover air travel for critical needs. The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § CFR 440.170(a). The Contractor shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services. The Contractor shall cover transportation to and from Medicaid covered community mental health and rehabilitation services. ID, DD, and DS Wavier members shall receive acute and primary medical services via the Contractor and shall receive waiver services and related medical transportation to waiver services via the fee-for-service program. The Contractor must provide door-to-door transportation when indicated for waiver services transportation.
Vision Services	12 VAC 30-50-210	Yes	Yes	The Contractor shall cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. The Contractor shall also cover eyeglasses for children under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.
Waiver Services (Home and Community Based)	See Part 3 (LTSS) of this Attachment			

SUMMARY OF COVERED SERVICES - PART 2 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
INPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE DISORDER TREATMENT SERVICES Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital (state or private)	12 VAC 30-50-230 12 VAC 30-50-250	Yes	Yes	The Contractor shall cover medically necessary inpatient psychiatric hospital stays in free standing psychiatric hospitals for covered members over age sixty-four (64) or under age twenty-one (21). The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members between the ages of 21 and 64.
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes	Yes	The Contractor shall provide coverage for medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital for all members, regardless of age. Coverage must comply with Federal Mental Health Parity law.
Inpatient Substance Use Disorder Treatment for Children	12 VAC 30-50-130 42CFR § 441; Section 1905(r) of the Social Security Act	Yes – Children	Yes – Children	The Contractor shall provide coverage for medically necessary inpatient substance use disorder treatment services in accordance with Federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria for members under age twenty-one (21).
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO)	42 C.F.R. § 441.150 and Code of Virginia § 16.1-340 and 340.1 and §§ 37.2-808 through 810.	Yes	Yes	The Contractor shall provide coverage for TDO and ECO services in accordance with the regulatory guidelines at: Code of Virginia § 16.1-340 and 340.1 and §§ 37.2-808 through 810.
RESIDENTAL TREATMENT SERVICES FOR CHILDREN				
Residential Treatment Facility Services (RTF) for children under age 21 years – Level A, B & C	12 VAC 30-130-850 to 890 12 VAC 30-60-61 and 12 VAC 30-50-130 And emergency regulations for IMD cases (Level C and freestanding psych) are defined at http://townhall.virginia.gov/L/ViewStage.cfm?stageid=6572	Yes	No	**DMAS authorization into a RTF level C program will result in disenrollment of the member from MLTSS. The RTF provider must contact the DMAS BHSA for authorization. Level A & B placements are group homes and members remain enrolled with the Contractor, and members enrolled in Level C are exempted from MLTSS participation. The Contractor must work closely with the Department's BHSA to ensure against unnecessary institutional placement; i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative.
OUTPATIENT BEHAVIORAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES				
Electroconvulsive Therapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. Coverage must comply with Federal Mental Health Parity law.

SUMMARY OF COVERED SERVICES - PART 2 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Pharmacological Management	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary pharmacological management, including for behavioral health and substance abuse treatment services.
Psychiatric Diagnostic Exam	12 VAC 30-50-180 12 VAC 30-50-140	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. Coverage must comply with Federal Mental Health Parity law.
Psychological/ Neuropsychological Testing	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. Coverage must comply with Federal Mental Health Parity law.
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. Coverage must comply with Federal Mental Health Parity law.
Substance Use Disorder Treatment Services *(traditional outpatient SUD treatment services)*	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover substance assessment and evaluation and outpatient services for substance abuse treatment. Coverage must comply with Federal Mental Health Parity law.
COMMUNITY BASED BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES				
The Contractor shall contract with the Department's BHSA for the provision of non-traditional or community behavioral health and substance abuse treatment services within the Department's established coverage criteria and guidelines until such time that the DMAS BHSA contract expires (anticipated to be no later than November 30, 2018). Once the DMAS contract with the BHSA expires, the Contractor shall continue to be responsible for the full scope of community behavioral health and substance abuse treatment services, whereby the Contractor may manage these services in-house or through the Contractor's contracted behavioral health services administrator. Additional information on behavioral health services is available on the Department's BHSA website.				
Behavioral Therapy Services under EPSDT	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	Yes	Yes	The Contractor is required to provide coverage for Behavioral Therapy (BT) Services as defined by 12 VAC 30-50-130,12 VAC 30-130-2000, and the DMAS EPSDT Behavioral Therapy Provider Manual available at https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal. The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Community Intellectual	12 VAC 30-50-440	Yes	No	The Contractor shall provide information and referrals as

SUMMARY OF COVERED SERVICES - PART 2 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Disability Case Management				appropriate to assist members in accessing these services through the individual's local community services boards. These services will continue to be covered through the DMAS fee-for-service program.
Crisis Intervention Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Crisis Stabilization Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Day Treatment/Partial Hospitalization	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Day Treatment/Partial Hospitalization Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12VAC 30-60-61 12VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Intensive Community Treatment Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Intensive Community Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage

SUMMARY OF COVERED SERVICES - PART 2 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143			criteria and guidelines.
Intensive In-Home Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Intensive In-Home Services (IIH) for Children/Adolescents	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Mental Health Case Management	12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Mental Health Skill-building Assessment	12 VAC 30-50-226 ER 12 VAC 30-60-143ER	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Mental Health Skill-building Services	12 VAC 30-50-226 ER 12 VAC 30-60-143ER	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Psychosocial Rehabilitation Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Psychosocial Rehabilitation Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.

SUMMARY OF COVERED SERVICES - PART 2 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	12 VAC 30-60-143			
Residential Services (Community-Based) for Children and Adolescents under 21 (Level A)	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 130-850-890 12 VAC 30-50-130	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Therapeutic Behavioral Services (Level B)	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 130-850-890 12 VAC 30-50-130	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Therapeutic Day Treatment Assessment	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Therapeutic Day Treatment (TDT) for Children and Adolescents	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years.	12 VAC 30-60-170 12 VAC 30-50-480 12 VAC 30-130-900 to 950 12 VAC 30-80-111	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
COMMUNITY BASED SUBSTANCE USE DISORDER SERVICES				
Opioid Treatment	12 VAC 30-60-180 12 VAC 30-50-228	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage

SUMMARY OF COVERED SERVICES - PART 2 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				criteria and guidelines.
Substance Abuse Case Management	12 VAC 30-60-185 12 VAC 30-50-431	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Substance Abuse Crisis Intervention	12 VAC 30-60-180 12 VAC 30-50-228	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Substance Abuse Day Treatment	12 VAC 30-60-180 12 VAC 30-50-228	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Substance Abuse Day Treatment for Pregnant Women	12 VAC 30-50-510 12 VAC 30-60-147	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Substance Abuse Intensive Outpatient Services	12 VAC 30-60-180 12 VAC 30-50-228	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.
Substance Abuse Residential Treatment Facility Services (RTF) for children under age 21 years	12 VAC 30-130-850 to 890 12 VAC 30-60-61 and 12 VAC 30-50-130 And emergency regulations for IMD cases (Level C and freestanding psych) are defined at http://townhall.virginia.gov/L/ViewStage.cfm?stageid=6572	Yes	No	**DMAS authorization into a RTF program will result in disenrollment of the member from MLTSS. The RTF provider must contact the DMAS BHSA for authorization. Level C refers to RTF. Level A & B settings remain enrolled with the Contractor, and members enrolled in Level C are exempted from MLTSS participation.
Substance Abuse Residential Treatment for Pregnant Women	12 VAC 30-50-510 12 VAC 30-60-147	Yes	Yes	The Contractor shall contract with the Department's BHSA for the provision of this service within DMAS established coverage criteria and guidelines.

