Facesheet: 1. Request Information (1 of 2)

A. The **State** of **Virginia** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
PRGR102321	Medallion 4.0	MCO;	

Waiver Application Title (*optional - this title will be used to locate this waiver in the finder*):

MEDALLION 4.0 Waiver Renewal

C. Type of Request. This is an:

☒ **Renewal request.**

☒ **The State has used this waiver format for its previous waiver period.**
The renewal modifies (Sect/Part):

All

Requested Approval Period:*(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **1 year**
◉ **2 years**
○ **3 years**
○ **4 years**
○ **5 years**

Draft ID:VA.016.13.00
Waiver Number:VA.0003.R13.00

D. Effective Dates: This renewal is requested for a period of 2 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Proposed Effective Date: (mm/dd/yy)

07/01/21

Proposed End Date:06/30/23
Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name:

Scott Cannady

Phone: (804) 909-4815 **Ext:** ☐ **TTY**

Fax: (804) 786-5799

E-mail:

scott.cannady@dmas.virginia.gov

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ **Medallion 4.0**

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Tribal representatives where notified via email and letter on by DMAS on March 27, 2021 (list below)and made aware of the Department's intention to submit the proposed MEDALLION 4.0 waiver renewal, the major changes that were proposed and the tribal comment period for the proposed waiver changes and were provided contact information.

Robert Gray, Chief
Pamunkey Indian Tribe
Pamunkey Indian Tribal Office
1054 Pocahontas Trail
King William, VA 23086

Stephen Adkins, Chief
Chickahominy Indian Tribe
8200 Lott Cary Road
Providence Forge, VA 23140

Chickahominy Indian Tribe, Eastern Division
2895 Mt. Pleasant Road
Providence Forge, VA 23140

Dean Branham, Tribal Chief
Monacan Indian Nation Inc.
P.O. Box 1136
Madison Heights, VA 24572

Barry Bass, Chief
Nansemond Indian Tribe
1001 Pembroke Lane
Suffolk, Virginia 23434

G. Anne Richardson, Chief
Rappahannock Tribe
5036 Indian Neck Road
Indian Neck, VA 23148

Upper Mattaponi Tribe
P.O. Box 184
King William, VA 23086

Program History.

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

The Medallion II program began January 1, 1996 in seven Tidewater localities. The program underwent multiple geographic expansions. Medallion II expanded into the Roanoke-Alleghany region (formerly a MEDALLION/Medallion II area) in January 2012, and finally into far southwestern Virginia (formerly an all—MEDALLION area) in July 2012. The 2012 expansions made the Medallion II program statewide with the option of two or more health plan choices in every locality, making the MEDALLION program obsolete.

Although DMAS experienced the exodus of health plans from certain localities during the Medallion II program, the following MCO partners remained viable during this period: Anthem Healthkeepers Plus/Wellpoint; Optima Family Care; Southern Health/CareNet (which underwent a name change to CoventryCares in Virginia in December 2012); Amerigroup Community Care (which was purchased by INOVA Health Systems and rebranded as INTotal Health in November 2012); Virginia Premier Health Plan; MajestaCare (in January 2012); and Kaiser Permanente in November 2013 in the Northern Virginia region. One of the most positive aspects of Virginia's managed care program is the consistency and continuity received from its MCOs along with their commitment in providing quality services to recipients throughout the Commonwealth. This was most evident in the expansions to the Roanoke-Alleghany and far southwestern regions in 2012, where both these expansions included participation of six (6) health plans.

Virginia expanded the mandatory populations enrolled in MEDALLION 3.0 with the addition of foster care (FC) and adoption assistance (AA) children (previously excluded).

In 2014, Virginia renamed its mandatory capitated managed care (MCO) program Medallion 3.0. Medallion 3.0 represented the progression and evolution of Virginia's managed care delivery system, to reflect the Commonwealth's continuous focus on improvement and governmental oversight to provide the highest quality care to Virginia's Medicaid members.

Effective August 1, 2017, the Department of Medical Assistance Services (DMAS), with support from the Governor and the General Assembly, implemented a new managed long term services and supports (MLTSS) initiative called Commonwealth Coordinated Care Plus (CCC+). CCC+ launched August 1, 2017 and operates statewide across six regions as a mandatory Medicaid managed care program. Two (2) populations transitioned from the Medallion 3.0 program to the CCC+ program: Aged, Blind, and Disabled (ABD) members and Health and Acute Care Program (HAP) members, effective January 1, 2018 and August 1, 2017 (respectively).

As a result of a competitive procurement, DMAS entered into contractual agreements with 6 MCOs for MEDALLION 4.0. 5 of the 6 MCOs were already contracted with DMAS in the Medallion 4.0 Program (Aetna Better Health, Healthkeepers, Inc, Optima Health Plans, United Healthcare of the Mid-Atlantic, and Virginia Premier). INTotal Health Plan, which participated in MEDALLION 3.0 was acquired by United Health Plan. Magellan Complete Care of Virginia was a new MCO for the Medallion program, although they already contract with DMAS for the CCC+ program. Kaiser Health Plan, which participated in MEDALLION 3.0, was not chosen for Medallion 4.0 during the competitive procurement process. The Medallion 4.0 program has been divided into 6 regions (Tidewater, Central, Northern/Winchester, Western/Charlottesville, Roanoke Alleghany and Southwest) versus the 7 regions in MEDALLION 3.0. . All 6 health plans will participate in each region.
The MEDALLION 4.0 program built on the MEDALLION 3.0 program and makes several programmatic changes resulting in this proposed amendment:
The internal administrative processes and waiver changes to comply with the 2016 Medicaid Managed Care Final Rule to include:
adding members with Third Party Liability (TPL) insurance, including members who are enrolled in the Health Insurance Premium Payment (HIPP) program in MEDALLION 4.0;
carving in Community Mental Health Rehabilitative Services (CHMRS) into the MEDALLION program
carving in services received under Part C of the Individuals with Disabilities Education Act (IDEA) for children;
The regional roll out of the proposed MEDALLION 4.0 beginning with the Tidewater area on August 1, 2018, the Central area on September 1, 2018, the Northern/Winchester area on October 1, 2018, the Charlottesville/Western area on November 1, 2018 and the Roanoke/Alleghany and Southwest areas on December 1, 2018.

DMAS then amended the Medallion waiver in August of 2018 to include the addition of a new population of enrollees, Section 1931 adults and related populations (expansion population). As of March 11, 2019, approximately 233,000 expansion members have enrolled. The Medicaid Expansion population are enrolled into one of two Managed Care Programs depending on whether they classify as medically complex or non-medically complex. Individuals classified as medically complex are enrolled into the CCC Plus program. Individuals classified as non-medically complex are covered under the Medallion 4.0 program. DMAS utilizes the current six (6) managed care organizations for Medicaid expansion, Anthem, Virginia Premier, Optima, Magellan, United, and Aetna.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

   a. ☒ **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
   -- Specify Program Instance(s) applicable to this authority

   ☒ **PRGR102321**

   b. ☐ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
   -- Specify Program Instance(s) applicable to this authority

   ☐ **PRGR102321**

   c. ☐ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
   -- Specify Program Instance(s) applicable to this authority

   ☐ **PRGR102321**

   d. ☒ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
   -- Specify Program Instance(s) applicable to this authority

   ☒ **PRGR102321**

   The 1915(b)(4) waiver applies to the following programs

   ☒ **MCO**

   ☐ **PIHP**

   ☐ **PAHP**

   ☐ **PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

   ☐ **FFS** Selective Contracting program
   Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

   a. ☐ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
   -- *Specify Program Instance(s) applicable to this statute*

   ☐ **PRGR102321**

   b. ☒ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
   -- *Specify Program Instance(s) applicable to this statute*

   ☒ **PRGR102321**

   c. ☒ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
   -- *Specify Program Instance(s) applicable to this statute*

   ☒ **PRGR102321**

   d. ☐ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

   -- *Specify Program Instance(s) applicable to this statute*

   ☐ **PRGR102321**

   e. ☐ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

   -- *Specify Program Instance(s) applicable to this statute*

   ☐ **PRGR102321**

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. Delivery Systems. The State will be using the following systems to deliver services:

a. ☒ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ☐ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ○ **The PIHP is paid on a risk basis**
- ○ **The PIHP is paid on a non-risk basis**

c. ☐ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- ○ **The PAHP is paid on a risk basis**
- ○ **The PAHP is paid on a non-risk basis**

d. ☐ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ **the same as stipulated in the state plan**
- ○ **different than stipulated in the state plan**

Please describe:

f. ☐ **Other:** (Please provide a brief narrative description of the model.)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. Procurement. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☒ **Procurement for MCO**

- ◉ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and

targets a wide audience)

- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PIHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PAHP**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for PCCM**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

☐ **Procurement for FFS**

- ○ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ **Open** cooperative procurement process (in which any qualifying contractor may participate)
- ○ **Sole source** procurement
- ○ **Other** (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. Assurances.

☒ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

☐ The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " **Medallion 4.0.** *"*

☒ **Two or more MCOs**

☐ **Two or more primary care providers within one PCCM system.**

☐ **A PCCM or one or more MCOs**

☐ **Two or more PIHPs.**

☐ **Two or more PAHPs.**

☐ **Other:**
please describe

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.

☐ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.

○ **Beneficiaries will be limited to a single provider in their service area**
Please define service area.