SUMMARY OF COVERED SERVICES - PART 3 – LONG-TERM SERVICES AND SUPPORTS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes

SUMMARY OF COVERED SERVICES - PART 3 – LONG-TERM SERVICES AND SUPPORTS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
Alzheimer's Assisted Living Waiver (AAL)	12 VAC 30-120-1600 through 12 VAC 30-120-1680 Additional information can be found in the AAL waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	AAL Waiver services will be excluded from the MLTSS Contract and will be covered under the DMAS fee-for-service program in accordance with DMAS established coverage criteria and guidelines. (See the AAL Provider Manual for additional information). AAL Waiver services require service authorization through the appropriate DMAS contractor. Through person-centered care planning, the Contractor shall ensure that members are aware of other community based treatment options available through the Contractor designed to serve members in the settings of their choice
Day Support (DS) Waiver	12 VAC 30-120-1500 through 12 VAC 30-12-01550 Additional information can be found in the DS waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	DS Waiver services include: day support, supported employment and pre-vocational services for individuals with intellectual disabilities. Individuals on the DS Waiver will continue to receive their waiver services, including transportation to the DS Waiver services, through Medicaid fee-for-service. =.
Developmental Disabilities (DD) Waiver	12 VAC 30-120-700 through 12 VAC 30-120-790 Additional information can be found in the DD waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	DD Waiver services include: therapeutic consultation, day support, environmental modifications, crisis stabilization in-home residential, family caregiver training, personal emergency response systems (with or without medication monitoring), supported employment, pre-vocational services, companion services, skilled nursing, respite care, personal care, assistive technology and transition services. Both agency directed and consumer directed services are a service delivery method for personal care, companion, and respite care services. Transition services and transition coordination are covered for those individuals seeking services in the community after transition from a qualified institution. Transition may be associated with the Money Follows the Person program. Support coordination services are also covered as a state plan option in association with the provision of DD waiver services. Individuals on the DD Waiver will continue to receive their waiver services, including transportation to the DD Waiver services, through Medicaid fee-for-service.
Elderly or Disabled with Consumer Directed Services (EDCD) Waiver	12 VAC 30-120-900 through 12 VAC 30-120-995	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing these services. The Contractor shall cover personal care, respite care, adult day health care, personal

SUMMARY OF COVERED SERVICES - PART 3 – LONG-TERM SERVICES AND SUPPORTS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	Additional Information can be found in the EDCD waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			emergency response systems, transition services and transition coordination. The Contractor shall cover both agency directed and consumer directed services as a service delivery model for personal care and respite care services. Personal emergency response systems may include medication monitoring as well. Transition services and transition coordination are covered for those individuals seeking services in the community after transition from a qualified institution. When transition is associated with the Money Follows the Person program, transition services and transition coordination are carved out. The Contractor shall make provisions for the collection and distribution of the individual member's monthly patient pay for waiver services (if appropriate). The contactor shall cover transportation services for the EDCD waiver.
Hospice Services	12 VAC 30-50-270; and 12 VAC 30-60-130 Additional information can be found in the Hospice provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of hospice services.
Intellectual Disabilities (ID) Waiver	12 VAC 30-120-1000 through 12 VAC 30-120-1090 Additional information can be found in the ID waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	ID Waiver services include: therapeutic consultation, congregate residential, day support, environmental modifications, crisis stabilization in-home residential, personal emergency response systems (with or without medication monitoring), supported employment, pre-vocational services, companion services, skilled nursing, respite care, personal care, assistive technology and transition services. Both agency directed and consumer directed services are a service delivery method for personal care, companion, and respite care services. Transition services and transition coordination are covered for those individuals seeking services in the community after transition from a qualified institution. Transition may be associated with the Money Follows the Person program. Case management services are also covered as a state plan option in association with the provision of ID waiver services. Individuals on the ID Waiver will continue to receive their waiver services,

SUMMARY OF COVERED SERVICES - PART 3 – LONG-TERM SERVICES AND SUPPORTS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
				including transportation to the ID Waiver services, through Medicaid fee-for-service.
Long Stay Hospital – State Plan Only Service	12 VAC 30-60-30; 12 VAC 30-130-100 through 12 VAC 30-130-130 Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of long stay hospital services for adults. Long Stay Hospital services are a state plan only service which covers individuals requiring mechanical ventilation, individuals with communicable diseases requiring universal or respiratory precautions, individuals requiring ongoing intravenous medication or nutrition administration, and individuals requiring comprehensive rehabilitative therapy services. The Contractor shall make provisions for the collection and distribution of the individual member's monthly patient pay for long stay hospital services. The Contractor shall cover transportation services for long stay hospital services.
Nursing Facility	12 VAC 30-90-305 through 12 VAC 30-90-320 for RUGS reimbursement Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of nursing facility level of care. The Contractor shall use the existing reimbursement system for payment of nursing facility level of care which is based on the RUGs payment methodology. The Contractor shall make provisions for the collection and distribution of the individual member's monthly patient pay for nursing facility services. Transition services and transition coordination are covered for those individuals seeking services in the community under the Money Follows the Person program. The Contractor shall cover transportation services for nursing facility residents.
Money Follows the Person	12 VAC 30-120-2000; 12 VAC 30-120-935; 12 VAC 30-120-935; and 12 VAC 30-120-2010 Additional information can be found in the Waiver provider manuals (as Appendix E)	Yes	No	Individuals enrolled in MFP who are transitioning out of an MLTSS-included institution and who qualify for, and enroll into upon discharge, the DD, EDCD, ID, or Tech Waiver will be enrolled in MLTSS for their non-waiver services (e.g., institutional, acute, behavioral health, pharmacy, and non-LTSS waiver transportation services). Their MFP and LTSS waiver services, including transportation to waiver services, will be paid through Medicaid fee-for-service as "carved out" services.

SUMMARY OF COVERED SERVICES - PART 3 – LONG-TERM SERVICES AND SUPPORTS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			MFP demonstration services include: transition coordination up to two months prior to and 12 months following discharge from an institution (only for individuals who are enrolled in MFP and transition to the EDCD Waiver); assistive technology for individuals who are enrolled in the MFP and the EDCD Waiver, for up to 12 months after discharge from an institution; environmental modifications for individuals who are enrolled in MFP and the EDCD Waiver, for up to 12 months after discharge from an institution; and transition services up to nine months, two of which can be prior to discharge from an institution.
Out of State NF Placements	42 CFR § 431.52 12 VAC 30-10-120 12 VAC 30-60-21 12 VAC 30-70-420 12 VAC 30-90-10	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of out of state placements if services cannot be provided in the Commonwealth of Virginia. The Contractor shall make provisions for the collection and distribution of the individual member's monthly patient pay for out of state placements. The Contractor shall cover all services in the negotiated rate for out of state NF placements to include such services as medical, behavioral, pharmacy, transportation, and any other services which are provided as part of the Contractor for placement.
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 DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing services. The Contractor shall cover all services associated with the provision of specialized care services for adults. Specialized care services are a state plan only service which covers complex trach and ventilator dependent nursing facility residents at a higher reimbursement rate. The Contractor shall make provisions for the collection and distribution of the individual member's monthly patient pay for specialized care services. Transition services and transition coordination are covered for those individuals seeking services in the community under the Money Follows the Person program. The Contractor shall cover transportation services for specialized care residents.
Technology Assisted (Tech) Waiver	12 VAC 30-120-1700 through 12 VAC 30-120-1770	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist members in accessing these services. The Contractor shall

SUMMARY OF COVERED SERVICES - PART 3 – LONG-TERM SERVICES AND SUPPORTS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	MLTSS Contract Covered	Notes
	Additional information can be found in the Tech waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			cover skilled private duty nursing, skilled respite, personal care services (for adults only), environmental modifications, assistive technology, and transition services. Private duty nursing services and respite care services can be provided as either individual or congregate services. The Contractor shall make provisions for the collection and distribution of the individual member's monthly patient pay for waiver services (if appropriate). The Contractor shall cover transportation services for the Tech waiver.

Appendix B – MLTSS and Medallion 3.0 Eligibility Chart(s)

MLTSS List of Medicaid Eligibility Groups

Mandatory Categorically Needy

Eligibility Group Name	Social Security Act and CFR	Income Level
Low Income Families	1931	3 locality group[6]
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	First six months no new test; 6-12 months, 185% fpl
Extended Medicaid due to Child or Spousal Support Collections	408(a)(11)(B) 42 CFR 435.115 1931(c)(1)	No new income test must meet extended rules
Children with Title IV-E Adoption Assistance, Foster Care – *if individual is a dual or receiving a HCBS waiver service*	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145	No income test
Qualified Pregnant Women and Children	42 CFR 435.116 - old 1902(a)(10)(A)(i)(III) 1905(n)	143% fpl
Mandatory Poverty Level Related Pregnant Women	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	143% fpl
Mandatory Poverty Level Related Infants	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	143% fpl
Mandatory Poverty Level Related Children Aged 1-5	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	143% fpl
Mandatory Poverty Level Related Children Aged 6-18	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	143% fpl
Deemed Newborns	1902(e)(4) 42 CFR 435.117	No income test
Aged, Blind and Disabled Individuals in 209(b) States	1902(f) 42 CFR 435.121	SSI limit—approx. 74% fpl
Individuals Receiving Mandatory State Supplements	42 CFR 435.130	No income test
Blind or Disabled Individuals Eligible in 1973	42 CFR 435.133	Currently, None
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	42 CFR 435.134	Less than current SSI or F&C limit
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	1939(a)(5)(E) 42 CFR 435.135 Section 503 of P.L. 94-566	Current SSI or AG limits

[6] DMAS will provide explanation for CMS if needed during the Special Terms and Conditions negotiation.

Optional Categorically Needy

Eligibility Group Name	Social Security Act and CFR	Income Level
Individuals Eligible for Cash except for Institutionalization	1902(a)(10)(A)(ii)(IV) 42 CFR 435.211 1905(a)	300% SSI, about 250% fpl
Individuals Receiving Home and Community Based Services under Institutional Rules	42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	300% SSI, about 250% fpl
Individuals Receiving Hospice Care[7]	1902(a)(10)(A)(ii)(VII) 1905(o)	300% SSI, about 250% fpl
Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements	42 CFR 435.234 1902(a)(10)(A)(ii)(XI)	AG recipients, no income test
Qualified Disabled Children under 19	1902(e)(3)	SSI—74% fpl
Institutionalized Individuals Eligible under a Special Income Level	42 CFR 435.236 1902(a)(10)(A)(ii)(V) 1905(a)	300% SSI, about 250% fpl
Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) 1902(m)(1)	80% FPL
Individuals Eligible for Home and Community-Based Services	1902(a)(10)(A)(ii)(XXII) 1915(i)	300% SSI, about 250% fpl
Individuals Eligible for Home and Community-Based Services - Special Income Level	1902(a)(10)(A)(ii)(XXII) 1915(i)	300% SSI, about 250% SSI

Medically Needy

n/a

[7] Individuals will remain enrolled in MLTSS if MLTSS enrolled at the time hospice is determined to be needed and individual is subsequently enrolled into hospice. Those in hospice, already, will not be enrolled into demonstration

Appendix C – Budget Neutrality and Financing Forms

Budget Neutrality Spreadsheet:

Budget Neutrality.xlsx

Financing Form:

Financing Form.docx

Appendix D – Public Comment Aggregated Themes and DMAS Summary Responses

The development of this 1115 waiver application has been an evolution, engaging stakeholders at each point of the process. DMAS recognizes that the unified waiver approach, merging MLTSS and DSRIP together, is significant; however, the opportunity is greater. To that end, each component of the application was given unique attention, resulting in 3 key public comment opportunities, all meeting the CMS requirements. The final public comment exercise merged the previous efforts and included many suggestions and elements of feedback, as acknowledged by many stakeholders in the third public comment solicitation responses. As reflected in the requested documentation, DMAS extended public comment requests in writing, in person, and via teleconference and WebEx. In addition to these formal public comment solicitations, there have been significant efforts to engage stakeholders in meetings and brain storming sessions, all in attempt to ensure the Departments efforts are strategic, comprehensive, and innovative. DMAS fully intends to maintain engagement of stakeholders both at large, and in targeted groups as the Department further refines and develops program specifics. DMAS will also look to form an advisory coalition to ensure ongoing engagement over the course of the 5 year demonstration.