◉ **Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Medallion 4.0 Medicaid enrollees can choose from 6 health plans that are operating statewide - Aetna, Anthem, Magellan, Optima, United Healthcare, and Virginia Premier. Magellan, which is in the process of being purchased by Molina Health Care will be renamed Molina once the DMAS and State Corporation Commission review process is finalized and approved. Optima has purchased a share of Virginia Premier but both plans will continue to operate as separate health plans under Medallion 4.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - **Statewide** -- all counties, zip codes, or regions of the State
     -- Specify Program Instance(s) for Statewide

     ☒ **PRGR102321**
   - **Less than Statewide**
     -- Specify Program Instance(s) for Less than Statewide

     ☐ **PRGR102321**
2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Accomack	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Southampton	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Bedford County	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Winchester	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Smyth	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Goochland	MCO	Aetna, Healthkeepers, Magellan, Optima, United

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		Healthcare, Virginia Premier
Lunenburg	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Falls Church	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Radford	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Bath	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Alexandria	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Northumberland	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Scott	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Clarke	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Prince William	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Charles City	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Waynesboro	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Henrico	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Lee	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Martinsville	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Orange	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
King George	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Roanoke City	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Charlottesville	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Buchanan	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Frederick	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Buckingham	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Matthews	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Chesapeake	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Covington	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Wise	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Bedford City	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Bland	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Augusta	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Virginia Beach	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Amherst	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Patrick	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Shenandoah	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Lancaster	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Floyd	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Botetourt	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Warren	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Stafford	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Campbell	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Danville	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Harrisonburg	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Hopewell	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Hanover	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Grayson	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Staunton	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Portsmouth	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Greene	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Highland	MCO	Aetna, Healthkeepers, Magellan, Optima, United

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		Healthcare, Virginia Premier
Mecklenburg	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Fauquier	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Norfolk	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Nelson	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Pulaski	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Surry	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Charlotte	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
James City County	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Prince Edward	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Richmond City	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Henry	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Middlesex	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Dinwiddie	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Appomattox	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
York	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Buena Vista	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Tazewell	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Caroline	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Petersburg	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Hampton	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Halifax	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Galax	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Sussex	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Fairfax County	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Isle of Wight	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Culpeper	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Amelia	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Gloucester	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Loudoun	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Fredericksburg	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Norton	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Newport News	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Nottoway	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Colonial Heights	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Arlington	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Page	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Greenville	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Westmoreland	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Rockbridge	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Cumberland	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Madison	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Russell	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Washington	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Franklin City	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Manassas Park	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Essex	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Dickenson	MCO	Aetna, Healthkeepers, Magellan, Optima, United

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		Healthcare, Virginia Premier
New Kent	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
King William	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Pittsylvania	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Fairfax City	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Wythe	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Giles	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Franklin	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Powhatan	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Allegheny	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Montgomery	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Bristol	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Williamsburg	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Salem	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Carroll	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Albemarle	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Fluvanna	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Suffolk	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Craig	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Richmond County	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Northampton	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Rockingham	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
King and Queen	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Brunswick	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Lexington	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Chesterfield	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Poquoson	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Lynchburg	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Emporia	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Roanoke County	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Manassas	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Louisa	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Rappahannock	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Prince George	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier
Spottsylvania	MCO	Aetna, Healthkeepers, Magellan, Optima, United Healthcare, Virginia Premier

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the States specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

☒ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- ○ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☒ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Childrens Health Insurance Program (SCHIP) through the Medicaid program.

- ◉ **Mandatory enrollment**
- ○ **Voluntary enrollment**

☐ **Other** (Please define):

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. Excluded Populations. Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the Aged population may be required to enroll into the program, but Dual Eligibles within that population may not be allowed to participate. In addition, Section 1931 Children may be able to enroll voluntarily in a managed care program, but Foster Care Children within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☒ **Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ **Other Insurance** --Medicaid beneficiaries who have other health insurance.

☒ **Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

☒ **Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☒ **Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☒ **Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ **American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ **Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ **SCHIP Title XXI Children** Medicaid beneficiaries who receive services through the SCHIP program.

☒ **Retroactive Eligibility** Medicaid beneficiaries for the period of retroactive eligibility.

☒ **Other** (Please define):

a. Those members enrolled in the Health Insurance Premium Payment Program (HIPP) for Medicaid enrollees and the HIPP program for CHIP Title XXI enrollees called FAMIS Select are excluded from MEDALLION 4.0
b. Individuals who are placed on Spend-down;
c. Individuals who are institutionalized in state facility until DMAS amends current state regulation;
d. Individuals who are aliens/refugees (Refugee Medical Assistance);
e. Individuals enrolled in the VA Birth-Related Neurological Injury Compensation Fund;
f. Individuals, other than students, who permanently live outside their area for greater than 60 consecutive days, except those individuals placed there for medically necessary services.
g. Individuals who live on Tangier Island. While in a Medallion 4.0 area, its location does not allow for accessibility standards;hi. Newly eligible individuals who are hospitalized at the time of MCO enrollment or are scheduled for inpatient stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion shall NOT apply to recipients admitted to the hospital while already enrolled in a department-contracted MCO;
h. Individuals who request exclusion during assignment to an MCO, who have been diagnosed with a terminal condition and have a life-expectancy of six months or less.
i. Any recipient who has been consistently non-compliant with the policies and procedures of managed care or is threatening to providers/MCOs/DMAS. There must be sufficient documentation from various providers/MCOs/DMAS of these non-compliance issues and any attempts at resolution. Recipients excluded from the Medallion 4.0 program will be converted to the Medicaid FFS network, contingent upon their continued Medicaid eligibility.
j. Individuals in inpatient long-stay hospitals.
k. Individuals in the PACE program.
l. Individuals in an expansion aid category who are identified as "medically complex" are not included in the Medallion 4.0
m. Medicaid individuals who enter a Medicaid-approved hospice program;
n. Individuals enrolled in the CCC+ Program
o. Individuals enrolled in the Governor's Access Program for the seriously mentally ill who do not qualify for Medicaid expansion

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

DMAS will be enrolling undocumented immigrant pregnant women in SCHIP temporarily during the pregnancy to include prenatal care, labor and delivery and one postnatal care visit as a cost saving measure (unborn child option). DMAS will amend the waiver once the SCHIP SPA has been submitted to CMS

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

☒ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.

- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

☒ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. Emergency Services. In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

☐ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Emergency Services Category General Comments (optional):

3. Family Planning Services. In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

☒ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

☐ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State

will pay for family planning services from out-of-network providers.

☐ The State will pay for all family planning services, whether provided by network or out-of-network providers.

☐ Other (please explain):

☐ Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

☐ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

☒ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

The Department does monitor MCO networks including FQHC participation. Currently all FQHC's in Virginia contract with all participating MEDALLION MCOs. Additionally, members have the option to change MCOs at any time if the FQHC they use does not participate with the MCO in which they are assigned.

☐ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

5. EPSDT Requirements.

☒ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

The Contractor is responsible for all EPSDT services for their Members under age twenty-one (21). EPSDT services for Members under age twenty-one (21) also apply to the Medicaid Expansion population. Federal EPSDT regulations provide that all eligible Medicaid recipients under age 21 and their families be informed of the nature and availability of EPSDT services and how to access them. Informing is accomplished through a number of outreach activities including face-to-face discussions, telephone conversations, and written communications. The purpose of outreach is to increase EPSDT screening participation. Outreach and informing is the joint responsibility of DMAS, the Department of Social Services (DSS), participating MCO's, primary care physicians (PCPs) and EPSDT screening providers. Additionally, DMAS has a include that we have a subject specific email box where members and providers can have their ESPDT questions and concerns addressed and DMAS produces an EPSDT newsletter that is age specific and mailed to members under 21 annually based on their date of birth. DMAS also works closely with the VA Department of Health Family Health Services Division around issues related to pregnant women and children.
The Contractor is responsible for all EPSDT services for their Members under age twenty-one (21). EPSDT services for Members under age twenty-one (21) also apply to the Medicaid Expansion population. Federal EPSDT regulations provide that all eligible Medicaid recipients under age 21 and their families be informed of the nature and availability of EPSDT services and how to access them. Informing is accomplished through a number of outreach activities including face-to-face discussions, telephone conversations, and written communications. The purpose of outreach is to increase EPSDT screening participation. Outreach and informing is the joint responsibility of DMAS, the Department of Social Services (DSS), participating MCO's, primary care physicians (PCPs) and EPSDT screening providers. Additionally, DMAS has a include that we have a subject specific email box where members and providers can have their ESPDT questions and concerns addressed and DMAS produces an EPSDT newsletter that is age specific and mailed to members under 21 annually based on their date of birth. DMAS also works closely with the VA Department of Health Family Health Services Division around issues related to pregnant women and children.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

☐ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. Self-referrals.

☒ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Medallion 4.0 Expansion enrollees may self-refer for:
a. Routine dental services through the Department's Smiles for Children program
b. Routine dental services
c. Emergency services
c. Family planning services
d. OB/GYN Services and services related to pregnancy

Female enrollees age 13 or older may directly access a participating Obstetrician-Gynecologist for annual examinations and routine health services without prior authorization from the primary care physician.

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Individuals in the Medicaid Expansion population receive the same amount, duration and scope of services as other Medicaid Members, with the following four (4) additional federally-required essential health benefits, according to the United States Preventive Services Task Force (USPSTF).
1) Annual adult wellness exams;
2) Individual and group smoking cessation counseling;
3) Nutritional counseling for individuals with obesity or chronic medical diseases;
4) Recommended adult vaccines or immunizations.

DMAS will be implementing a comprehensive adult dental benefit for members enrolled in the Medallion 4 program on 7/1/2021 vthat will be provided as a "carve out" administered by our current dental benefits administrator, which currently provided comprehensive dental benefits for children and pregnant mothers. MCOs will be required to stop providing dental as an enhanced benefit for adults and will be required to provide non-emergency transportation to members for these services.

DMAS will be modifying two DMAS will also implement changes to the existing behavioral health services provided to Medallion 4 members on 7/1/2021. DMAS will be replacing the behavioral health service for children called “Intensive Community Treatment” with a new service called “Assertive Community Treatment”. “Intensive Community Treatment” will continue to be a service for adults. “Mental Health Partial Hospitalization Programs for Youth and Adults” will also replace the current Partial Hospitalization Program for adults. The “Mental Health Intensive Outpatient Program” will also be implemented, which will be a new service for both youth and adults. Each of these programs are designed to be more clinically focused and collaborative with improved quality metrics to assist providers and members in achieving behavioral health treatment goals for members.

DMAS will also be providing smoking cessation coverage through the MCOs participating in Medallion 4 for all adults on 7/1/2021.

DMAS will also be providing a doula benefit for pregnant mothers enrolled in Medallion 4 in October of 2021. DMAS will seek a waiver amendment to obtain approval for this service. A state plan amendment has been submitted to CMS for each of these additional services and changes to existing services described in this section.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. ☐ **Availability Standards.** The States PCCM Program includes established maximum distance and/or travel time requirements, given beneficiarys normal means of transportation, for waiver enrollees access to the following providers. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Hospitals

Please describe:

6. ☐ Mental Health

Please describe:

7. ☐ Pharmacies

Please describe:

8. ☐ Substance Abuse Treatment Providers

Please describe:

9. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☐ **Appointment Scheduling**means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The States PCCM Program includes established standards for appointment scheduling for waiver enrollees access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ **In-Office Waiting Times**: The States PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ Other Access Standards

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the States standard:

c. ☐ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the States standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

d. ☐ The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

Please note any limitations to the data in the chart above:

e. ☐ The State ensures adequate **geographic distribution** of PCCMs.