1. MLTSS:
    - General Approach Proposal: May 18 – June 16, 2015 Public Comment Document
    - Model of Care: September 1 – September 30, 2015 Public Comment Document
2. DSRIP:
    - Concept Paper: September 11 – October 19, 2015 Public Comment Document
3. Unified Waiver (MLTSS, DSRIP, §1915(c) waiver authority):
    - Waiver: December 4, 2015 – January 6, 2016 Public Comment Document

Unified Waiver (MLTSS, DSRIP, §1915(c) waiver authority):

Public Comment Themes and Departmental Response

Period 12/04/15—1/06/16

The comments are organized to reflect themes that surfaced across the range of public comments received, with headers indicating the represented perspective.

Note: no comments were received regarding the administrative transition of the §1915(c) waivers to the §1115 authority.

Stakeholder Group	Comment Theme	DMAS Response
Overall Approach		
Advocates	The combination of the Medicaid Managed Long-Term Services and Supports (MLTSS) initiative with the Delivery System Reform Incentive Payment (DSRIP) Program is ingenious and creates exciting synergies to transform Virginia's Medicaid program.	DMAS appreciates the recognition that the combination of these two initiatives allows Virginia to further transform the Virginia Medicaid program.
Health Plans	Expression that it is positive to see the focus on beneficiaries with high utilization as a key objective of the proposed DSRIP Program and is embedded in the approach in MLTSS as well. Acknowledgment that the MLTSS hypothesis includes reducing service gaps and providing coordination between physical and behavioral health, and LTSS is a key opportunity. Acknowledgment that DSRIP and MLTSS have the opportunity to be leveraged together to both improve care in the short-term and to make systematic improvements in the longer term, thereby helping lock in the gains of both quality of care and cost effectiveness.	DMAS appreciates the acknowledgement that leveraged together, DSRIP and MLTSS offers a significant opportunity to strengthen and improve the Medicaid delivery system, resulting in better health and experience for Medicaid beneficiaries, and better supported providers, facilitating stronger relationships between members, providers, community partners, the state, and MCOs.
	Affirmation that as currently proposed, the waiver design represents a shift in the right direction towards improved communication, accountability, and value.	DMAS appreciates the recognition of a thoughtful approach and proposal.
Providers	…the waiver program is designed to, "enable providers,	DMAS agrees that aligning DSRIP and MLTSS is a

Stakeholder Group	Comment Theme	DMAS Response
	community support services, and Medicaid managed care plans (MCOs) the opportunity to better coordinate and integrate member care. Taken together, alignment of the programs and providing care coordination opportunities among providers, community support services and MCOs promotes a strong infrastructure likely to strengthen and integrate Virginia's Medicaid community delivery structure and accelerate value-based payment structures.	significant opportunity to strength the Medicaid delivery structure and accelerate value-based payment methods. DMAS looks forwarding to working together to identify opportunities to infuse stronger relationships with community partners as part of the VIP structure in providing care to Medicaid beneficiaries.
	Pleased to see the references to workforce development especially for working with individuals with behavioral health needs and developmental and physical/sensory disabilities and the variety of clinical improvement projects (C1-10) many of which address critical needs in the ID/D community.	DMAS recognizes the significant opportunity enabled through DSRIP to focus on workforce development, particularly as it pertains to strengthening community based options for individuals with disabilities. DMAS intends to work with community based providers and stakeholders to further develop this training framework and model.
Concerns Regarding Overall Approach		
Advocates	Concerns expressed regarding the waiver amount, duration, and scope	This waiver strategy is common in allowing states to 'waive' the requirement that all Medicaid services must be provided in the same amount duration and scope. This is the authority granted that allows for different waiver populations to receive the targeted services needed, while not requiring the state to make them available for the general Medicaid population.
Health Plans	Suggests applying DSRIP to the MLTSS program is premature.	DMAS understands the nuances and complexities of providing care and coverage to the MLTSS populations; however, coordinating the DSRIP and MLTSS opportunities allows for providers to be

Stakeholder Group	Comment Theme	DMAS Response
		supported in a way that traditional Medicaid funds cannot support them. DMAS is confident in this approach and anticipates that supporting providers to be able to move towards a value-based payment model will ultimately render a more financially sustainable Medicaid program.
MLTSS Specific Comments		
Advocates	Ensure that changes are person-centered and family-centered and allow individuals to live as independently as possible and to exercise control over their own care arrangements. Encourage the State to require MCO contracts to have more involvement and training regarding relationships with family caregivers Enrollment into Managed Care needs to ensure continuity with current providers DMAS should employ a robust MCO readiness criteria for participating plans and then take a hands on management approach in overseeing the managed care contracts Reinvestment of savings should be a priority. The key investment would be back into community-based settings	The Department appreciates this perspective and has included language to emphasize the importance of family caregivers in the care planning of individuals enrolled in the program. Additionally, DMAS values the relationships with MCOs and will look to selected plans to be accountable for creating strong provider networks and relationships with beneficiaries. Additional standards of accountability and transparency will be incorporated into the MCO/DMAS contractual agreement.
Health Plans	Encourages use of any auto-assignment preference based on D-SNP affiliation with the full operationalization of the D-SNP provision	This policy decision has not been finalized and program staff will be considering all options prior to making the decision regarding auto-assignment.
	Requests MCOs owned by health systems do not receive preferential treatment in rates or membership by contracting with their own health plan	This policy decision has not been finalized and program staff will be considering all options prior to setting the final policy.
	Supports the provision of a fully integrated benefit	DMAS appreciates the support and acknowledges

Stakeholder Group	Comment Theme	DMAS Response
	through the MLTSS program.	that fully integrated care is the best care model for Medicaid beneficiaries.
	Supports the proposed requirement of MCOs to be certified as D-SNP plans in the same locality	DMAS understands that there is significant benefit in providing the continuity of coverage between Medicaid and Medicare. This proposed requirement is intended to support this understanding.
	Requests consideration of enrollment process which auto-assigns dual eligible members with Medicaid MCOs already providing members with medical benefits through a MA program in instances where the MA plan also participates in the MLTSS program.	DMAS has not set this policy decision though agrees that continuity between Medicare and Medicaid is valuable.
	Recommends the use of standardized quality metrics applicable to the LTSS population	DMAS agrees that standardization is critical in being able to support multiple plans and provider types who capture and report multiple data elements to multiple systems. DMAS will work with all parties to identify the best existing tools and other needed measures for quality reporting purposes.
	We do not feel that the Department's experience with the CCC program justifies the need to create an additional administrative layer for managing 'high-risk' members. If the goal is to bring greater budget predictability and highest-quality care to our most complex and vulnerable members by including them into Managed Care arrangements, we do not believe the current 1115 draft waiver has laid out the most effective way of meeting these goals.	DMAS believes the opportunity provided through the §1115 innovation waiver allows the Department to test new models of care delivery for Virginia's high-risk Medicaid beneficiaries. DMAS values managed care and will use the opportunity provided through a §1115 waiver to modify 'business as usual' with the goal of creating a more efficient, high-touch, care delivery model for its Medicaid members.
Providers	Concern regarding increased audits and other administrative processes as a result of MLTSS and the potential inclusion of more than 3 MLTSS health plans.	DMAS respects this concern and is considering how best to maintain accountability among providers and plans, while acknowledging the cumbersome nature of audits and reporting. DMAS intends to consider the needs and resource capacity of partners when