Please describe the States standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

f. ☐ **PCP:Enrollee Ratio**. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ **Other capacity standards**.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) for facility programs, or vehicles (by type, per contractor) for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ☐ The plan is a PIHP/PAHP, and the State has determined that based on the plans scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

b. ☒ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

Adoption assistance and foster care children are identified by DMAS on the MCO's enrollment report. Children with special health care needs are identified either by the completion of the Medicaid Medical Health Assessment (MMHS) if they are in part of the expansion population identified on the DMAS enrollment report or are identified by medical claims data submitted to the MCO for its members.

c. ☒ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

DMAS carries out health risk screening on Children and Youth with Special Health Care Needs as defined in the contract, including children in Foster Care and Adoption Assistance. The Medicaid Expansion population is given a screening called the “Medicaid Medical Health Screening” – which assists with determining if this population has a serious health care need and should be placed in the CCC+ program. Additionally, the DMAS enrollment broker does a Health Risk Assessment for all new MEDALLION members contacting the Managed Care Helpline, which is provided to the MCOs via secure FTP.

d. ☐ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. ☐ Developed by enrollees primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee.
2. ☐ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. ☐ In accord with any applicable State quality assurance and utilization review standards.

Please describe:

e. ☒ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollees condition and identified needs.

Please describe:

Children and Youth with special health care needs are required by contract to be assigned a case manager and to be allowed direct access to specialists as needed. Staff within the DMAS Division of Health Care Services monitors and provides oversight of the patients who have determined to have special health care needs. This direct access to specialist requirement is communicated to members via the model member handbook.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.

b. ☐ Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.

c. ☐ Each enrollee is receives **health education/promotion** information.

Please explain:

d. ☐ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ☐ There is appropriate and confidential **exchange of information** among providers.

f. ☐ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ☐ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ☐ **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

i. ☐ **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

MEDALLION 4.0 members are assigned an MCO based on member choice, family members who are already enrolled in an MCO, or random assignment. The member is notified in writing that he can choose a different MCO for any reason without cause during the first 90 days of initial eligibility by calling the DMAS enrollment broker, Maximus, or by utilizing their web site or smart phone mobile application to make an informed MCO choice. The member may change their MCO at any time for cause. Each MCO provides its network provider data to the enrollment broker by provider type to allow members to choose an MCO that their doctor is enrolled with.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☒ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:
04/01/20 (mm/dd/yy)

☒ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.
Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Health Services Advisory Group	Annual Technical Report	Operational Systems Review (every 3 years) Annual Validation of PIPs Annual Validation of Performance Measures	: focused studies, satisfaction surveys, calculation of measures
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ☐ The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

b. ☐ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
2. ☐ Initiate telephone and/or mail inquiries and follow-up
3. ☐ Request PCCMs response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to States medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollees PCCM
9. ☐ Institute a restriction on the types of enrollees
10. ☐ Further limit the number of assignments
11. ☐ Ban new assignments
12. ☐ Transfer some or all assignments to different PCCMs
13. ☐ Suspend or terminate PCCM agreement
14. ☐ Suspend or terminate as Medicaid providers
15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

c. ☐ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ☐ Initial credentialing

B. ☐ Performance measures, including those obtained through the following (check all that apply):

- ☐ The utilization management system.
- ☐ The complaint and appeals system.
- ☐ Enrollee surveys.
- ☐ Other.

Please describe:

4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

DMAS is responsible for evaluating the quality of care and services provided to eligible enrollees in the contracted managed care organizations. To ensure that the care and services provided meets acceptable standards for quality, access, and timeliness, DMAS follows both state and federal regulations in addition to DMAS' policies.
Quality improvement (QI) is a continuous improvement process. QI is a proactive approach to improve members' experience of care, improve member health, and reduce per capita costs of health care. Additionally, the Contractor shall cooperate with the Department or its designated agent (EQRO) with quality improvement activities in accordance with CMS recommended protocols and the processes utilized by the Department or its designated agent.
DMAS has developed a Medicaid Comprehensive Quality Strategy (2020-2022) in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.200 et. Seq. DMAS's Quality Strategy functions as a roadmap for developing a dynamic approach to assessing, improving the quality of care and services provided to Medicaid members by Managed Care Organizations and Fee For Services providers and entities, and toward monitoring outcomes. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients. DMAS's Quality Strategy Includes the following four AIMS: 1. Enhance member care experience 2. Effective patient care 3. Smarter spending 4. Improve population health. DMAS expanded its scope to address the following areas:

• Plan for improving quality of care and services
• Standards for network adequacy and availability of services
• Transition of care policy
• Identifying, evaluating, and reducing health disparities

DMAS will fully comply with 42 CFR Part 438 Subpart E as applicable to MCOs by the applicability dates specified in 42 CFR 438.310(d) and 438.334(a)(3)

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. ☐ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. ☒ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

   Please list types of indirect marketing permitted:

   The MCOs can do indirect marketing and have done radio, TV and billboard ads with pre-approval of content by Health Care Services Division staff from DMAS.
3. ☒ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

   Please list types of direct marketing permitted:

   Approved direct marketing to members by the MCOs include newsletters, post cards, health fairs, and other DMAS approved meetings.

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the States procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☒ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

   Please explain any limitation or prohibition and how the State monitors this:

   DMAS limits gifts and incentives to no more than $25 per member, for a total or $100 per year.
2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

   Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3. ☒ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

   Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

The following languages Spanish, Korean, Vietnamese, Chinese, Tagalog, Amharic, French, Russian, Hindi, German, Bengali, Bassa, Yoruba and IBO, are required for translation of marketing materials upon request.

The State has chosen these languages because (check any that apply):

a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b. ☒ The languages comprise all languages in the service area spoken by approximately 5 percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

☒ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the

CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. ☒ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

DMAS provides a multi-language insert to all enrollee material that includes the prevalent languages spoken in the Commonwealth. Spanish is the only language that comes close to the 5% threshold.

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. ☐ The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines significant.:

b. ☐ The languages spoken by approximately [ ] percent or more of the potential enrollee/enrollee population.

c. ☒ Other

Please explain:

languages spoken by approximately 5% or more of the potential enrollee/enrollee population. DMAS and the MCOs does not directly or indirectly communicate with potential Medicaid enrollees, with the exception of marketing material distributed statewide for potential expansion members about the process for enrollment and the eligibility requirements.

2. ☒ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

DMAS requires by contract that each MCO offer oral translation services to all of its members if requested. This information is communicated to members through the member handbook and written member communications

3. ☒ The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

In addition to the outreach material on the Coverva web site, mailings, and in person trainings by DMAS staff statewide, DMAS is currently working with the free clinics, the community services boards, the Department of Social Services and their local offices, and Federally Qualified health centers and has hired two contractors for a targeted ad campaign for marketing and outreach.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

☒ State

☒ Contractor

Please specify:

DMAS and the MCOs do not directly or indirectly communicate with potential Medicaid enrollees, with the exception of marketing material distributed statewide for potential expansion members about the process for enrollment and the eligibility requirements by the enrollment broker and the CoverVA contracted eligibility vendor.

☐ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

☒ the State

☒ State contractor

Please specify:

Maximus is the DMAS enrollment broker responsible for choice counseling, which includes providing objective information to MEDALLION 4.0 members on MCO networks, enhanced benefits and other information relevant to the member which allows him/her to make an informed choice.

☒ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

☒ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the States enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☒ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

DMAS trains advocates in government agencies, providers and provider associations, and higher education to provide information to individuals in their communities about Medicaid health coverage options. Training occurs through webinars, presentations and an advocacy summit. Information is also be disseminated through social media, the Cover Virginia website and call center. Provider outreach is conducted through meetings, conferences and electronic newsletters.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☐ State staff conducts the enrollment process.

☒ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☒ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Maximus

Please list the functions that the contractor will perform:

☒ choice counseling

☒ enrollment

☒ other

Please describe:

DMAS has implemented a smart phone application for all MEDALLION 4.0 enrollees that allows members to make plan selections using their android or apple smart phone.

☐ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

☐ This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

☐ This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

☒ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. ☒ Potential enrollees will have 90 ◉ **day(s)** / ○ **month(s)** to choose a plan.

ii. ☒ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

DMAS will use the following Enrollment process for the Medicaid expansion population:
1) For Members with an active Medicaid case history, such as parents of children already enrolled in Medicaid that attest to not having a complex medical need, the Department shall assign the parent to the same MCO as their dependent is enrolled with.

2) Members who do not attest to having a complex medical need and have no active case history will be assigned to an MEDALLION 4.0 MCO in random order.

3)Members will have ninety (90) days to make an active choice until the next expansion open enrollment period.

☐ The State automatically enrolls beneficiaries.

☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).

☐ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).

☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☒ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

The member may dis-enroll from any contracted health plan to another at any time, for cause. Members shall have the right to dis-enroll from their assigned MCO to another MCO pursuant with Federal regulation and law. Pregnant women, who are in their third trimester of the pregnancy, may request good cause exemption to temporarily return to fee-for-service if the provider is enrolled in Medicaid FFS. A member has the right to dis-enroll from the Contractor's plan without cause once every twelve (12) months; upon reenrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period; when the Department imposes intermediate sanctions on the Contractor, if the member moves out of the services area, if the Contractor does not cover the services the member seeks, because of moral or religious objections; and if the enrollee needs related services to be performed at the same time, or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

☒ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☒ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- **i.** ☒ Enrollee submits request to State.
- **ii.** ☐ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- **iii.** ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☐ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☒ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollees health care needs):

Approved good cause exemption requests can include a demonstrated lack of quality care, lack of access to necessary providers for services covered under the State Plan, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs, or other reasons satisfactory to the Department. DMAS cause exemptions are in compliance with the cause for disenrollment criteria defined in 42 C.F.R. § 438.56(d)(2) and 12 VAC 30-120-370.

☐ The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

☒ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

- **i.** ☒ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

As specified in 42 C.F.R. § 438.56(b)(2), the Contractor may not request disenrollment because of: an adverse change in the member's health status; the member's utilization of medical services; the member's diminished mental capacity; or the member's uncooperative or disruptive behavior resulting from his or her special needs.

ii. ☒ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☒ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.

iv. ☒ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

☒ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

☒ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

    a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

    b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

    c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

    ☒ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

    ☒ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

    Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

    ☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. **Details for MCO or PIHP programs**

a. Direct Access to Fair Hearing

☒ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

☐ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

☐ The States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is [ ] days (between 20 and 90).

☐ The States timeframe within which an enrollee must file a **grievance** is [ ] days.

c. Special Needs

☐ The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollees freedom to make a request for a fair hearing or a PCCM or PAHP enrollees direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☐ The State has a grievance procedure for its ☐ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure): The grievance procedures are operated by:

- ☐ the State
- ☐ the States contractor.

  Please identify: [ ]
- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs equity;

3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

☒ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;

3. Employs or contracts directly or indirectly with an individual or entity that is

a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

☒ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

☒ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

enrollees can file a grievance at anytime. There is no timeframe for filing a grievance. For an appeal, the member has 120 days from the date of service.