Stakeholder Group	Comment Theme	DMAS Response
		determining the policy for these business practices.
	Suggest planning an abundance of provider training early in 2016 with the MCOs and DMAS as was completed with the CCC rollout. Establish provider advisory groups early in 2016 to get input on how to have a successful MLTSS rollout	DMAS agrees that having provider trainings with all parties is necessary in order to ensure a successful rollout of the MLTSS demonstration. DMAS intends on engaging partners early and often.
	Concern expressed regarding the exclusion of the IDD waiver population	The application explains, "individuals enrolled in the Intellectual Disability, Developmental Disability, and Day Support waivers will continue to receive their HCBS through Medicaid fee-for-service until the Department of Behavioral Health and Developmental Services completes the redesign of these waivers. Individuals residing in ICF-ID facilities will be excluded from MLTSS until after the completion of the redesign."
	Suggestion that DMAS require any MLTSS MCO to undergo claims testing with providers prior to the system "go live"	DMAS appreciates this suggestion and will take strong consideration in encouraging a testing environment for future program development.
	The case management process under the CCC program was not effective in providing services to individuals in the long-term care setting. The MLTSS program needs to clearly define the role of the case managers. While case management may benefit individuals in the community setting to identify and obtain services, case management is not needed during the time the person is in a long-term	DMAS appreciates the spirit of this comment and agrees that roles need to be clearly defined between providers, including long-term care facility providers, and health plans. DMAS will work with all partners to consider roles and responsibilities so that Medicaid beneficiaries can be best supported no matter the setting they choose to receive care.

Stakeholder Group	Comment Theme	DMAS Response
	care facility.	
	Where opportunities exist to mandate uniformity of processes between insurance carriers this should be included in the contracts between the state and insurance carriers to maximize the success of the program.	DMAS agrees that where possible, uniformity of processes and procedures is ideal. DMAS will work with providers and MCOs to identify any possible streamlining of documentation while respecting the proprietary nature of some MCO processes.
	Any measurements of performance on the part of the insurance carriers built into the program need to be carefully constructed to insure they truly measure compliance with the contract between the state and the carriers.	Checks and balances is an important part of any program and DMAS intends to create a contract that provides flexibility to providers and MCOs while requiring accountability in order to ensure program success.
	Concerns expressed regarding the potential increased administrative burdens on home care agencies that implementation of MLTSS will cause. This concern is particularly worrisome because of the Centers for Medicare and Medicaid Services ("CMS") requirement that at least two managed care organizations ("MCO") be contracted within each region and DMAS' stated goal of contracting with at least three MCOs in each region. DMAS and/or its MCO contractors' data requests should be uniform and should utilize the same format for submission. This will reduce the administrative burden on home care agencies by permitting them to submit the same data in the same manner regardless of the MCOs they contract.	DMAS agrees that in order to address administrative burdens, where possible, uniformity of processes and procedures is ideal. DMAS will work with providers and MCOs to identify any possible streamlining of documentation while respecting the proprietary nature of some MCO processes.

Stakeholder Group	Comment Theme	DMAS Response
Health Plan/VIP Relationship		
Advocates	Encourages DMAS to allow VIPs, Affiliate Providers, and health systems to operate independent of MCOs (especially capitated, risk-based MCOs).	As a managed care state, it is important to maintain the continuity of coverage through the procured MLTSS and existing Medallion 3.0 managed care plans. MCOs and VIPs will work in partnership.
Health Plans	Encourages DMAS to consider allowing managed care organizations to serve as the coordinating entity for the VIPs	The DSRIP demonstration is an opportunity to support providers in a way that is not traditionally allowed through Medicaid funds. To this end, DMAS intends on maintaining the VIP model with the health systems serving as the coordinating entity. There will be contractual expectations that VIPs and MCOs work together.
	VIPs should be seen as an extension and partner with the MCOs, that together improve the current state. VIPs should not be thought of as a replacement for the MCO.	DMAS agrees that the VIPs and MCOs should have a strong partner relationship, bringing shared value to each partner and better health to the Medicaid beneficiary. DMAS has at no time considered VIPs as a vehicle to replacing MCOs.
	We do not support the formation of Virginia Integrated Partnerships as it is structured in the current draft as this seems to promote fragmentation and duplication, as opposed to reducing it.	The proposed formation of VIPs is a vehicle to bring together various providers, creating synergy between care and care coordination and infusing a comprehensive technology platform in order to share data for better continuity of health provider, community supports, and health plan information.
Payment Reform		
Health Plans	Requests flexibility in development of proposed alternate payment models and value based-purchasing	DMAS supports this idea and intends to work with all parties to create the expectations and milestones to be met, while allowing flexibility in model design.
	Suggests value-based purchasing incentives should be required but allowed to develop as the LTSS network	DMAS has full intention for the movement to value-based purchasing to be an evolution. There will be

Stakeholder Group	Comment Theme	DMAS Response
	migrates to managed care.	expectations and milestones to advance the system towards value based purchasing but there is not an expectation that this will be a "turn key" process.
	It is mentioned that alternative payment models will be implemented through the VIPs in tandem with the MCOs. If this is to be done with a specific population, such as MLTSS, we do not recommend prescribing specific VBP models in the first seven years of implementations, particularly those that involve the provider's capability to share risk. There may be some pockets of PCPs/other providers that are capable of and have the critical mass necessary to engage in these models, but we feel strongly against the Department dictating any one model in its contract with MCOs, as this may ultimately present unintentional consequences the member.	DMAS has explained that the movement towards value-based purchasing models is considered to be an evolution. The approach to implementing MLTSS and DSRIP in tandem is to support the provider community in order to ensure that the providers, MCOs, and the department are all ready to participate in value-based purchasing arrangements in future years. DMAS expects milestones to be met in working towards value-based purchasing arrangements which will result in the delivery of high quality care for Medicaid beneficiaries.
Providers	It will be important to develop alternative payment models that 1) encourage the willing participation of all providers needed to support the population's needs, 2) preserve existing, effective provider relationships to support patient-centered and coordinated care, 3) introduce reimbursement policies that support the integration of clinical services with community social supports, and 4) provide funding support for interdisciplinary teams that can address the needs of the targeted complex patient populations.	DMAS appreciates the thoughtful nature of this response and the suggested tenants on which to develop the initial framework around alternative or value-based payment strategies. DMAS has included these elements in the waiver application and is committed to working with all stakeholders to develop the best solution towards a system that rewards and drives further quality care for Medicaid members.
	Concerns regarding base methodology for value-based payment/alternative payment models	DMAS recognizes the differentiation among provider reimbursement and understands that value-based reimbursement strategies may vary depending upon the provider. DMAS will work to ensure that there is