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
Accreditation for Non-duplication	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS
Enrollee Hotlines	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☐ PIHP	☒ MCO ☐ PIHP	☒ MCO ☐ PIHP	☒ MCO ☐ PIHP	☒ MCO ☐ PIHP	☒ MCO ☐ PIHP

Evaluation of Program Impact						
Monitoring Activity	**Choice**	**Marketing**	**Enroll Disenroll**	**Program Integrity**	**Information to Beneficiaries**	**Grievance**
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Accreditation for Non-duplication	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
Enrollee Hotlines	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ FFS	☐ FFS	☐ FFS
Performance Improvement Projects	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Accreditation for Non-duplication	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☒ MCO	☒ MCO	☒ MCO

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
Performance Improvement Projects	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
PRGR102321	MCO;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Medallion 4.0

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☒ **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

During the development of the original Medallion II program, Virginia made a conscious decision to require its contracted health plans to attain and maintain NCQA accreditation status. NCQA is the "gold standard" for quality care provided by health plans, and Virginia is only one of a handful of states with this requirement. By following NCQA guidelines, the Department ensures that the plans meet and/or exceed all quality guidelines and required reporting. Careful evaluation of quality and reporting requirements of NCQA allowed the Department to identify duplication of review efforts in some areas and through "deeming," these areas are now reviewed through the NCQA process. A prime example of this is the credentialing/recredentialing standards for providers.

All of Virginia's six (6) Medallion 4.0 contracted health plans have NCQA accreditation.In order to maintain NCQA accreditation, NCQA conducts on-site reviews for each health plan every 3 years. During these reviews areas that are targeted include recipient choice, provider selection and capacity, availability of providers including PCPs and specialists, behavioral health, grievances/appeals, information to beneficiaries, coverage and authorization of covered services, and overall quality of care. MCOs must also provide documentation to NCQA annually in order to maintain their status and adjust their rating, if warranted. Denial of NCQA accreditation status may be cause for the Department to impose remedies or sanctions, to include suspension, depending upon the reasons for denial by NCQA.
DMAS requires all of the contracting MCOs to be accredited by the National Committee for Quality Assurance (NCQA). As such, DMAS deems certain external quality review (EQR)-related activities (On-Site Reviews (Protocol 1) standards) that crosswalk to CMS requirements. There is some overlap between NCQA'S Quality standards the MCOs must meet to maintain accreditation and the three CMS mandated quality activities performed by DMAS's contracted external quality review organization (EQRO). The following link:https://www.dmas.virginia.gov/media/2649/2020-2022-dmas-quality-strategy.pdf provides a graphic (figure 3, Page 25) of Federally required EQR activities and the potential for duplication for each with NCQA Accreditation standards. When overlaps between the Federally required EQR activities and NCQA accreditation standards are clear, DMAS deems most of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming"), as long as the MCO meets the accreditation standards. The criteria for deeming is supported in 42 CFR §438.360 (non-duplication of mandatory activities). Although the performance measure validation activity seems duplicative of annual HEDIS audits experienced by the MCOs, it may not be deemed, according to CMS.
In instances where MCO accreditation information is deemed in order to decrease duplication of activities, DMAS will send the accreditation results, reports and documentation directly to the contracted EQRO for the EQRO to use in completing the mandatory EQR activities of compliance review, performance measures validation and PIP validation.

☒ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

b. ☒ **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

During the development of the original Medallion II program, Virginia made a conscious decision to require its contracted health plans to attain and maintain NCQA accreditation status. NCQA is the "gold standard" for quality care provided by health plans, and Virginia is only one of a handful of states with this requirement. By following NCQA guidelines, the Department ensures that the plans meet and/or exceed all quality guidelines and required reporting. Careful evaluation of quality and reporting requirements of NCQA allowed the Department to identify duplication of review efforts in some areas and through "deeming," these areas are now solely reviewed through the NCQA process. A prime example of this is the credentialing/recredentialing standards for providers.
All of Virginia's six (6) Medallion 4.0 contracted health plans have NCQA accreditation. In order to maintain NCQA accreditation, NCQA conducts on-site reviews for each health plan every 3 years. During these reviews areas that are targeted include recipient choice, provider selection and capacity, availability of providers including PCPs and specialists, behavioral health, grievances/appeals, information to beneficiaries, coverage and authorization of covered services, and overall quality of care. MCOs must also provide documentation to NCQA annually in order to maintain their status and adjust their rating, if warranted. Denial of NCQA accreditation status may be cause for the Department to impose remedies or sanctions, to include suspension, depending upon the reasons for denial by NCQA.

On April 1, 2016 Coventry Cares of Virginia became Aetna Better Health of Virginia.
On November 1, 2017 INTotal Health became United Healthcare of Mid-Atlantic, Inc.

☒ **NCQA**

☐ **JCAHO**

☐ **AAAHC**

☐ **Other**

Please describe:

c. ☒ **Consumer Self-Report data**

Activity Details:

One of the primary sources for consumer self-report data is use of the CAHPS survey for both the adult and child populations. Each health plan conducts the CAHPS annually as a part of their NCQA requirements. Beginning in 2013, DMAS contracted with the EQRO to conduct the CAHPS survey for the fee-for-service and MCO children in the CHIP program. This will continue to be performed each year, in compliance with CMS requirements.

The CAHPS survey is a useful tool to gage customer satisfaction with their health plan and health providers. The survey poses direct questions to recipients regarding: provider selection and choice; timeliness and access to services; access to providers and specialists (including 24/7 availability of PCPs); coverage and authorization of services; ease of communications with providers; information provided to recipients; satisfaction with customer services; compliance with enrollee rights; coordination of care issues; and satisfaction with overall care/quality of care. The administration of an annual CAHPS survey allows each health plan to assess customer satisfaction with the services it provides and with provider network and availability, and assists the plan in identifying its strengths and weaknesses in order to continually improve on the quality of care provided to Virginia's managed care population.

Another means through which the Department monitors consumer self-report data is through contractually required monthly complaint reports (provider and member appeal and grievance summary) received from each of the health plans and weekly complaint reports received from the Managed Care Helpline, some of which require intervention from Department staff. In addition to these formal required reports, the Department's Health Care Services Division maintains an internal complaint database (referred to as the case tracking system or CTS). This includes inquiries from providers, recipients, legislators and the general public. Items are entered into this database after being individually and personally addressed by a Health Care Services staff member. The CTS database offers the Department the ability to run ad hoc reports which are useful in identifying patterns with issues in specific areas, with specific MCOs, or with specific enrollees.

During the two expansions in 2012 (Roanoke-Alleghany in January 2012, and far southwestern Virginia in July 2012), the Department transitioned approximately 53,000 recipients into the mandatory capitated managed care program. In CY 2020 DMAS received 365 member grievances.

☒ **CAHPS**

Please identify which one(s):

DMAS requires that the Medallion 4.0 MCOs administer the CAHPS survey annually using an NCQA Certified vendor. The MCOs are required to administer both the Adult and Child Versions of the survey. The most recently completed Medallion 4.0 CAHPS 5.0H surveys were in 2020 (for CY2019). In fall 2020, the 5.1H version of the CAHPS survey was released but has not yet been administered to the Medallion 4.0 population.

☐ **State-developed survey**

☐ **Disenrollment survey**

☐ **Consumer/beneficiary focus group**

d. ☒ **Data Analysis (non-claims)**

Activity Details:

Non-claim data analyses are conducted by the Department, contracted health plans, the EQRO, and the enrollment broker. Each entity provides reports used in overall program monitoring. For example, the Department produces an Annual Performance Report on the status of Medicaid Managed Care in Virginia, and the EQRO completes an annual technical report (ATR) which includes information on the status of each health plan. The EQRO also reports annually on their evaluations of the health plans' performance measures and performance improvement projects, and conducts a comprehensive operational systems review (OSR) on-site every three years as required by CMS.DMAS is conducting the comprehensive operational systems review (OSR) this year (2021) with our EQRO. The full Medallion 4.0 compliance review was delayed from 2020 to 2021 to occur separately, but concurrently, with the Commonwealth Coordinated Care Plus (CCC Plus) managed care program compliance review. This approach for the compliance review was previously approved by CMS. The Department's Health Care Services Division contains a Systems and Reporting Unit with staff who can conduct SAS runs, network analyses, ad hoc reporting, and encounter data validations. Network analyses and "geomapping" capability are utilized at times of expansions or if there are access complaints within a specific area. SAS runs are used frequently to extract data regarding specific services, populations, data clean-up, etc. For example, some of the types of runs done in the past year include those for the expansion areas (e.g. moving the MEDALLION population into the MCOs), looking at addresses to identify out-of-state recipients, looking at language ratios in certain areas to ensure translation requirements are met, SAS runs to create dashboards by populations, and tracking newborns to ensure enrollment under the correct MCO and with the correct coverage dates.
Last year the Department conducted an in-depth analysis of the contractually mandated reporting requirements from the health plans as described in its reporting manual (its Managed Care Technical Manual, MCTM). As a result of this review which identified why the reports were requested (historically) and if and how the information in these reports were currently being utilized by the Department, the Department was able to significantly change and reduce its reporting requirements. While some reports were able to be eliminated, others (such as the newborn and infant mother identification reports) were able to be consolidated. The Department also created standardized templates to avoid reporting discrepancies and duplicative information. The Department requires a monthly report of recipients enrolled in the plan's pharmacy and/or provider utilization management programs and a report to identify recipients with a period of incarceration during their MCO enrollment.
Efforts to review and consolidate reporting requirements are on-going, the goal of which is to capture those elements specifically required by CMS or NCQA, as well as information utilized by the Department to ensure quality of care services are being provided to our managed care population.
A Technical Manual which has standardized and documented reporting requirements as a part of the Medallion 3.0 Contract has been developed and is under continual revision. A Technical Manual has been created as part of the Medallion 4.0 Contract and is under continual revision.

☐ **Denials of referral requests**

☐ **Disenrollment requests by enrollee**

- ☐ **From plan**
- ☐ **From PCP within plan**

☒ **Grievances and appeals data**

☒ **Other**

Please describe:

The Department defines the following reporting timeframes for the Medallion 4.0 MCOs: 1. Prior to signing the original contract, upon revision, or upon request; 2. Annually; 3. Quarterly; 4. Monthly; and 5. Miscellaneous. All MCO reporting requirements can be found in the MEDALLION 4.0 Contract, but a sampling of the requirements are as follows:

Prior to Signing Original Contract/Upon Revision*/Upon Request/As Needed:
(*Contracts are revised and signed annually. Asterisk indicates also required annually.)
*NCQA Accreditation Information
* Disclosure of Ownership and Control Interest (CMS 1513)
*Quality Improvement Program (QIP)
*Utilization Management Plan
Member Information Packets
Enrollment/disenrollment/educational materials made available to Medallion 3.0 members
Health Education and Prevention Plans and related member materials
Formulary and pre-authorization requirements
Written Policies and Procedures to cover multiple areas (For example, PCP/provider access and referrals, member rights, medical record confidentiality, security and access, EPSDT secondary reviews, prevention, detection, and reporting of potential fraud, waste, and abuse (provider and recipient), etc.) Annually:
Report on the percentage of two-year old children who have received each immunization specified in the most current Advisory Committee on Immunization Practices (ACIP) recommendations
Bureau of Insurance (BOI) Annual Financial Report and any changes Marketing Plan
Submission of Handbooks and letter identifying any changes
Health Plan Assessment Plan
Physician Incentive Plans
HEDIS Information
Quality Improvement Plan
Prior Year' s Outcomes (HEDIS, performance measures, quality studies, etc.)
MCO Organization Chart
Program Integrity Plan
Program Integrity Compliance Audit Annual Audit Report (required by BOI)Quarterly:

BOI Quarterly Financial Report and any revisions
Provider Network File (also submitted to the enrollment broker monthly) Providers Who Have Failed Credentialing/Recredentialing or have been denied application
Disproportionate Share Hospital Report
Abuse, Corrective Action, Overpayment/Recovery Report List of full-time case managers by region Monthly:
Provider and Member Grievances and Appeals Summary
CSHCN Report Assessment
Encounter Data Certification
MCO Report
Providers without Virginia Medicaid ID number/NPI/or API numbers
Pharmacy Management Provider Management
Other Coverage Report
Comprehensive Health Coverage Estate Recoveries
Monies recovered by Third Party
Member Assessments
Returned ID Cards
Miscellaneous

e. ☒ **Enrollee Hotlines**

Activity Details:

The enrollment broker operates an enrollee hotline (aka the Managed Care Helpline) which is a key component in the monitoring process for both the State and the contracted health plans. This is often the first point of contact for recipients during their MCO initial assignment phase. Enrollment broker staff are able to answer questions about the managed care program, and provide information to beneficiaries about providers in each MCO' s network, enrollment/disenrollment processes, covered and carved-out services, EPSDT services, and exemption reasons. In addition, during the initial contact the enrollment broker staff will complete a Health Status Survey Questionnaire. This is an important tool that assists the assigned health plan in identifying case management or medical management needs or potential transition issues. The enrollment broker also provides DMAS with a weekly complaint report of issues identified during their contacts with recipients (for example, if a recipient is unable to obtain a needed service or medication and is in transition into an MCO, if they request a good cause change in MCO assignment outside of their open enrollment period, if they have not received an ID card from their MCO, or often, they are just asking to remain in FFS Medicaid).
Enrollment broker staff also developed and maintain the interactive website (www.virginiamanagedcare.com) which provides comprehensive and up-to-date information on Virginia's managed care program. Website activity, as well as call volume activity, wait/hold times, and number of Health Status Surveys completed during the calls are reported to the Department monthly. During 2012, a significant increase (61%) in the use of this website was noted and was attributed to the two expansions which made the Medallion II program, as it was then known, statewide and the MEDALLION program obsolete.
Continuing with the goal to improve quality of care and services to Virginia's Medicaid managed care population, in August 2012, the enrollment broker added an optional satisfaction survey to their call script. Recipients who opt to participate through an interactive voice response system complete five questions related to responsiveness, timeliness, and overall satisfaction with the helpline's services. To date, 97.2% of the responses have been favorable. Members are now able to make MCO selections via the enrollment broker website.
DMAS also operates two helplines for the fee-for-service population, one for recipients and one for providers. Any calls received by these helplines regarding managed care questions are deferred to the managed care helpline or are sent to the Managed Care Unit (within the Division of Health Care Services) as a "heat ticket." These inquiries or complaints are personally addressed by the Department's managed care staff and are tracked in the unit's internal complaint database (from which ad hoc reports can be run as needed). The types of questions and issues presented to the helplines or received through other venues by Department staff allow for identification of patterns or problem areas which can then be targeted for improvements. The Managed Care Helpline script was modified as a result of expedited enrollment.

f. ☒ **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

Focused studies are conducted annually by the EQRO and are used to research, in depth, certain aspects of clinical or non-clinical services. Because the majority of Virginia's managed care population is made up of pregnant women, babies, and children, the Department continues to utilize prenatal care and its impact on birth outcomes as the focus study topic. The EQRO follows the CMS-recommended protocols for focused studies and includes Virginia Department of Health birth record data in its analysis of low birth weight and gestational ages, to determine the impact of prenatal care by Medallion 4.0 enrollees. Findings from the 2015-2016 focused study suggest that CY 2014 births to Virginia Medicaid women were associated with early and adequate prenatal care and generally favorable outcomes (i.e., low rates for preterm births and low birth weight newborns). Overall, more women in the study population received early and adequate prenatal care, suggesting that continuous enrollment prior to delivery played a role in the initiation of women's prenatal care and number of prenatal care visits throughout the pregnancy.
DMAS also conducts annual focused studies on Improving the Health of Children in Foster Care and Dental Utilization in Pregnant Women.

DMAS will continue to monitor, trend, and evaluate prenatal care and birth outcomes, prenatal care and dental utilization and the health of children in foster care among Medicaid members and will work with the MCOs to identify and evaluate specific interventions and outreach programs implemented to improve these outcomes.

g. ☒ **Geographic mapping**

Activity Details:

The Department has "geomapping" capability and uses this to assess appropriate access for a health plan's PCPs, specialty providers, and designated specialty services (for example OB/GYNs and Community Service Boards), choice of providers during expansions or when an MCO withdraws from an area, or when there are complaints or grievances regarding access to services or specialties in specific areas.

Each of the health plans also has “geomapping” capability (or a comparable software) and may use this during expansion efforts in the development of provider networks within a specific region or when there are complaints regarding provider access in a specific area or with a specialty. The health plans submit their networks monthly to the enrollment broker and quarterly and as requested to the Department.

Each of the health plans also has “geomapping” capability (or a comparable software) and may use this during expansion efforts in the development of provider networks within a specific region or when there are complaints regarding provider access in a specific area or with a specialty. The health plans submit their networks monthly to the enrollment broker and quarterly and as requested to the Department.

h. ☐ **Independent Assessment** (Required for first two waiver periods)

Activity Details:

Not required. Virginia is beyond the first two waiver periods.

i. ☐ **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. ☒ **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

The contracted health plans monitor network adequacy as a required NCQA element, as well as provide network data to DMAS on a quarterly and as-needed basis (for example when there are expansions or retractions in specific localities), and to the enrollment broker on a monthly basis. The health plans are contractually required to list in their provider directories languages spoken by the provider and if a provider is not accepting new clients. All the health plans also have websites which can be accessed by enrollees.

Submission of a plan's network is a required element when a plan desires expansion into new localities. The health plan must meet the needs of the recipients in the region in question, as well as the needs of the Department for increased providers or MCO options in specific regions. The Department conducts an in-depth analysis of the submitted networks paying close attention to PCPs, Pediatricians, OB-Gyn's, and Community Service Boards and mental health providers.

The current MCO networks are extensive. All of the participating health plans have contracted arrangements with hospitals in the localities they service including specialty facilities such as Children's Hospital of the King's Daughters in Norfolk, Children's National Medical Center in Washington, D.C., the University of Virginia Health Center in Charlottesville, and Virginia Commonwealth University Health System in Richmond. Specialty hospitals such as these host numerous pediatric specialists, ancillary providers and support systems and facilitate access to the best and most experienced health care providers in the region. The MCOs also utilize out-of-network, often out-of-state, facilities especially for children when these facilities are identified as centers of excellence for the specific diagnosis or illness at hand, and therefore has the potential to offer the most optimal outcomes.

Comparison charts, which are updated annually at open enrollment and as needed, are provided to enrollees with their pre-assignment letters to help them when making a choice of health plans. These charts identify the localities each health plan covers as well as with which of the local hospitals each plan is contracted and extra programs and services offered by each MCO.

Network analyses and complaint tracking are just two ways that access to care is monitored and ensured. Because of the low reimbursement rates by Medicaid there have been some providers who gave up their contracts with Medicaid. One of the issues frequently identified in the complaints received by the Department is when a recipient had a change in their eligibility which dropped them from MCO enrollment for a few months. Although the recipient remained eligible for FFS, the providers the recipient sees were only enrolled in the MCO network and were not Medicaid providers.

k. ☐ **Ombudsman**

Activity Details:

Virginia has a Managed Care Ombudsman through the State Corporation Commission for commercial and privately insured enrollees; however, any complaints received by their office regarding Medicaid-contracted MCOs are forwarded to the Department's Managed Care Unit within the Health Care Services Division.

The Department also works closely with various recipient advocacy groups to help identify, track, and resolve any inquiries or complaints filed on behalf of Medicaid MCO-enrolled recipients.

l. ☒ **On-Site Review**

Activity Details:

CMS requires each state with managed care programs to utilize an EQRO and conduct an Operational Systems Review (OSR) every three years. This last OSR for Virginia's mandatory capitated managed care program was conducted in 2017, and took place within the health plan's establishment and to place emphasis on areas such as: adequacy and availability of services; coordination and continuity of care; coverage and authorization of services; provider selection, credentialing and recredentialing; subcontractual relationships and delegation; member rights and protections; member information/ enrollment and disenrollment; grievance system; confidentiality of health information; practice guidelines; quality assessment and performance improvement; health information.
Other areas the Department has considered or requested to be added to the OSR reviews include EPSDT screenings and guidelines (including the contractual second level of review for denials), assessments of individuals identified with special needs, and program integrity and reporting efforts.
In the years when there is not a scheduled OSR by the EQRO, DMAS may convene a team of internal subject matter experts to perform a "modified" OSR of each MCO in the form of a desk review audit. These reviews focus on any elements identified in the most recent (EQRO) OSR as needing improvement, or any critical elements of the MCO contract which require more focused attention.
The Department also reserves the right to conduct on-site visits as a part of readiness reviews when a new health plan is coming into the market or there is an expansion into a region.
The next OSR is scheduled to take place in 2020.

m. ☒ **Performance Improvement Projects** [Required for MCO/PIHP]

Activity Details:

DMAS has transitioned from the traditional PIP process to a more proactive and outcome oriented model of improvement. This unique collaborative approach to quality improvement in Virginia's Medicaid managed care delivery system will be the vehicle for a rapid-cycle PIP, and subsequent PIP validation. DMAS' external quality review organization (EQRO), is leading and facilitating each phase and providing technical assistance to the MCOs and DMAS. This approach places greater emphasis on improving outcomes using rapid-cycle improvement methods to pilot small changes. The selected PIP topic focuses on diabetes care. Using data, each MCO narrowed the selected PIP topic of diabetes care to an area in need of improvement (e.g., retinal eye exams for members assigned to a specific provider). The measures for Medallion 4.0 will be communicated by DMAS to the contracted MCOs at a time and in a format determined by DMAS.
DMAS continues its Quality Collaborative in partnership with the contracted MCOs. This committee meets quarterly with staff members from the Health Care Services Division at DMAS, appointed representatives from each of the health plans, EQRO staff, and at times, outside guests who are key stakeholders with mutual interests in priority topics (for example CIOX Health medical record retrieval vendor).
The committee shares best practices, lessons learned, and strategies developed to address barriers to quality of care. Specific topics of interest for this committee are consistent well child and adolescent visits, immunization schedule compliance, and prenatal and postpartum care.
DMAS and its EQRO will focus on both clinical and non-clinical areas for performance improvement

☒ **Clinical**

☒ **Non-clinical**

n. ☒ **Performance Measures** [Required for MCO/PIHP]

Activity Details:

Performance measures are a key feature in measuring a health plan's quality of care. They are an important part of the OSR review and other evaluations conducted by the EQRO. To meet the CMS requirement of EQR validation of performance measures, the EQRO validates a select group of MCO HEDIS scores on an annual basis.
As part of NCQA requirements, the MCOs must perform all HEDIS measures that meet the minimum criteria for calculation. The MCO is to follow the most current version of Medicaid HEDIS technical specifications and discontinue measures as they are retired. NCQA also requires that each MCO's HEDIS scores be audited by an external audit firm as approved by NCQA, before the scores can be submitted and accepted. Annual HEDIS measures, by health plan, can be found on the NCQA Quality Compass.
DMAS selects a subset of HEDIS measures for tracking and trending MCO performance and to set benchmarks for improving the health of the populations served through the managed care delivery system. The HEDIS measures that are a priority for continuous improvement are selected based on the needs of the populations served and the favorable health outcomes that result when the relevant clinical guidelines are adhered to by each MCO's provider network. An example of a performance measure that has shown favorable increases as a result of concentrated efforts is an increase in adolescent well-care visits (of which Virginia is above the national average).
HEDIS score ratings are closely monitored by the Department's Quality Improvement Analyst. DMAS has specified the following measures to be reported during the first contract period for Medallion 4.0:
-Childhood Immunization Status (Combo 3)
-Comprehensive Diabetes Care (all indicators: Hemoglobin Alc testing and control, retinal eye exam, medical attention for nephropathy, and blood pressure control)
-Controlling High Blood Pressure
-Medication Management for People with Asthma
-Postpartum visits
-Timeliness of Prenatal Care
-Breast Cancer Screening
-Antidepressant Medication Management (2 indicators acute phase and continuation phase)
-Follow-up Care for Children Prescribed ADHD Medication (2 indicators, initiations phase; continuations and maintenance phase)
-Follow-up After Hospitalization for Mental Illness (7 day follow up only)
-Well-Child Visits in the First 15 Months of Life (6 or more visits)
-Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (one visit annually)
-Adolescent Well-Care Visits
-Cervical Cancer Screening
-Medical Assistance with Smoking and Tobacco Use Cessation (Different facets include: advising smokers to quit, discussing cessation medication, discussing cessation strategies) -
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics
-Adults' Access to Preventative/Ambulatory Health Services
-Children and Adolescents Access to Primary Care Practitioners
- Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
-Colorectal Cancer Screening
-Flu Vaccinations for Adults Ages 18-64

☒ **Process**

☒ **Health status/ outcomes**

☒ **Access/ availability of care**

☒ **Use of services/ utilization**

☐ **Health plan stability/ financial/ cost of care**

☐ **Health plan/ provider characteristics**

☐ **Beneficiary characteristics**

o. ☒ **Periodic Comparison of # of Providers**

Activity Details:

The health plans continually monitor their networks to ensure adequate coverage of PCPs and specialty providers within required guidelines. The contract specifies that a health plan must have at least one (1) full-time equivalent (FTE) PCP for every 1,500 Medicaid members, and one (1) FTE PCP with pediatric training for every 1,500 members under age 18. In addition, in establishing and maintaining the network, the MCOs must consider the anticipated Medicaid enrollment, the expected utilization of services, the geographic location of providers and members, taking into account time and distance specifications, the number and type of providers (including specialties) required to furnish the contracted services, and the number of network providers NOT accepting new Medicaid enrollees.

The MCO networks are submitted to the enrollment broker monthly and to the Department quarterly or as requested, especially during expansions or when plans are withdrawing from certain areas. MCO providers are encouraged to also be enrolled as Virginia Medicaid providers, but this is not mandated.

The Department has "geomapping" capability and is able to conduct provider analyses as needed, when there is a question or complaint about access. There were no noted access issues during the previous waiver period.

DMAS is implementing a new provider enrollment subsystem in December of 2019. As a part of this implementation, all MCO providers will be enrolled into the Medicaid fee for service system and will be required to meet all of the requirements of the 21st Century Cures Act in order to continue to participate in MEDALLION.

p. ☒ **Profile Utilization by Provider Caseload** (looking for outliers)

Activity Details:

The MCOs are required by contract and through the most current NCQA standards to have a written utilization management (UM) program which includes procedures to evaluate medical necessity, criteria used, information source and the process used to review and approve or deny the provision of medical services. The UM program must ensure consistent application of review criteria, and must demonstrate that members have equitable access to care across the network and that UM decisions are made in a fair, consistent, impartial manner that serves the best interests of the members. The program must have mechanisms to detect under utilization and /or over-utilization of care including, but not limited to provider profiles.

Some of the types of measurements used are denial rates (to identify patterns) and comparisons to benchmarks or the MCO's target goals. Outcomes that are identified as potential problems are usually taken before the medical management departments, or certain relevant committees within the MCO for evaluation and resolution planning. Outcomes of over-or under utilization may lead to the development of new policies and procedures in the identified problem areas.

The MCOs submit reports to the Department's Systems and Reporting Unit on a quarterly basis regarding providers who have failed credentialing/recredentialing. The MCO's also submit to the Department a quarterly report of abuse, corrective action, and overpayment/recovery. This data is shared with the Department's Program Integrity Division for potential provider monitoring activities.

In support of the growing emphasis on Program Integrity monitoring activities and to help better identify and monitor suspected fraudulent activity and prevent duplication of efforts, the MCOs and the Department's Health Care Services and Program Integrity Division staff have established a quarterly collaborative. This collaborative has allowed for the standardization of program integrity reports and reporting processes and enables all Medicaid delivery systems (FFS and managed care) to identify potential fraud/waste/abuse.

The health plans have also been working to develop a relationship with the State's Medicaid Fraud Control Unit. The MFCU now sends to DMAS a quarterly update of cases under review. DMAS then shares relevant information from this report with the MCOs for ongoing monitoring.

q. ☒ **Provider Self-Report Data**

Activity Details:

Provider self-report data is conducted annually by the health plans as a part of their NCQA requirements.

☐ **Survey of providers**

☐ **Focus groups**

r. ☒ **Test 24/7 PCP Availability**

Activity Details:

As a part of the Contract requirements and as required by NCQA the MCOs must maintain adequate provider network coverage to serve the entire eligible Medallion 4.0 population in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days/week (24/7). This requirement may be met through an after-hours telephone service staffed by appropriate medical personnel (for example a physician on call or a covering physician) who can render medical advice and determine and if necessary authorize the need for emergency and other after-hours services. This coverage requirement is monitored through the CAHPS survey questions, as well as during the EQRO's evaluations and on-site visits.

In addition to the 24/7 PCP availability requirement, the health plans are contractually required to provide a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week., staffed by medical professionals to assist members. This is referred to as a 24-hour nurse line and is one of the documented benefits of the managed care program (as opposed to the FFS program). Recipients are provided with information regarding access to and use of the nurse line and are encouraged to call the nurse line after hours for questions or concerns. Recipients who contact these nurse lines are provided with treatment advice, or are advised to seek immediate attention through the ER. Use of the nurse lines not only provides peace of mind for the MCO's enrollee population, but is seen as a mechanism to divert inappropriate emergency room utilization.

s. ☒ **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

Utilization review for Medallion 4.0 recipients is conducted by each MCO as a part of their medical management program and is used to determine appropriate use of referrals, authorizations, etc. The MCOs look at both over-and under-utilization as well as referral and authorization patterns. The Contract requires health plans to operate a Pharmacy Utilization Management Program and allows MCOs to operate a Primary Care (Provider) Utilization Management program (similar to the Department's Client Medical Management or utilization management programs). The need for this was identified through rising costs and the ability to track abuse of certain recipients, or certain medications. Recipients may select a lead PCP or pharmacy to serve as a conduit for services, and may appeal the decision to be placed in these programs; however, the MCOs must report to the Department on a monthly basis a detailed summary report of their programs (and enrollment therein). This information may be shared between FFS and the health plans in order to promote consistency across delivery systems and to help identify potential "plan jumping" by members and providers engaged in fraudulent behaviors.

If an MCO utilizes a Physician Incentive Plan, then this plan must be submitted to DMAS annually. Contractually, the MCOs are prohibited from making any payments under a Physician Incentive Plan as an inducement to limit or reduce medically necessary services to a recipient.

DMAS staff monitors appropriate utilization and overall quality of care through complaints/complaint logs, grievances and appeals, and corresponding monthly or quarterly reports.

t. ☒ **Other**

Activity Details:

The Division of Health Care Services, in collaboration with other divisions within the Department, the MCOs, EQRO, other state agencies, and stakeholders conducts on-going monitoring activities to ensure compliance to managed care program requirements and the provision of quality of care for all Medallion 4.0 enrollees. Monitoring mechanisms include frequent meetings or conference calls, evaluation of complaint and other required reports, Good Cause requests, Program Integrity audits, EQRO reviews, information provided to recipients through mailings or that is available on the DMAS/Managed Care websites, and information provided by the enrollment broker and DMAS helplines. This continual monitoring is not only to meet federal and state regulatory compliance, but to fulfill the DMAS managed care goal which is, "to provide a cost-effective managed care delivery system for eligible Medicaid and CHIP enrollees that far exceeds the industry standards for timeliness, access and quality of care."

The Department prides itself on the open communication with our health plan partners and their willingness towards collaboration(e.g. in areas of Program Integrity, Quality, or expansions). The health plans as a group readily participate with the Department in quarterly (MCO) Workgroup meetings and in quarterly individual plan meetings. Our plan partners have also participated in the Virginia Health Reform Initiative (VHRI) Center committees, and are always open to discussions with the Department and other entities (e.g. the Health Department or Department of Behavioral Health and Development Services) regarding service needs of the population, ideas for new programs, and identified target areas for improvement.

We continue to anticipate growth within the Medicaid program and seek to improve access and quality of services through mechanisms such as Patient Centered Medical Homes and Integrated Care efforts. Our plans share the goal of accessible and quality health care services for residents of the Commonwealth and are always willing to entertain new ideas and approaches to collaboratively meet this goal.

The close monitoring efforts and hands-on attention to individual complaints allows the Department to identify potential problem areas, patterns or trends in the type of problems, and whether the problems stem from programmatic issues, which may be corrected or addressed through clarification memos or contract amendments.

In addition to the MCO monitoring efforts listed above, DMAS' Health Care Services Division established a Compliance Program ("Program") in 2015 to provide oversight of the MCOs in the delivery of a state managed care system. The Program consists of a Compliance Lead and staff focused on ensuring MCO compliance with all elements of the Medallion 4.0 contract. In instances of non-compliance, a newly-developed Compliance Review Committee comprised of subject matter experts in key contract areas meet monthly to discuss and vote on appropriate enforcement activity.

In Medallion 4.0, the Compliance Unit will conduct on-going monitoring of MCOs compliance. The Program will use various methods to monitor the efficiency and effectiveness of MCO compliance with both contractual and regulatory requirements. The following methods will include, but not be limited to: monthly, quarterly, and annual MCO report review, desk reviews, onsite monitoring, interviews, and surveys/questionnaires.

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the States Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver

request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

- ○ **This is the first time the State is using this waiver format to renew an existing waiver.** The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ◉ **The State has used this format previously** The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ **Yes** ○ **No**

If No, please explain:

Provide the results of the monitoring activities:

DMAS fully complied with all applicable provisions for quality measurement and improvement as mandated under 42 CFR Subpart E, Quality Measurement and Improvement; External Quality review section. DMAS updated the agency's Quality Strategy for 2020-2022 as mandated in 42 CFR 438.340. This Quality Strategy aims to guide Virginia's Medicaid program by establishing clear aims and goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding managed care entities accountable for desired outcomes, and is available on the DMAS website. DMAS monitored results of various data analysis conducted for mandatory and optional EQR activities by the EQRO in the activity deliverable reports as outlined in 42 CFR 438.330 and 42 CFR 438.358. Reports included performance measure validation; performance improvement projects: birth outcomes focused study; oral health care for pregnant women focused study; functional, operational and systems compliance reviews; and CAHPS surveys. The EQRO summarized in the annual technical report, available on the DMAS website, the monitoring results from the mandatory and optional activities in compliance with 42 CFR 438.350. Data collection, review/analysis and reporting included results of performance measure validation; performance improvement projects; focused studies; CAHPS surveys; and operational and systems reviews, enrollment and disenrollment; program integrity; information to members; grievance systems; primary care and specialty provider capacity; coverage and authorization of services; provider selection and quality of care. DMAS published the Consumer Decision Support Tool, the Virginia quality rating system tool pursuant to 42 CFR 438.334, which documents MCO level performance on a number of quality performance measures and utilizes a star rating system to assess the MCOs. This tool is updated annually and published on the DMAS website. DMAS
contracted with its EQRO to conduct clinical focused studies regarding improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study) and improving the health of children in foster care (Foster Care Focused Study and Perinatal Dental Utilization),activities performed as outlined in 42 CFR 438.358 and are available on the DMAS website. DMAS will begin the thorough functional operational and systems compliance reviews in 2021 to meet the three year federal requirement as found in 42 CFR 438.358(b)(iii) and will utilize the most recent CMS protocols for compliance reviews as well as Medallion 4.0 contract standards, Virginia also required the Medallion 4.0 managed care
organizations (MCOs) to attain and maintain the National Committee for Quality Assurance (NCQA) accreditation. The MCO NCQA
accreditation process involves an evaluation of the quality of health care and services provided, along with an assessment of clinical and member satisfaction performance measures [HEDIS®]and CAHPS). The Medallion 4.0 MCOs all have attained and maintained NCQA accreditation
during this evaluation period. The NCQA MCO accreditation process included standards that reviewed member choice; enrollment and disenrollment;
program integrity; information to members; grievance systems; timely access to care; primary care and specialty provider capacity; coordination and continuity of care; coverage and authorization of services; provider selection and quality of care.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
AA - MCO - NonTPL	
FC - MCO - NonTPL	
Medicaid Expansion - NonTPL	
Title XIX TANF - MCO Adult - NonTPL	
Title XIX TANF - MCO Child - NonTPL	
MCHIP - MCO - NonTPL	
AA - MCO - TPL	
FC - MCO - TPL	
Medicaid Expansion - TPL	
Title XIX TANF - MCO Adult - TPL	
Title XIX TANF - MCO Child - TPL	
MCHIP - MCO - TPL	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	07/01/2019	06/30/2020	07/01/2020	12/31/2020
Enrollment Projections for the Time Period*	07/01/2021	06/30/2022	07/01/2022	06/30/2023

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Vision Services	☒	☐	☒	
Dental Services (<21 YO)* Emergency Dental Services only;	☒	☐	☒	
Lab and Radiology	☒	☐	☒	
Physician Services (includes psych)	☒	☐	☒	
Private Duty Nursing	☒	☐	☒	
Day Treatment for Pregnant Women	☒	☐	☒	
Smoking Cessation Counseling	☒	☐	☒	
PT, OT, Speed, Audiology	☒	☐	☒	
Other Practitioners (includes psych)	☒	☐	☒	
Transplants	☒	☐	☒	
Outpatient Hospital (includes psych)	☒	☐	☒	
Refer to services in spreadsheet tab"D2.S Services in Waiver Costs". Spreadsheet trumps below.	☒	☐	☒	
Psychiatric Residential Treatment Facilities (PRTF)	☒	☐	☐	
Case Management Services	☒	☐	☒	
Rural Health Clinic	☒	☐	☒	
Early Intervention	☒	☐	☒	
Substance Abuse and ARTS	☒	☐	☒	
EPSDT Screening, Diagnosis, and Treatment	☒	☐	☒	
Nutritional Counseling for Obesity Chronic Disease	☒	☐	☒	
Temporary Detention Orders	☒	☐	☐	
Immunizations	☒	☐	☒	
Adult Vaccines and Immunizations	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Lead Investigations	☒	☐	☒	
Clinic Services	☒	☐	☒	
Regular Assisted Living	☒	☐	☐	
School-Based Services	☒	☐	☐	
Podiatry	☒	☐	☒	
Targeted Case Management to SMI	☒	☐	☒	
Sterilizations	☒	☐	☒	
Inpatient Hospital (includes pysch except for State Psych Hospitals)	☒	☐	☒	
Community Mental Health	☒	☐	☒	
Prescribed Drugs, Prosthetic Devices, and Eyeglasses	☒	☐	☒	
Nurse Midwife	☒	☐	☒	
Community Health Centers	☒	☐	☒	
Community Mental Retardation	☒	☐	☒	
Family Planning	☒	☐	☒	
Nursing Facility	☒	☐	☐	
	☐	☐	☐	
Transportation	☒	☐	☒	
Managed Care Capitated Services	☒	☐	☒	
Residental Treatment for Pregnant Women	☒	☐	☒	
Other Rehabillitation Services	☒	☐	☒	
Federally Qualified Health Center	☒	☐	☒	
Annual Adult Wellness Exams	☒	☐	☒	
Abortions	☒	☐	☒	
Home Health Services	☒	☐	☒	
Durable Medical Equipment	☒	☐	☒	
Comprehensive Adult Dental for Adults, Children and Pregnant Women	☒	☐	☐	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the States waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS

Regional Office for approval.

- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the States submitted CMS-64 forms.

Signature: Scott Cannady

State Medicaid Director or Designee

Submission Date: Jun 28, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Cost-effectiveness spreadsheet is required for all 1915b waiver submissions.

---

b. Name of Medicaid Financial Officer making these assurances:

Chris Gordon

c. Telephone Number:

(804) 786-7933

d. E-mail:

chris.gordon@dmas.virginia.gov

e. The State is choosing to report waiver expenditures based on

- (●) **date of payment.**
- ( ) **date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

b. ☐ The State provides additional services under 1915(b)(3) authority.

c. ☐ The State makes enhanced payments to contractors or providers.

d. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.

e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the*

Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete ***Appendix D3***
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

a. ☒ **MCO**
b. ☐ **PIHP**
c. ☐ **PAHP**
d. ☐ **PCCM**
e. ☐ **Other**

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ☐ **Management fees are expected to be paid under this waiver.**
The management fees were calculated as follows.
1. ☐ **Year 1: $** _____ **per member per month fee.**
2. ☐ **Year 2: $** _____ **per member per month fee.**
3. ☐ **Year 3: $** _____ **per member per month fee.**
4. ☐ **Year 4: $** _____ **per member per month fee.**

b. ☐ **Enhanced fee for primary care services.**
Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ **Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives

inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☐ **Other reimbursement method/amount.**

$

Please explain the State's rationale for determining this method or amount.

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☒ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ☒ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. ☒ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Enrollment is projected to increase or remain constant due to population growth and aging.

d. ☒ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

Eligible members are projected to increase slightly or remain constant due to population growth and aging.

e. ☒ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

RI is state fiscal year 2020, which runs from July 1, 2019 through June 30, 2020. R2 is the first six months of state fiscal year 2021, which runs from July 1, 2020 through December 31, 2020.

Appendix D1 Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. ☒ **[Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.**

Explain the differences here and how the adjustments were made on Appendix D5:

There is no change in services covered and reported in the previous waiver period. Annual Adult wellness, nutrition counseling, smoking cessation and adult vaccines and immunizations are provided to the Adult Medicaid expansion population not other adults in other aid categories covered under the waiver (pregnant women do receive smoking cessation counseling and nutrition counseling).

b. ☒ **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**

For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

Per CMS guidance, dental services are excluded from the cost-effectiveness analysis, as they are provided through a dental ASO arrangement.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Vision Services	☒	☐	☐	☐	☐	☐	☐
Dental Services (<21 YO)* Emergency Dental Services only;	☐	☐	☐	☐	☐	☐	☐
Lab and Radiology	☒	☐	☐	☐	☐	☐	☐
Physician Services (includes psych)	☒	☐	☐	☐	☐	☐	☐
Private Duty Nursing	☒	☐	☐	☐	☐	☐	☐
Day Treatment for Pregnant Women	☒	☐	☐	☐	☐	☐	☐
Smoking Cessation Counseling	☒	☐	☐	☐	☐	☐	☐
PT, OT, Speed, Audiology	☒	☐	☐	☐	☐	☐	☐
Other Practitioners (includes psych)	☒	☐	☐	☐	☐	☐	☐
Transplants	☒	☐	☐	☐	☐	☐	☐
Outpatient Hospital (includes psych)	☒	☐	☐	☐	☐	☐	☐
Refer to services in spreadsheet tab"D2.S Services in Waiver Costs". Spreadsheet trumps below.	☐	☐	☐	☐	☐	☐	☐
Psychiatric Residential Treatment Facilities (PRTF)	☐	☐	☐	☐	☐	☐	☐
Case Management Services	☒	☐	☐	☐	☐	☐	☐
Rural Health Clinic	☒	☐	☐	☐	☐	☐	☐
Early Intervention	☒	☐	☐	☐	☐	☐	☐
Substance Abuse and ARTS	☒	☐	☐	☐	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
EPSDT Screening, Diagnosis, and Treatment	☒	☐	☐	☐	☐	☐	☐
Nutritional Counseling for Obesity Chronic Disease	☒	☐	☐	☐	☐	☐	☐
Temporary Detention Orders	☐	☒	☐	☐	☐	☐	☐
Immunizations	☒	☐	☐	☐	☐	☐	☐
Adult Vaccines and Immunizations	☒	☐	☐	☐	☐	☐	☐
Lead Investigations	☒	☐	☐	☐	☐	☐	☐
Clinic Services	☒	☐	☐	☐	☐	☐	☐
Regular Assisted Living	☐	☒	☐	☐	☐	☐	☐
School-Based Services	☐	☒	☐	☐	☐	☐	☐
Podiatry	☒	☐	☐	☐	☐	☐	☐
Targeted Case Management to SMI	☒	☐	☐	☐	☐	☐	☐
Sterilizations	☒	☐	☐	☐	☐	☐	☐
Inpatient Hospital (includes pysch except for State Psych Hospitals)	☒	☐	☐	☐	☐	☐	☐
Community Mental Health	☒	☐	☐	☐	☐	☐	☐
Prescribed Drugs, Prosthetic Devices, and Eyeglasses	☒	☐	☐	☐	☐	☐	☐
Nurse Midwife	☒	☐	☐	☐	☐	☐	☐
Community Health Centers	☒	☐	☐	☐	☐	☐	☐
Community Mental Retardation	☒	☐	☐	☐	☐	☐	☐
Family Planning	☒	☐	☐	☐	☐	☐	☐
Nursing Facility	☐	☒	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
Transportation	☒	☐	☐	☐	☐	☐	☐
Managed Care	☒	☐	☐	☐	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Capitated Services							
Residental Treatment for Pregnant Women	☒	☐	☐	☐	☐	☐	☐
Other Rehabillitation Services	☒	☐	☐	☐	☐	☐	☐
Federally Qualified Health Center	☒	☐	☐	☐	☐	☐	☐
Annual Adult Wellness Exams	☒	☐	☐	☐	☐	☐	☐
Abortions	☒	☐	☐	☐	☐	☐	☐
Home Health Services	☒	☐	☐	☐	☐	☐	☐
Durable Medical Equipment	☒	☐	☐	☐	☐	☐	☐
Comprehensive Adult Dental for Adults, Children and Pregnant Women	☐	☒	☐	☐	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*
The allocation method for either initial or renewal waivers is explained below:

a. ☐ **The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees***Note: this is appropriate for MCO/PCCM programs.*

b. ☒ **The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.***Note: this is appropriate for statewide PIHP/PAHP programs.*

c. ☐ **Other**
Please explain:

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☐ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

b. ☐ **The State is including voluntary populations in the waiver.**
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c. ☒ **Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
Basis and Method:

1. ☒ **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**
2. ☐ **The State provides stop/loss protection**
   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

d. ☐ **Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. ☐ **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document
   - **i. Document the criteria for awarding the incentive payments.**
   - **ii. Document the method for calculating incentives/bonuses, and**
   - **iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

2. ☐ **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).**). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

   Document:
   - **i. Document the criteria for awarding the incentive payments.**
   - **ii. Document the method for calculating incentives/bonuses, and**
   - **iii. Document the monitoring the State will have in place to ensure that total payments to the**

MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Appendix D3 Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

a. State Plan Services Trend Adjustment the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. ☒ **[Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).**

   The actual trend rate used is: 2.31

   Please document how that trend was calculated:

   DMAS obtained the services from a Certified Actuary to establish trends for different MEGs. The projected trend for each MEG was calculated as a weighted average of the PMPM trend of the major service categories within each MEG. MCO MEG trend was developed by service category within each aid category, not separated by TPL vs. Non-TPL (TANF Child, TANF Adult, MCO Chip, Foster care, Adoption Assistance). The MCO MEG service categories were hospital inpatient, hospital outpatient, professional (physician and other providers), outpatient pharmacy, other, and carve out services. For P1, the major service category trend relied upon analysis of 45 months of historical FFS and encounter data from January 2017 through September 2020. Trends for P2 are preliminary estimates based primarily on the same data used for P1 trends but with added emphasis on more recent values. Trend is applied from the midpoint of the base period to the midpoint of the projection period. Underlying trend models were adjusted to account for fee schedule changes and CCF adjustments in order to account for their impact only once. This was done to assure that program and policy adjustments were not duplicated in the trend adjustment.

2. ☒ **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations)** *(i.e., trending from present into the future).*

   i. ☒ **State historical cost increases.**

   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

Projection period trends were developed using historical FFS and encounter data from January 2017 through September 2020. Trends are calculated using a least squares regression methodology. The projection period trend for each MEG was calculated as a weighted average of the PMPM trend of the major service categories within each MEG. To further supplement the trend analysis, Mercer reviewed information from proprietary work with other states' Medicaid programs, publicly available reports on general health expenditure trend and Medicaid trends, and Bureau of Labor Statistics Consumer Price Index medical trend information. These sources provide a cross-section of information pertaining to the dynamics of the healthcare marketplace that help inform the process of developing prospective trend assumptions. This information combined with professional actuarial opinion was used to develop the final trend assumptions.

ii. ☐ **National or regional factors that are predictive of this waivers future costs.**
Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waivers future costs. Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☐ **The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**
Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
ii. Please document how the utilization did not duplicate separate cost increase trends.

Appendix D4 Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the

capitation rates. However, GME payments must be included in cost-effectiveness calculations.

- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ☒ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. ☒ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
Please list the changes.

The following program adjustments were incorporated and are reflected in D5. Waiver Cost Projections - Column L:
Common Core Formulary (CCF), Fee Schedule Changes for freestanding psych hospitals, OP hospitals, inflation adjustments for IP hospitals, Expansion Utilization Ramp-up Adjustment, Adjustments related to the COVID-19 pandemic and to account for TPL vs. Non-TPL acuity differences.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment
0.00

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment
0.00

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment
0.00

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☒ Other:
Please describe

Changes were evaluated by analyzing base claims experience during CY 2018 and CY 2019. No adjustment was included for the ACA Health insurer fee as the fee was repealed for calendar years after December 31, 2020.

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ Changes brought about by legal action:
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

iv. ☐ Changes in legislation.
Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA
PMPM size of adjustment

D. ☐ Other
Please describe

v. ☐ Other
Please describe:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☐ Other
Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

c. Administrative Cost Adjustment: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.

2. ☒ An administrative adjustment was made.

i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.
Please describe:

ii. ☒ Cost increases were accounted for.

A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. ☐ State Historical State Administrative Inflation. THe actual trend rate used is PMPM size of adjustment
0.00
Please describe:

D. ☒ Other
Please describe:

The growth in Virginia's administrative program is driven by the operational launch of CMS approved Medicaid Enterprise Systems, increased administrative costs associated with new programs, and interagency agreements with sister agencies. The increased inflation adjustment is a direct reflection of the increased projections of medical program waiver costs as reported on the CMS37 for P1 and P2.

iii. ☐ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.J.a. above

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in ***Section D.I.H.a*** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. ☐ [Required, if the States BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

2. ☐ [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years

2. Please provide documentation.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

3. Explain any differences:

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. ***Other adjustments*** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
3. ☒ Other

Please describe:

1. ☐ No adjustment was made.

2. ☐ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

• Common Core Formulary (CCF) - The Medallion 4.0 contract requires the MCOs to adopt the DMAS Preferred Drug List (PDL) and all 90 classes as the basis of their formularies.
• Fee Schedule Changes for freestanding psychiatric hospitals, outpatient hospitals, inflation adjustments for inpatient hospitals – These adjustments represent inflation and provider reimbursement fee changes authorized by VA General Assembly.
• Expansion Utilization Ramp-up Adjustment - The Expansion Utilization Ramp-Up adjustment factors were developed to adjust the base CY2019 data for lower utilization for the Expansion population in the initial months of CY2019.
• High Cost Drugs - This adjustment accounts for additional potential utilization above and beyond what is accounted for in the inflation adjustment for high cost drug products (specifically Zolgensma) anticipated to be available in FY2022.
• Pharmacy Rebates - A downward rebate adjustment is applied to the pharmacy component of the capitation rates to account for market-share rebates achievable during the contract period.
• Adjustments related to the COVID-19 pandemic – Adjustments include increases in testing and treatment costs, vaccinations, and changes in behavioral health utilization due to the pandemic.
• Adjustment account for TPL vs. Non-TPL acuity differences (TPL-only MEG) - Members with comprehensive private insurance as the primary payer will receive a proportion of the capitation rate compared to members without any third party liability (TPL) coverages.

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Please see attached/emailed Excel spreadsheets.

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

Overall R1-P2 Variance Changes are minimal due to the stabilization of populations and benefits after the implementation of the Medallion 4.0 program. These annualized changes reflect 1.37% for TANF Adult Non-TPL, 1.62% for TANF Child Non-TPL, .03% for MCHIP Non-TPL, 4.84% for Foster Care Non-TPL, 1.48% for Adoption Assistance Non-TPL, -11.82% for TANF Adult TPL, -5.67% for TANF Child TPL, -7.14% for MCHIP TPL, -4.78% for Foster Care TPL, 3.67% for Adoption Assistance TPL. The primary drivers for the aforementioned annualized percent changes can be attributed to the trend and program change adjustments from the R1 to P2 time period. For the TPL MEGs, the largest variance is driven by the TPL vs. Non-TPL acuity difference described above.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

Caseload changes consider projected growth in DMAS Medicaid and, specifically in the Medallion 4.0 (MCO) populations, anticipated enrollment growth for the Medicaid Expansion groups.

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of cost increase given in Section D.I.I and D.I.J:

Hospital inpatient, psychiatric hospital, outpatient services unit cost increases, IMD services, Hepatitis C unit costs, revised TPL factors, Physician and hospital directed payments have been incorporated as adjustments to the capitated portion of the Med 4.0 MCO MEGs.

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

Utilization changes are anticipated from the continued expansion of community based mental health services that were previously carved out wrap-around services.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

While the trend and program change adjustments are the main drivers for the overall annualized rate change, the most significant change is due to the TPL factor adjustment. This adjustment accounts for the acuity differences between the TPL and Non-TPL populations and applies to the TPL population only. This adjustment represents impacts of -34.59% for TANF Adult TPL, -20.21% for TANF Child TPL, -20.21% for MCHIP TPL, -25.36% for Foster Care TPL, and 6.67% for Adoption Assistance TPL.

Appendix D7 - Summary