Stakeholder Group	Comment Theme	DMAS Response
		no unnecessary harm to providers, while moving towards a more value-based and accountable system of care.
High Risk/High Utilizer		
Health Plans	Currently, MCOs employ sophisticated risk-stratification tools to identify their 'high-risk' populations, for which they subsequently allocate internal resources to better manage these individuals. How will 'super-utilizer' populations be defined and identified in this proposal?	General definitions for high-risk and high-utilizer are outlined in the proposal. DMAS has requested information from health plans regarding their ideas and existing methodologies used to identify high-risk/high-utilizer beneficiaries. DMAS will work with all appropriate stakeholders to ensure the definition meets the stated intent of the proposal, while being appropriate for the health plan and provider communities.
Providers	We encourage DMAS to promote the inclusion of maternal child health home visiting programs as affiliates / community partners in the DSRIP application. While pregnant women and young children are generally not considered to be Medicaid cost drivers, specific high risk and high utilizer subpopulations such as pregnant women with gestational diabetes, preterm / low birth weight infants and young children with special health care needs would certainly fall within this definition as expensive to serve populations.	DMAS appreciates this perspective and will consider this recommendation as it further develops the DSRIP program.
	It is suggested that the population in the waiver be expanded to include the "emerging high utilization population" to mitigate the inappropriate utilization and	DMAS agrees and has added to the application, a definition and expectation that an 'emerging high-utilization population' be included in the VIP

Stakeholder Group	Comment Theme	DMAS Response
	engage with the population prior to the expenditure of significant costs.	catchment. Emerging high-utilization population shall be defined as beneficiaries that have the proclivity to become high utilizers. VIPs will work in collaboration with the Managed Care Plans to develop predictive models to identify factors for high utilization and introduce preventive strategies with community partners.
Data and Technology		
Health Plans	Suggests MCOs be allowed to retain their technology platforms and proprietary processes while still facilitating simple data exchange through a central system	DMAS intends to invest in technology to support the data sharing goals and acknowledges the significant investment of both plans and providers, alike.
	Process flows and technology are equally important	DMAS agrees and works diligently to ensure that both information technology staff and general program and policy staff work in tandem to ensure the technology is driven by the business processes.
	How would this system integrate with the HIE/APCD and other tools/HIT systems that are currently in use with the health plans and hospital systems?	The waiver document states: "DSRIP will allow DMAS to work with participating VIP partners to leverage and build upon existing systems and resources and develop an optimal data system." DMAS understands the significant investments made to date and plans to leverage existing systems and resources for health plans and hospital systems as well.
Providers	DMAS encouraged to consider a successful but sizeable expectation around data integration	DMAS understands the ideal of "full data integration" is significant. The Department will work with stakeholders to identify and prioritize an

Stakeholder Group	Comment Theme	DMAS Response
		optimal data integration plan in order to be successful across providers, to include community based providers, health plans, and DMAS. DMAS responded in the waiver application with the removal of "full" therefore emphasizing the importance of data integration, without unachievable expectations.
Evaluation/Metrics		
Providers	In order to truly evaluate the effectiveness of the alignment of these strategic initiatives, we encourage DMAS to develop quality measurements of the healthcare provided at the beginning of the program	DMAS agrees that quality measurements need to be identified and monitored as soon as possible in order to gain insight into the benefit of the aligned MLTSS and DSRIP initiatives. DMAS will work consider the proposed quality measurements in determining the best metrics to monitor and report. Further, DMAS appreciates the suggested elements for inclusion into the RFP design for selecting MLTSS health plans and further DSRIP design.
	DMAS encouraged to include process measures	The Department recognizes this distinction and will incorporate such measures during the negotiation of Special Terms and Conditions between the department and CMS. The addition of metrics to this expectation has been included in the application.
Future Stakeholder Involvement		
Health Plans	Notes that a threshold issue experienced and overcome in other markets is engaging providers (acute and LTSS), consumer advocates, regulators, and other key	DMAS appreciates this perspective and agrees that it is essential that all stakeholders work together to design and implement a beneficiary centered care

Stakeholder Group	Comment Theme	DMAS Response
	stakeholders early in the process.	system that rewards improving quality, balances HCBS, and keeps the member in their setting of choice.
Providers	Requests for DMAS to engage the provider community in the further development of DSRIP related specifics	DMAS appreciates the recognition that staff has aimed to put together a thoughtful program framework to support providers, at varying levels of practice capacity, in order to create a stronger Medicaid delivery system. DMAS will incorporate and include provider representatives as more targeted program details are identified.
Suggestions/Comments Regarding Services or Provider Groups		
Advocates	Coverage should be provided for routine oral health care and follow up procedures, prescriptions, following an emergency procedure. Oral health should be included in care models and data sharing information	The Department agrees that oral health is a valuable component to overall health of Medicaid beneficiaries. DMAS also understands that there is a marked association between oral disease and systemic illness. From the onset, DMAS shared that this waiver application process would not be able to add services or benefits apart from what is currently covered under Medicaid. Oral health services will be covered only in the scope of which they are covered under the current Medicaid program. To that end, in a desire to capture and share more than claims related data, DMAS will consider the benefit and policy behind capturing and sharing oral health data information.
	Community Health Workers (CHWs) are aligned to support the outreach, education, and navigation proposals included in the waiver application.	The Department appreciates these thoughtful comments and as discussed in conversation, will look forward to working out potential details and partnership options with CHWs in their support of

Stakeholder Group	Comment Theme	DMAS Response
	CHWs can also help facilitate diversion from Emergency Departments and help link beneficiaries to housing and employment resources CHWs have developed workforce training criteria and would be able to modify the criteria for participation with VIPs	DSRIP efforts.
Health Plans	Encourages DMAS to consider including dental providers in the VIP partnerships, regardless of coverage as there are safety net and charity dental providers available.	DMAS appreciates this acknowledgement and agrees that oral health is a valuable component to overall health of Medicaid beneficiaries. Where geographically available, DMAS will encourage VIPs to identify and partner with willing dental providers, further supporting a fully integrated care model.
	In this structure, do MCOs have the autonomy to choose who they contract with in the VIP?	As currently proposed, MCOs would have the choice between VIPs if more than one existed in the region in which the MCO participated; however, the VIP is considered to be one entity and therefore the MCO would not be able to select individual providers to provide VIP related services to high-utilizers. Individual providers within a VIP may be chosen to participate in the MLTSS network for beneficiaries not assigned to a VIP.
	Will members be required to change their providers during the attribution process? If so, how will continuity of care be mitigated?	Details regarding the attribution of high-risk/super utilizer members have not been finalized. The Department intends on doing an initial analysis of member providers to determine if there is continuity of providers currently serving this population. DMAS will work with providers and MCOs to help identify the best method of attribution. Further, continuity of care will in no way be mitigated, rather policies

Stakeholder Group	Comment Theme	DMAS Response
		will be set to ensure continuity of care is in place for members at all times.
Providers	As DMAS begins to develop DSRIP related focused initiatives, we respectfully request that the services currently provided through CHIP and other validated MCH home visiting programs be considered and included.	DMAS appreciates the work already accomplished by CHIP of Virginia and their related partners and will consider this request and encourage CHIPs continued engagement in this process as it evolves.
	Appreciation that the DSRIP component of the waiver addresses this issue of behavioral health workforce capacity and recognizes the value of investing in the training of more Psych NPs, in particular.	DMAS believes fully in the integration of physical and behavioral health care and appreciates the opportunity, afforded through DSRIP to potentially invest in training more practitioners. DMAS will work with engaged partners to further develop this strategy.
	Encouraged to incorporate and leverage the work of Area Agencies on Aging across the Commonwealth	DMAS appreciates the relationship with local Area Agencies on Aging and will rely on AAAs to advise and support the Department in developing models that leverage existing work and best practices already under way throughout the Commonwealth.
General Questions/Comments		
Providers	DMAS encouraged to exercise and request maxim flexibility when considering programs for optimal transformation	DMAS agrees that there are many project opportunities that have not been described, yet could render significant transformations in the Medicaid delivery system. DMAS is open to many options, including those not yet defined, in order to strengthen Virginia's Medicaid program.

Stakeholder Group	Comment Theme	DMAS Response
	Concerning the VIP geographic regions, there is an expressed concern that there needs to be a definition around 'geographic regions.'	DMAS agrees that more clarity is valuable and has included in the application clarification of geographic regions, described as suggested: 'where there is an adequate volume of MLTSS and Medallion 3.0 enrollees who meet the criteria to support the transformation of the regional delivery system."
	Clarification is needed regarding how the VIP will interact with the nursing center residents who are Medicaid beneficiaries, the managed care entity and the providers.	DMAS acknowledges that this relationship is not yet detailed and will include nursing facilities in the creation of this model as it interfaces with nursing facility residents.

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORICAL DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5	**LTSS Population**	**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**5-YEARS**
6	**TOTAL EXPENDITURES**	$ 1,460,084,543	$ 1,583,696,205	$ 1,656,259,637	$ 1,718,733,918	$ 1,862,348,804	$ 8,281,123,107
7	**UNDUPLICATED ANNUAL MEMBERS**	56,499	60,052	63,764	66,461	68,913	
8	**PMPY COST**	$ 25,842.66	$ 26,372.08	$ 25,974.84	$ 25,860.79	$ 27,024.64	
9	**TREND RATES**						**5-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE		8.47%	4.58%	3.77%	8.36%	6.27%
12	UNDUPLICATED ANNUAL MEMBERS		6.29%	6.18%	4.23%	3.69%	5.09%
13	PMPY COST		2.05%	-1.51%	-0.44%	4.50%	1.12%
14							
15	Notes:						
16	1. LTSS populations in the community in MLTSS include members in the EDCD, AIDS (discontinued in 2013), Tech, ID, DD and Day Support waivers						
17	2. Acute services are included in MLTSS for all LTSS populations in the community; LTSS included only for EDCD, AIDS and Tech waiver populations in MLTSS						
18	3. LTSS populations in institutions in MLTSS are in nursing facilities, specialized care facilities and long-stay hospitals						
19	4. All acute and LTSS are included in MLTSS for LTSS populations in institutions						
20							
21	**Institutional LTSS Population**	**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**5-YEARS**
22	**TOTAL EXPENDITURES**	$ 809,268,101	$ 839,607,570	$ 852,004,442	$ 860,246,689	$ 901,021,322	$ 4,262,148,124
23	**UNDUPLICATED ANNUAL MEMBERS**	27,259	27,358	27,499	27,142	26,806	
24	**PMPY COST**	$ 29,688.11	$ 30,689.65	$ 30,983.11	$ 31,694.30	$ 33,612.67	
25	**TREND RATES**						**5-YEAR**
26				**ANNUAL CHANGE**			**AVERAGE**
27	TOTAL EXPENDITURE		3.75%	1.48%	0.97%	4.74%	2.72%
28	UNDUPLICATED ANNUAL MEMBERS		0.36%	0.52%	-1.30%	-1.24%	-0.42%
29	PMPY COST		3.37%	0.96%	2.30%	6.05%	3.15%
30							
31	Notes						
32	1. The LTSS populations in institutions are in nursing facilities, specialized care facilities, long-stay hospitals and ICF-IDs						
33	2. All acute services and LTSS are included for LTSS populations in institutions except that only acute services are included for the ICF-ID population						
34							
35	Source: 1915c Waiver Cost Effectiveness						
36							
37							
38	**LIFC and ABAD Populations**	**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**5-YEARS**
39	**TOTAL EXPENDITURES**	$ 2,379,266,473	$ 2,775,492,080	$ 2,411,488,113	$ 2,674,947,546	$ 3,024,206,691	$ 13,265,400,903
40	**ELIGIBLE MEMBER MONTHS**	6,684,835	7,068,436	7,112,695	7,585,491	7,659,128	
41	**PMPM COST**	$ 355.92	$ 392.66	$ 339.04	$ 352.64	$ 394.85	
42	**TREND RATES**						**5-YEAR**
43				**ANNUAL CHANGE**			**AVERAGE**
44	TOTAL EXPENDITURE		16.65%	-13.11%	10.93%	13.06%	6.18%
45	ELIGIBLE MEMBER MONTHS		5.74%	0.63%	6.65%	0.97%	3.46%
46	PMPM COST		10.32%	-13.66%	4.01%	11.97%	2.63%
47							
48	Source: 1915B Waiver Cost Effectiveness for the Medallion 3.0 program						

	A	B	C	D	E	F	G	H	I	J	K	L
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**											
2												
3												
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**	
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00**	**RATE 2**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**	
6												
7	**LTSS Population**											
8	**Pop Type:**	**Medicaid**										
9	UNDUPLICATED ANNUAL MEMBERS	5.09%	36	79,981	5.09%	84,052	88,330	92,826	97,551	102,516		
10	PMPY Institutional Cost	3.15%	36	$36,890.18	3.15%	$38,052.22	$39,250.86	$40,487.26	$41,762.61	$43,078.13		
11	Total Expenditure					$ 3,198,355,250	$ 3,467,027,370	$ 3,758,269,090	$ 4,073,976,412	$ 4,416,203,851	$ 18,913,831,974	
12												
13												
14	**LIFC and ABAD Populations**											
15	**Pop Type:**	**Medicaid**										
16	Eligible Member Months	3.46%	36	8,481,970	3.46%	8,775,447	9,079,077	9,393,213	9,718,218	10,054,469		
17	PMPM Acute Care Cost	2.63%	36	$426.83	2.63%	$438.06	$449.58	$461.40	$473.53	$485.98		
18	Total Expenditure					$ 3,844,172,104	$ 4,081,771,426	$ 4,334,028,495	$ 4,601,867,868	$ 4,886,270,630	$ 21,748,110,524	
19												

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
LTSS Population								
Pop Type:	**Medicaid**							
UNDUPLICATED ANNUAL MEMBERS	79,981	5.09%	84,052	88,330	92,826	97,551	102,516	
PMPY LTSS Cost	$ 27,942.87	1.12%	$ 28,255.83	$ 28,572.30	$ 28,892.31	$ 29,215.90	$ 29,543.12	
Total Expenditure			$ 2,374,951,638	$ 2,523,790,463	$ 2,681,956,636	$ 2,850,034,695	$ 3,028,646,794	$ 13,459,380,226

With the proposed 1115 Demonstration waiver, 70% of individuals served through MLTSS program are assumed to be receiving HCBS services by 2022. The proposed 1115 Demonstration waiver seeks to reform the delivery system so that long-term savings are possible.

LIFC and ABAD Populations								
Pop Type:	**Medicaid**							
Eligible Member Months	8,481,970	3.46%	8,775,447	9,079,077	9,393,213	9,718,218	10,054,469	
PMPM Acute Care Cost	$426.83	2.63%	$ 438.06	$ 449.58	$ 461.40	$ 473.53	$ 485.98	
Total Expenditure			$ 3,844,172,104	$ 4,081,771,426	$ 4,334,028,495	$ 4,601,867,868	$ 4,886,270,630	$ 21,748,110,524

The proposed 1115 Demonstration waiver seeks to reform the delivery system so that long-term savings are possible.

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
LTSS Population	$ 3,198,355,250	$ 3,467,027,370	$ 3,758,269,090	$ 4,073,976,412	$ 4,416,203,851	$ 18,913,831,974
LIFC and ABAD Populations	$ 3,844,172,104	$ 4,081,771,426	$ 4,334,028,495	$ 4,601,867,868	$ 4,886,270,630	$ 21,748,110,524
TOTAL	$ 7,042,527,355	$ 7,548,798,796	$ 8,092,297,585	$ 8,675,844,280	$ 9,302,474,481	$ 40,661,942,497

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
LTSS Population	$ 2,374,951,638	$ 2,523,790,463	$ 2,681,956,636	$ 2,850,034,695	$ 3,028,646,794	$ 13,459,380,226
LIFC and ABAD Populations	$ 3,844,172,104	$ 4,081,771,426	$ 4,334,028,495	$ 4,601,867,868	$ 4,886,270,630	$ 21,748,110,524
TOTAL	$ 6,219,123,743	$ 6,605,561,889	$ 7,015,985,131	$ 7,451,902,563	$ 7,914,917,424	$ 35,207,490,750

VARIANCE	$ 823,403,612	$ 943,236,907	$ 1,076,312,455	$ 1,223,941,717	$ 1,387,557,057	$ 5,454,451,748

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

☑ State General Funds

☑ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☑ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Provider taxes. (Provide description the narrative section – Section VI of the application).

☐ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

☑ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ☑ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Not Applicable

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

All funding of the NFS for the MLTSS program, as described in this application, is funded from appropriations from the legislature to the Medicaid agency. Funding of the NFS for the DSRIP program will be from certified public expenditures and intergovernmental transfers from Designated State Health Programs (operated by Children's Services and the Department of Behavioral Health and Developmental Services) and the University of Virginia Health System and Virginia Commonwealth University Health System Authority.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

All funding of the NFS for the MLTSS program, as described in this application, is funded from appropriations from the legislature to the Medicaid agency. Funding of the NFS for the DSRIP program will be from certified public expenditures and intergovernmental transfers from Designated State Health Programs (operated by Children's Services and the Department of Behavioral Health and Developmental Services) and the University of Virginia Health System and Virginia Commonwealth University Health System Authority.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

Total MLTSS expenditures in the first year of the demonstration (FY18) are estimated to be approximately $2.4 billion. The NFS (50% match) for the MLTSS program will be funded by state appropriations.

DMAS will spend approximately $1 billion over five years for DSRIP. $300 million in expenditures will be supported by Intergovernmental Transfers of $150 million from two state academic medical centers. $700 million in expenditures will be supported by $700 million in DSHPs and IGTs from two state agencies.

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

CPEs and IGTs will be certified or transferred quarterly.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

DMAS will instruct each agency on requirements and require each agency to attest to compliance with 42 CFR433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of Non-federal appropriations in SFY15
UVAHS	State	$15 mil annually	No	Yes	$1,418,605,170
VCUHS Authority	State	$15 mil annually	No	No	none
DBHDS (CPE)	State	$70 mil annually	No	Yes	$656.4 million
Children's Srvcs (CPE)	State	$70 mil annually	No	Yes	$219.1 million

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Not Applicable

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

Not Applicable

☐ Yes ☐ No

If yes, provide an explanation.

All payments are in compliance with the State Plan, Medicaid law and Medicaid regulation. If DMAS determines that payments have been made in excess of that permitted in the State Plan, it promptly seeks recovery. Based on our understanding of Medicaid law and regulation, the state is not required to determine if payments to governmental providers exceed the cost of services, to recoup the excess and to return the Federal share of the excess to CMS on the quarterly expenditure report.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☐ Yes ☑ No ☐ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Not Applicable

☐ Yes ☐ No

All payments are in compliance with the State Plan, Medicaid law and Medicaid regulation. If DMAS determines that payments have been made in excess of that permitted in the State Plan, it promptly seeks recovery. Based on our understanding of Medicaid law and regulation, the state is not required to determine if payments to governmental providers exceed the cost of services, to recoup the excess and to return the Federal share of the excess to CMS on the quarterly expenditure report.

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program? ☐ Yes ☑ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding