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	
Cardinal Care	Cardinal Care Managed Care	MCO;	

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

Cardinal Care Managed Care Program Waiver

C. Type of Request. This is an:

☒ **Amendment request for an existing waiver.**

The amendment modifies (Sect/Part):

Section A; Part I; Program Overview
* Tribal Consultation ? Description of consultation process
* Program History ? Description of the proposed amendment.
* Populations Included in Waiver, Additional Information ? Affirm that AI/AN managed care enrollment is voluntary for AI/AN members.
* Populations Included in Waiver (1 of 3) - Description of AI/AN members ability to opt-out and opt-in including the MCO assignment and "lock-in" processes and allowances.
* Services; 4. FQHC Services - Add language affirming AI/AN members ability to see tribal FQHC's even if that provider is not in network with their MCO.

Section A; Part IV; Program Operations;
* (C) Enrollment and Disenrollment (2)(a) - Description of AI/AN specific outreach methodologies.
* (C) Enrollment and Disenrollment (6 of 6) - Added description of AI/AN members ability to opt-out and opt-in including the MCO assignment and "lock-in" processes and allowances.

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.026.01.03
Waiver Number:VA.0006.R01.02

D. Effective Dates: This amendment is requested for a period of 5 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)

Approved Effective Date of Base Waiver being Amended: 10/01/23

Proposed Effective Date: (mm/dd/yy)

07/01/25

Approved Effective Date: 12/01/25

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

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

Name:

Matthew Behrens

Phone: (804) 625-3673 **Ext:** ☐ **TTY**

Fax:

E-mail:

matthew.behrens@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:

☐ **Cardinal Care Managed Care**

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.

For the Cardinal Care Waiver renewal (VA.0006.R01.00) which is approved and was effective 10/1/2023, DMAS notified tribal representatives and Indian Health Services offices of the intention to submit proposed waiver changes associated with Cardinal Care. This notice included information about the Tribal Comment period for the proposed waiver changes.
Tribal representatives and Indian Health Services offices were notified via email on January 28, 2022, and the comment period was from January 28, 2022 to March 30, 2022.

No comments from the tribes were received.

Note: Services provided through tribal clinic provider types are carved out of the MCO contract and reimbursed thru fee-for-service, per the provider?s agreement with the Department.

The following tribes were notified:

Tribal Office - TribalOffice@monacannation.com - Monacan
Chief Anne Rich - chiefannerich@aol.com; chiefannerich@aol.com - Rappahannock
Gerald Stewart - wasandson@cox.net - Eastern Chickahominy
Pam Thompson - Pamelathompson4@yahoo.com - Monacan
Tribal Office - rappahannocktrib@aol.com - Rappannock
Gerald Stewart - regstew007@gmail.com - Chickahominy
Robert Gray - robert.gray@pamunkey.org - Pamunkey
Rufus Elliott - tribaladmin@monacannation.com - Monacan
Stephen Adkins - chiefstephenadkins@gmail.com - Chickahominy
Frank Adams - WFrankAdams@verizon.net - Upper Mattaponi
Brady Brown - bradbybrown@gmail.com - Pamunkey
Keith Fanders - Keithfanders@gmail.com - Nansemond

For the amendment to implement the Foster Care Specialty Plan (VA.0006.R01.01), which was approved and effective 07/01/2024, DMAS notified tribal representatives and Indian Health Services offices via email on February 20, 2024 of the intention to submit proposed waiver changes associated with Cardinal Care. This notice included information about the Tribal Comment period for the waiver and a link to the Foster Care Specialty Plan addendum to the RFP. The comment period was from February 20, 2024 until March 21, 2024.

The Department did not receive any comments from the tribes

Note: Services provided through tribal clinic provider types are carved out of the MCO contract and reimbursed thru fee-for-service, per the provider?s agreement with the Department.

The following contacts were notified:

Gerald Stewart <jerry.stewart@cit-ed.org> - Eastern Chickahominy;
Reggie Stewart <regstew007@gmail.com> - Chickahominy;
Stephen Adkins (chiefstephenadkins@gmail.com) - Chickahominy;
Pam Thompson (pamelathompson4@yahoo.com) - Monacan;
TribalOffice@MonacanNation.com - Monacan;
Adrian Compton <tribaladmin@monacannation.com> - Monacan;
contact@Nansemond.gov - Nansemond;
administrator@nansemond.gov - Nansemond;
davehennaman@gmail.com - Nansemond;
Gray, Robert <robert.gray@pamunkey.org> - Pamunkey;
bradbybrown@gmail.com (bradbybrown@gmail.com) - Pamunkey;
rappahannocktrib@aol.com (rappahannocktrib@aol.com) - Rappahannock;
Ann Richardson <chiefannerich@aol.com> - Rappahannock;
brandon.custalow@mattaponination.com - Upper Mattaponi;
admin@umitribe.org - Upper Mattaponi
Garrett, Tabitha (IHS/NAS/RIC) (tabitha.garrett@ihs.gov) - Indian Health Service;
Kara Kearns (kara.kearns@ihs.gov) - Indian Health Service;
Eubank, Mia (IHS/NAS/RIC) (mia.eubank@ihs.gov) - Indian Health Service;

info@afwellness.com - Indian Tribe Health System Facility;
info@fishingpointhc.com - Indian Tribe Health System Facility;

For the amendment (VA.0006.R01.02) that implements changes to carve-in services provided by tribal clinic/FQHC provider types into managed care, and to permit AI/AN members to opt out of managed care for any reason, DMAS notified tribal representatives and Indian Health Services offices via email on December 20, 2024, of the intention to submit proposed waiver changes associated with Cardinal Care. This notice included information about the Tribal Comment/Consult period for the changes. The comment period was from December 20, 2024, through February 18, 2025, and then was extended until April 25, 20205. The consultation process followed was the approved process set forth in Virginia?s Tribal Consultation SPA. The Department received one comment on February 11, 2025. In summary, the comment concerned the consultation process, not the proposed changes to the 1915(b) Waiver. DMAS considered and responded to these comments. At CMS' request, DMAS has provided the comment and our response to CMS reviewers.

The following contacts were notified:

"TribalOffice@MonacanNation.com" <TribalOffice@MonacanNation.com>; "Ann Richardson" <chiefannerich@aol.com>; "Pamelathompson4@yahoo.com" <Pamelathompson4@yahoo.com>; "rappahannocktrib@aol.com" <rappahannocktrib@aol.com>; "regstew007@gmail.com" <regstew007@gmail.com>; "Gray, Robert" <robert.gray@pamunkey.org>; "chief@monacannation.gov" <chief@monacannation.gov>; "chiefstephenadkins@gmail.com" <chiefstephenadkins@gmail.com>; "bradbybrown@gmail.com" <bradbybrown@gmail.com>; "tabitha.garrett@ihs.gov" <tabitha.garrett@ihs.gov>; "Kara.Kearns@ihs.gov" <Kara.Kearns@ihs.gov>; "davehennaman@gmail.com" <davehennaman@gmail.com>; "administrator@nansemond.gov" <administrator@nansemond.gov>; "info@afwellness.com" <info@afwellness.com>; "info@fishingpointhc.com" <info@fishingpointhc.com>; "contact@Nansemond.gov" <contact@Nansemond.gov>; "brandon.custalow@mattaponination.com" <brandon.custalow@mattaponination.com>; "admin@umitribe.org" <admin@umitribe.org>; "lorraine.reels-pearson@ihs.gov" <lorraine.reels-pearson@ihs.gov>; "remedios.holmes@ihs.gov" <remedios.holmes@ihs.gov>; "lindsey.taylor@ihs.gov" <lindsey.taylor@ihs.gov>; "joni.lyon@ihs.gov" <joni.lyon@ihs.gov>; "Howard, Joanne" <Joanne.Howard@cit-ed.org>; jessie@culturalheritagepartners.com

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 CCC Plus program was implemented in 2017 to serve vulnerable populations, including older adults in need of LTSS, disabled children, disabled adults including the ABD, and waiver populations. CCC Plus also includes over 100,000 dual eligible individuals. In 2019, as a result of Medicaid Expansion being authorized in Virginia, medically complex Expansion adults were added to the CCC Plus program. CCC Plus currently serves just over 300,000 individuals. The CCC Plus model of care includes: operating using person-centered care coordination for all members; methods to identify, assess and stratify vulnerable and emerging high needs populations; comprehensive risk assessments, individualized care planning, and interdisciplinary care team involvement; integrating primary, acute behavioral health, and staff and provider training on the model of care to ensure members receive person-centered, culturally competent care and ensures seamless transitions between levels of care and care settings. Every CCC Plus member is assigned a dedicated care coordinator from the member?s health plan who works with them and their provider(s) to ensure timely access to appropriate, high-quality care.

The Medallion 4.0 program was implemented in 2018 and currently serves pregnant women, infants, children, parents/caregivers, and Expansion adults. Medallion 4.0 also includes individuals enrolled in Virginia?s State Children?s Health Insurance Program (S-CHIP), called Family Access to Medical Insurance Security (FAMIS), which provides vital coverage for pregnant women and children in families whose earnings are too high to qualify for Medicaid but cannot afford private insurance. In 2019, as a result of Medicaid Expansion being authorized in Virginia, non-medically complex Expansion adults were added to the Medallion 4.0 program. Care coordination in Medallion 4.0 is not mandatory for every member, however it is strongly encouraged for the vulnerable populations. The vulnerable populations include children and youth with special health care needs, adults with serious mental illness, members with substance abuse disorders, children in foster care or adoption assistance, women with a high-risk pregnancy, and members with other complex or multiple chronic conditions. Comprehensive health risk assessments are conducted for children and youth with special health care needs (CYSHCN) and members in foster care and adoption assistance. The MCO is required to develop and maintain a program to address and improve the care and access of services among members requiring assessments.

In 2023, Virginia combined its two managed care programs into one comprehensive program called Cardinal Care Managed Care. Five of the six managed care organizations (MCOs) that served CCC Plus and Medallion 4.0 continue to provide services under Cardinal Care (except for Virginia Premier Health Plan, which was recently acquired by Optima Health, now known as Sentara Community Plan, also a Virginia Medicaid MCO). The Medallion 4.0 and CCC Plus populations have been rolled into the Cardinal Care Managed Care 1915(b) waiver. Moving to one managed care delivery system has streamlined and added value for members by eliminating the need for unnecessary transitions between the two managed care systems and facilitating access to a fully-integrated, well-coordinated system of care, allowing the member to experience uninterrupted care. Under the combined program, DMAS strategically aligned the model of care requirements to ensure access to care coordination and a comprehensive model of care relevant to the population, based on the member?s needs and level of risk. Other areas of merging and alignment to effectuate one comprehensive program included aligning provider network adequacy standards to meet the needs of the Medicaid population; aligning quality reporting ensuring measures are consistent between the programs and that appropriate benchmarks are established by population; updates to rate cells (although no new populations will be added); and combining the medical loss ratios and underwriting gains.

In 2024, the Foster Care Specialty Plan (FCSP) was implemented as part of the re-procurement of the CCMC program. FCSP is the default MCO to serve the approximately 17,704 members in the Foster Care Population, which includes members under age 21 who are in foster care (aid category 076), former foster care members under age 26 who were in foster care until their discharge from foster care at age 18 or older, (aid category 070) and members under age 21 who receive adoption assistance (aid category 072) (collectively, and hereinafter, Foster Care Population). Members in foster care (approximately 5,400) can only be served by the Foster Care Specialty Plan; however, they may opt out of the FCSP to fee-for-service. Former foster care members (approximately 2,500)) and members receiving adoption assistance (approximately 9,400)) may opt out of enrollment in the Foster Care Specialty Plan and change their health plan at any time. No members of the Foster Care Population are restricted to their health plan selection or fee-for-service selection following the initial 90 day MCO enrollment period. Anthem Health Keepers was awarded the FCSP contract through the re-procurement process.

For the amendment (VA.0006.R01.02)submitted to CMS on May 15, 2025, DMAS is implementing changes to include services provided by tribal clinic/FQHC provider types as a managed care service. DMAS will adhere to all applicable managed care regulations, including 42 CFR 438.14. AI/AN members will be permitted to opt out of managed care for any reason including ?good cause? as described in 438.14(b)(5)(ii) and for any other reason. See Section A; Part I; E (1 of 3) and Section A; Part IV; C (6 of 6) for additional information regarding the AI/AN members ability to opt-out and opt-in to managed and the MCO assignment process including the MCO "lock-in" requirements. AI/AN members will have the right to select a tribal provider as their primary care provider. DMAS will make all required changes to managed care contracts in compliance with 42 CFR 438.14.DMAS notified tribal representatives and Indian Health Services offices in accordance with our State Plan tribal consultation policy. Notices and communications between DMAS and tribal representatives have been provided to CMS under separate cover.

The waiver as amended will end on 6/30/28.

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*

   ☒ **Cardinal Care**

   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*

   ☐ **Cardinal Care**

   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*

   ☐ **Cardinal Care**

   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*

   ☒ **Cardinal Care**

   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*

   ☐ **Cardinal Care**

   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*

   ☒ **Cardinal Care**

   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*

   ☒ **Cardinal Care**

   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*

   ☐ **Cardinal Care**

   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*

   ☐ **Cardinal Care**

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: " **Cardinal Care Managed Care.** *"*

☒ **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

The Foster Care children will be enrolled in the Foster Care Specialty Plan but will have a choice of the FCSP or FFS. Members receiving adoption assistance and former foster care members will be also assigned to the FCSP. These members are permitted to disenroll from the Foster Care Specialty Plan and enroll in one of the other available health plans, as the state is not the legal guardian for these two populations. See Section A: Part I: Program Overview: Program History for additional information.

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:

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*

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

     ☐ **Cardinal Care**
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)
Central,Tidewater,Northern&Winchester,Charlottesville,Roanoke,Southwest	MCO	Anthem HealthKeepers Plus
Central,Tidewater,Northern&Winchester,Charlottesville,Roanoke,Southwest	MCO	Sentara Community Plan
Central,Tidewater,Northern&Winchester,Charlottesville,Roanoke,Southwest	MCO	Aetna Better

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		Health of Virginia
Central,Tidewater,Northern&Winchester,Charlottesville,Roanoke,Southwest	MCO	United Healthcare
Central,Tidewater,Northern&Winchester,Charlottesville,Roanoke,Southwest	MCO	Humana Healthy Horizons

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 State?s 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 Children?s Health Insurance Program (SCHIP) through the Medicaid program.

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

☒ **Other** (Please define):

Foster Care Children will be able to opt-out of the FCSP and enroll in fee-for-service regardless of if they reside in/are admitted to a PRTF.

Managed care enrollment is voluntary for AI/AN members and they can opt-out for cause or for no cause. The initial MCO assignment, plan selection process, and lock-in period will be the same for AI/AN enrollees as for other enrollees. For the initial assignment (new to Medicaid), the AI/AN member will be auto assigned to an MCO. The members can switch MCO?s prior to their effective date or within the first 90 days past their effective date. After 90 days, they will be ?locked-in? with that MCO until the annual open enrollment period. As noted above, AI/AN members can choose to opt-out of managed care at any time, including during the initial assignment period.

For AI/AN members who have opted-out and are in FFS but would like to re-enroll in managed care, these individuals will be able to contact our enrollment broker and request enrollment into an MCO. The members will have to select an MCO, they will not be auto assigned. The enrollment broker will be able to assist them in making a MCO selection. As with initial enrollment, once the member is enrolled with the MCO for more than 90 days, they will be ?locked-in? with that MCO until the annual open enrollment period. Members ? including AI/AN members - are also able to switch plans outside of the open enrollment period for cause.

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):

Excluded: Individuals enrolled in PACE; Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program or the FAMIS Select program; Individuals with temporary eligibility coverage, retroactive eligibility coverage, or who are Medicaid eligible in limited coverage groups; Members who have an eligibility period that is less than three (3) months; Individuals in Medicare-Related Covered Groups (Medicare Savings Plans or MSPs) for whom Medicaid pays the Medicare costs on behalf of these beneficiaries. These individuals do not have full Medicaid benefits, and include, Qualified Medicare Beneficiaries (QMBs), Special Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), or, Qualifying Individuals (QIs); Medically Needy (spenddown) individuals who have a limited period of full coverage; (Medically Needy LTSS participants who meet their spenddown and maintain on-going eligibility will be managed care enrolled); Other individuals with temporary or limited Medicaid eligibility coverage; Individuals who elect hospice benefits while enrolled in fee-for-service will not be enrolled into managed care.(However, a managed care enrolled individual who subsequently enters a hospice program will remain managed care enrolled); Individuals who live on Tangier Island; Individuals with end stage renal disease and in FFS at the time of enrollment will be auto-enrolled into the CC program but may request to be disenrolled and remain in FFS (DMAS will manually exclude these individuals if requested by the Member within the first 90 days of enrollment.) However, an individual who does not request exclusion within the first 90 days of enrollment or who develops ESRD while enrolled in the CC program will remain in CC. Individuals of any age who are institutionalized in State or private ICF/ID and State ICF/MH facilities (a State acute care facility is not excluded); Individuals receiving care in a Christian Science Sanatoria Facility; Individuals aged twenty-one (21) to sixty-four (64) who are hospitalized in a State or private institution for mental disease (IMD), other than individuals admitted to an IMD as part of a Contractor approved admission, in lieu of an acute care hospital (psychiatric unit); Individuals who reside at Piedmont, Hiram Davis, and Hancock state facilities operated by DBHDS; Individuals who reside in nursing facilities operated by the U.S. Department of Veterans Affairs, the Virginia Home Nursing Facility, local government-owned nursing homes, and individuals authorized by the Department to receive care/treatment in facilities located outside of Virginia, including but not limited to Braintree Manor Nursing and Rehabilitation Center; Individuals who are incarcerated; and Individuals enrolled in the Birth Injury Fund.

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:

Please see Section A: Part I: Program Overview: Program History for additional information regarding the FCSP plan population and Section A: Program Description Part I: Program Overview E. Populations Included in Waiver for additional information regarding the FCSP population that reside in PRTFs.

Managed Care enrollment is voluntary for AI/AN members. Please see Section A: Part I: Program Overview: Program History

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:

DMAS values FQHCS as they serve as a key safety net provider group in the Commonwealth. As such, DMAS requires all five contracted MCOs to make a best effort to contract with all FQHCs and RHCs available in their service area (see Section 7.1.5 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) of the Cardinal Care Contract). DMAS also monitors MCO networks, including FQHC participation. Members may also request to change MCOs outside of open enrollment if the FQHC they use does not participate with the MCO in which they are assigned. See Section 3.13.1, For Cause Enrollment Changes. We have revised the contract at Section 3.13.1, For Cause Enrollment Changes (5) to make this good-cause criteria clear. The AI/AN enrollee who opts in to managed care may continue to receive services through a preferred IHCP, including those operating as FQHC's, whether the provider is in the managed care?s provider network or not.

☐ 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 MCO is responsible for EPSDT outreach, EPSDT medical necessity review, EPSDT screenings, EPSDT treatment and referrals, EPSDT services such as dental screenings, immunizations and vaccinations, hearing services, private duty nursing, tobacco cessation services, vision services, Services for Adolescents and Youth with Substance Use Disorder (SUD), clinical trials, as well as maintenance of document requirements such as medical record, comprehensive screening, and required elements to be encompassed within these documents. The state acknowledges that dental screening is not dental treatment, and the state provides a comprehensive array of diagnostic, preventive, and restorative dental services for children and adults through the state?s Smiles for Children Program, administered by the Dental Benefits Administrator. These services are carved out of the managed care contract.

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:

Enrollees may self-refer for emergency or urgently needed care, family planning services and services related to pregnancy, routine women's healthcare services, select addition and recovery treatment services, and for eligible AI/AN members, services by Indian health providers.

8. Other.

☒ Other (Please describe)

The Medicaid Expansion population receives the same amount, duration, and scope of services for annual adult wellness exams, individual and group smoking cessation counseling, nutritional counseling for individuals with obesity or chronic medical diseases, and recommended adult vaccines and immunizations in accordance with the USPSTF.

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:

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 State?s PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary?s 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 State?s PCCM Program includes established standards for appointment scheduling for waiver enrollee?s 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 State?s 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 State?s 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 State?s 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 State's 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 plan?s 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:

Virginia has several mechanisms for identifying Cardinal Care Managed Care Members with special health care needs including: 1) Medicaid eligibility data shared with the MCOs, which includes aid categories and long term services and supports (LTSS) level of care indicators; 2) medical transition data shared with plans that includes claims history and service authorization data, and 3) requirements for MCOs to utilize a risk scoring and stratification methodology on an ongoing basis that includes at least 18 required elements to stratify a member?s risk and needs. These mechanisms not only help identify members with special health care needs but also support the appropriate assignment of a member to a Priority Population for either Low, Moderate, or High Intensity Care Management, when expanded health risk assessments are conducted regularly for further awareness and understanding of a member's special health care needs. Foster Care Population members are contractually defined as enrollees with special health care needs.

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:

The Cardinal Care program includes the expectation of ongoing member monitoring and risk stratification of members to identify care needs. In addition to various analytical tools to identify ongoing special conditions and care management needs, the MMHS and Health Risk Assessments (HRAs) provide additional opportunities to identify member care needs. With respect to the Foster Care Population, the Foster Care Specialty Plan will have trauma-informed care managers dedicated specifically to this population to ensure they receive the appropriate level of care management, including automatic placement in the highest intensity care management upon enrollment and reassessment if a member experiences any of several contractually defined triggering events.

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:

An individualized care plan (ICP) is developed by the MCO in conjunction with the Member, the interdisciplinary care team (ICT) and the primary care provider or other pertinent providers. The ICP is required to be tailored to the Member?s needs and preferences and must be developed and implemented no later than the end date of any existing service authorization.

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 enrollee?s condition and identified needs.

Please describe:

The majority of Members are assigned a Care Coordinator and are allowed direct access to specialists as needed. The personnel who review and revise the ICP typically consist of specialists required by the Member?s health needs and those who participate in the ICT involve specialists required by the Member?s health needs. Staff within DMAS monitor and provide oversight of patients who have been determined to have special health care needs. The direct access to specialist benefit is described to the member by the Care Coordinator and can also be accessed through the Model Member Handbook, taking into consideration any developmental, sensory, mental, or emotional disabilities that the member may have. Members can get the handbook in various formats to accommodate specialty needs, consistent with 42 CFR §438.10(c)(4)(i) and 42 CFR §438.10(d)(3). The assigned care coordinator or care manager ultimately can help ensure member access to the handbook in the manner that suits the member's personal needs.

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 enrollee?s needs.

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

Cardinal Care 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 or by utilizing their web site or smart phone mobile application to make an informed MCO choice. The member may request to change their MCO at any time for cause (with the exception of the Foster Care Population, who can change their enrollment at any time). 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:

The continuity of care period is 30 days for transitions between Fee-For-Service and MCOs as well as transitions between MCOs, with two exceptions: members receiving High Intensity Care Management, for whom the continuity of care period is the 60 days of enrollment, and pregnant individuals, for whom the continuity of care period is the first 60 calendar days postpartum. The continuity of care period is an especially vulnerable time, so the state allows an extended period of time to promote a seamless transition for these populations. The member's assigned MCO must honor any Fee-For-Service authorizations for up to 30 days. For transfers between MCOs, the new MCO must honor the prior MCOs authorizations for up to 30 days. This timeframe must be extended for certain high-risk populations, as described in the Cardinal Care Contract. The MCO must also cover, pay for, and coordinate care during all member's continuity of care period when the Member?s provider is not part of the Contractor?s network, has an existing relationship with the Member, is out of state, and has not accepted an offer to participate in the MCO?s network. MCOs must allow members in a Nursing Facility (NF) at the time of Cardinal Care program enrollment to remain in that NF as long as the member continues to meet the Department?s NF level of care criteria, unless the member or their authorized representatives prefer to move to a different NF or return to the community.

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:
12/08/17 (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	HSAG	Annual Technical Report	Validation of Performance Measures Validation of Performance Improvement Projects Administrat Compliance Assessment Operational Systems Review (every 3 years)	Consumer Satisfaction Surveys, Focused Studies, Measure Development, Encounter Data Validation
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 PCCM?s response to identified problems
4. ☐ Refer to program staff for further investigation
5. ☐ Send warning letters to PCCMs
6. ☐ Refer to State?s medical staff for investigation
7. ☐ Institute corrective action plans and follow-up
8. ☐ Change an enrollee?s 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:

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 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:

   Allowable direct marketing to members by the MCOs include newsletters, post cards, social media, health fairs, and other DMAS approved in-person meetings with pre-approval by DMAS.

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the State's 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 $50 per member per medical goal 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):

Languages of Spanish, Korean, Vietnamese, Chinese, Tagalog, Amharic, French, Russian, Hindi, German, Bengali, Bassa, Yoruba and Igbo, 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 5.00 percent or more of the potential enrollee/enrollee population.

c. ☐ Other

Please explain:

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

DMAS participates in a contract for telephone-based interpretation/translation services, available to individuals seeking information. Language translation services are available to individuals seeking assistance. DMAS requires that each MCO offer oral translation services to all of its members (Information provided through 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 provided by DMAS Enrollment Broker, Cover Virginia web site, and mailings, DMAS offers in person trainings statewide. DMAS also works with free clinics, the community services boards, and Department of Social Services to provide helpful information for enrollees and potential enrollees.

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:

MCOs are permitted to notify the general public of the Cardinal Care program in an appropriate manner through appropriate media throughout its enrollment area. They may host or participate in health awareness events where representatives from DMAS, the enrollment broker, and/or local Health Departments and/or Departments of Behavioral Health and Developmental Services may be present.

☐ 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

☐ 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 State's 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:

Effective January 2023, all Cardinal Care Managed Care populations will follow the annual regional open enrollment schedule: (see Section 3.14, Open Enrollment):

I. Former Medallion 4.0 Populations and FAMIS Children, FAMIS MOMS, and FAMIS PC Members:

1. Roanoke/Allegheny and Southwest Regions: December 19 ? February 28
2. Tidewater Region: February 19 ? April 30
3. Central Region: April 19 ? June 30
4. Northern Virginia Region: June 19 ? August 31
5. Charlottesville/Western Halifax Regions: August 19 ? October 31

II. Medicaid MAGI Adult Members (Medicaid expansion) Aid Categories 100 ? 103: November 1 ? December 31

III. Former CCC Plus Populations, except MAGI Adults (per above): October 1 ? December 31

IV. Managed Care participants:
1. Tidewater Region: February 19 ? April 30
2. Central Region: April 19 ? June 30
3. Northern Virginia Region: June 19 ? August 31
4. Charlottesville/Western Halifax Regions: August 19 ? October 31
5. Roanoke/Allegheny and Southwest Regions: December 19 ? February 28

In accordance with 42 CFR §438.110, the MCO is required to establish a Member Advisory Committee that will provide regular feedback to the Contractor on issues related to Cardinal Care Managed Care program management and Member care. The Member Advisory Committee must reflect the diversity of the Cardinal Care Managed Care population, including: pregnant Members, parents and children, adults without children, LTSS Members, individuals with disabilities and individuals residing in NFs; Members with limited English proficiency and diverse cultural, racial, and ethnic backgrounds; and Members with differing abilities, genders, sexual orientations, and gender identities?or other individuals representing such Members.

For the Foster Care Population that are enrolled into the Foster Care Specialty Plan, the Department will issue a notice to all eligible enrollees regarding their assignment to the Specialty Plan. This notice informs the members that they can change their health plan assignment or opt out into FFS (foster care population only) at any time with or without cause. The notices will also include information about the benefits specific to the Foster Care Specialty Plan, such as the key personnel dedicated solely to the Foster Care Population, automatic placement into High Priority Care Management, and the services provided at enrollment in the Plan and transition out of the child welfare system.

The MCO selected to serve as the Foster Care Specialty Plan must participate in child welfare stakeholder collaboration work groups as requested by the Department, including but not limited to the Safe and Sound task force, Commission on Youth, OCS/CSA, and the Child Welfare Advisory Committee.

Virginia is considering additional outreach to inform AI/AN enrollees, providers and other interested parties, about the managed care delivery and/or CCMC program. This includes, but is not limited to, Member communications to AI/AN members making them aware of their ability to opt-out and opt-in of managed care at any time. We are considering one-time communications (targeted communications to AI/AN members) and on-going communications such as adding AI/AN specific language to our open enrollment notices.

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:

Member education and enrollment, assistance with and tracking of Member's complaint resolution, assistance with managed care enrollment verification and benefits. Role of enrollment broker is beneficiary support system for enrollment and disenrollment. Enrollment broker is responsible for the operation and documentation of a toll-free Member service helpline and web-based enrollment application.

☐ 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.):

Medallion 4.0 populations rolled into the CCC Plus program, and the combined program was renamed the Cardinal Care Managed Care program and implemented statewide on October 1, 2023. In preparation for this change, effective January 1, 2023, DMAS rebranded Virginia Medicaid to Cardinal Care. DMAS re-procured the CCMC program, including the FCSP in 2024 and the re-procured program went live on July 1, 2025.

☒ 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 factors like the following to enroll members, depending on population category and need. Not all factors below apply to every member and not every factor below will be applied. See Cardinal Care Managed Care Contract for more details.
1) Member Choice;
2) Previous MCO;
3) Foster Care Population;
4) Case Relationship;
5) Assignment to an MCO where the Member's PCP participates (based on claims history);
6) Member's Medicare Plan - if known, most recent previous Medicare plan, within the past two (2) months (excluding Part D only plans);
7) Previous MCO within the past two (2) months (re-enrollment);
8) MCO with the Member's LTSS provider (certain LTSS providers) in the MCO's network;
9) MCO Contractor with the Member's nursing facility in the MCO's network;
10) Members who do not meet one (1) of the above criteria will be equally distributed between the currently contracted MCOs.

☒ 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 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 enrollee?s health care needs):

The Contractor does not, because of moral or religious objections, cover the service the Member seeks; The Member needs related services to be performed at the same time; not all related services are available within the provider network; and the Member?s primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk; The Member who receives LTSS would have to change their residential, institutional, or employment supports provider based on that provider?s change in status from an in-network to an out-of-network provider with the MCO and would experience a disruption in their residence or employment; Pregnant individuals, in Medicaid or FAMIS MOMS, who are in their 3rd trimester of pregnancy to temporarily return to fee-for-service if their OB provider is enrolled in Medicaid FFS but does not participate in any health plan; Other reasons as determined by the Department, including but not limited to poor quality of care, lack of access to covered, aligning Cardinal Care managed care plan enrollment with DSNP plan enrollment, or lack of access to providers experienced in dealing with the Member?s care needs.

☐ 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

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 PCCM?s 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:

DMAS will continue to allow all individuals, including those in PRTFs, to change their health plan at least once per 12 months for any reason. Beginning in 2023 with the Tidewater region, members will have the opportunity to change their plan at least once every 12 months based on the member?s region of residence. The state, as the legal guardian for foster care children, elects to enroll all foster care children into the Foster Care Specialty Plan. Foster care children will have a choice of the FCSP or FFS. Members receiving adoption assistance and former foster care members will also be assigned into the Foster Care Specialty Plan. These members are permitted to disenroll from the Foster Care Specialty Plan and enroll in one of the other available health plans, as the state is not the legal guardian for these two populations.

For AI/AN memebers - The initial MCO assignment, plan selection process, and lock-in period will be the same for AI/AN enrollees as for other enrollees. For the initial assignment (new to Medicaid), the AI/AN member will be auto assigned to an MCO. The members can switch MCO?s prior to their effective date or within the first 90 days past their effective date. After 90 days, they will be ?locked-in? with that MCO until the annual open enrollment period. As noted above, AI/AN members can choose to opt-out of managed care at any time, including during the initial assignment period.

For AI/AN members who have opted-out and are in FFS but would like to re-enroll in managed care, these individuals will be able to contact our enrollment broker and request enrollment into an MCO. The members will have to select an MCO, they will not be auto assigned. The enrollment broker will be able to assist them in making a MCO selection. As with initial enrollment, once the member is enrolled with the MCO for more than 90 days, they will be ?locked-in? with that MCO until the annual open enrollment period. Members ? including AI/AN members - are also able to switch plans outside of the open enrollment period for cause.

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 State?s timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 30 days (between 20 and 90).

☐ The State?s 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:

External facing member materials including those with grievance or appeal information are available in alternative formats in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or limited English proficiency. All members, including those with special needs, have right to receive benefits while the State fair hearing is pending.

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 enrollee?s freedom to make a request for a fair hearing or a PCCM or PAHP enrollee?s

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 State?s 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 MCO?s, PCCM?s, PIHP?s, or PAHP?s 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 MCO?s, PCCM?s, PIHP?s, or PAHP?s 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:

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	☐ 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
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 ☐ 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
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	☒ 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
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 ☐ 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 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	☐ MCO	☐ MCO	☒ MCO	☐ MCO	☐ MCO

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

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

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
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 ☐ 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	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Access			
Monitoring Activity	**Timely Access**	**PCP / Specialist Capacity**	**Coordination / Continuity**
	☐ FFS	☐ FFS	☐ 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
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	☐ MCO ☐ PIHP ☐ PAHP	☒ MCO ☐ PIHP ☐ PAHP

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

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
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
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	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☒ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	**Coverage / Authorization**	**Provider Selection**	**Qualitiy of Care**
	☐ FFS	☐ FFS	☐ 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 ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ 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
Cardinal Care	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: Cardinal Care Managed Care

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 organization?s 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:

The Department requires its contracted health plans to attain and maintain NCQA accreditation status. As such, certain external quality review (EQR)-related activities (On-Site Reviews [Protocol 1] standards) 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). 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.

By following NCQA guidelines, the Department ensures that the plans meet and/or exceed all NCQA health plan accreditation requirements and required reporting. Careful evaluation of quality and reporting requirements of NCQA allow the Department to identify duplication of review efforts in some areas and through "deeming," these areas are now solely reviewed through the NCQA process.

All of Virginia's five (5) Cardinal Care 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. health plans 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.

In instances where MCO accreditation information is deemed in order to decrease duplication of activities, DMAS 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:

The Department requires its contracted health plans to attain and maintain NCQA accreditation status. By following NCQA guidelines, the Department ensures that the plans meet and/or exceed all health plan accreditation requirements 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.

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. Health plans 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.

☒ **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 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for both the adult and child populations. Each health plan will be required to conduct the CAHPS annually as a part of their NCQA requirements. The CAHPS survey is a useful tool to gauge 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.

In addition to CAHPS survey requirements, health plans will also be required to administer a state specific member experience survey. This survey focus on areas not covered by CAHPS, including member experience with health plan care management, member quality of life, and member experience with BH and LTSS services and supports.

Another means through which the Department monitors consumer self-report data is through contractually required appeals and grievance reports 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 Integrated Care (IC) division maintains an internal complaint database. This includes inquiries from providers, recipients, legislators and the general public. Items are entered into this database after being individually and personally addressed by division staff member. The database offers the Department the ability to run ad hoc reports which are useful in identifying patterns with issues in specific areas, with specific health plans, or with specific enrollees.

Cardinal Care health plans are required maintain a Member Advisory Committee composed of members and their representatives. Member experience and feedback will be gathered continuously as part of the Member Advisory Committee structure.

☒ **CAHPS**

Please identify which one(s):

CAHPS Health Plan Survey 5.0H Adult Version
CAHPS Health Plan Survey 5.0H Child Version, Children With Chronic Conditions

☒ **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. Enrollment data will be tracked and trended through various dashboards. Performance data including performance measure reporting data and survey data will be entered in our performance data to be tracked and trended. PCP termination rate will be tracked and monitored by each health plan. Other key none-claim data we will track and analyze to support program planning and operation will include authorization data and provider network data.

As part of NCQA requirements, the health plans will be required to perform all HEDIS measures that meet the minimum criteria for calculation. The health plan is to follow the most current version of Medicaid HEDIS technical specifications and discontinue measures as they are retired. NCQA also requires that each health plan'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. Health plans will also be required to track none HEDIS behavioral health measures and LTSS measures. Measure selection will be driven by the goals and objective of CCC + Program and align with Federal and state health care priorities. Ongoing performance measure trending will be conducted for Cardinal Care. The Department will require corrective action plans for those measures below Department established benchmarks. A subset of the Cardinal Care program measures will be designated as key performance indicators. These indicators will be the main focus of quality improvement efforts. They will also inform us on Cardinal Care value based payment program measures selection.

The EQRO 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. The Department will follow CMS requirements for managed care programs and utilize an EQRO and conduct an Operational Systems Review (OSR) every three years. These reviews will focus on, but not be limited to, provider licensure, insurance and other legal requirements; credentialing of providers; confidentiality and security; medical records content/retention; enrollee education/prevention programs; cultural competency; enrollment/disenrollment timeliness; grievances and appeals; network monitoring reports; coordination and continuation of care; quality assurance plan; health plan accreditation and audit; consumer and provider survey reports. 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 health plan in the form of a desk review and onsite audit. These reviews focus on any elements identified in the most recent (EQRO) OSR as needing improvement, or any critical elements of the health plan contract which require more focused attention. The Department also reserves the right to conduct on-site visits as a part of readiness reviews for program start up, when a new health plan is coming into the market, or there is an expansion into a region. The health plans are required to conduct performance improvement projects (PIPs) in accordance with 42 C.F.R. § 438.240(a)(2) and in focus areas as directed by the Department. 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 health plan performance measure scores on an annual basis. Focused studies will be conducted annually by the EQRO and used to research, in depth, certain aspects of clinical or non-clinical services. The Department will develop specific areas of study based on the Cardinal Program population. The EQRO will follow the CMS-recommended protocols for focused studies.

☐ **Denials of referral requests**

☒ **Disenrollment requests by enrollee**

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

☒ **Grievances and appeals data**

☒ **Other**

Please describe:

The Department requires a variety of other non-claims reporting from Cardinal Care MCOs either upon request, monthly, quarterly, annually, or upon material change. These reporting requirements are outlined in the Cardinal Care Technical Manual and include items such as: Disclosure of Ownership and Control Interest, Bureau of Insurance Annual Financial report, Physician Incentive Plans, written policies and procedures, provider network files, and Quality Improvement Plan.

e. ☒ **Enrollee Hotlines**

Activity Details:

The Department contracts with an enrollment broker operates an enrollee hotline and website. The Managed Care Helpline is the primary contact for all managed care participants on or after their assignment into managed care. Enrollment broker staff will be able to answer questions about the program, and provide information to members about providers in each health plan?s network, enrollment/disenrollment processes, covered services, and exemption reasons. Issues which the helpline is not able to address, or which are beyond their scope, are referred to DMAS.

The enrollment broker provides DMAS with a complaint report of issues identified during their contacts with members (for example, if a member is unable to obtain a needed service or medication, if they request a good cause change in health plan assignment outside of their open enrollment period, if they have not received an ID card from their health plan, etc.).

Enrollment broker staff also develop and maintain the non-interactive website with comprehensive and up-to-date information on Virginia's Cardinal Care program. Website activity, as well as call volume activity, and wait/hold times, are reported to the Department. The enrollment broker will have an optional satisfaction survey associated with their call script.

Data received from the hotline allow for identification of patterns or problem areas which can then be targeted for improvements.

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 used to research, in depth, certain aspects of clinical or non-clinical services. The EQRO follows the CMS-recommended protocols for focused studies and uses the HEDIS measures when appropriate.

g. ☒ **Geographic mapping**

Activity Details:

The Department has "geomapping" capability. This will be used to establish network adequacy. Each of the health plans also have ?geomapping? capability (or a comparable software) and may use this when there are complaints regarding provider access in a specific area or with a specialty. The health plans submit their networks to the enrollment broker and to the Department.

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

Activity Details:

An independent assessment for the Cardinal Care Program has been conducted as required by CMS and the contract. This study is in addition to the evaluations conducted by the EQRO and covers various aspects of the program, with emphasis on access to care, quality of care, cost effectiveness, care coordination, and health and safety issues of the participants. Program evaluations will also monitor the §1915(c) waiver requirements and coordination efforts between the two waivers with the goal of optimal outcomes for the Cardinal Care Program population.

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

Activity Details:

Each health plan is required to meet anti-discrimination standards as defined by CMS. If DMAS receives complaints of disparities or discrimination through our various channels of communication DMS staff has the ability to audit the plan and require any action necessary to correct the issue.

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

Activity Details:

Health plans are required to establish and maintain provider networks that at least meet State Medicaid access standards for all Medicaid covered services, and report regularly on their network status. The State will monitor network requirements via an in-depth analysis of the submitted networks.

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.

Network analyses and complaint tracking are just two ways that access to care is monitored and ensured.

k. ☒ **Ombudsman**

Activity Details:

As part of its efforts to educate members about the Cardinal Care Program, and to ensure that their rights are protected, DMAS has continued its partnership with the Virginia Insurance Counseling Program (VICAP) and the State Long-Term Care (LTC) Ombudsman. Under this partnership, VICAP is responsible for providing dual eligible (Medicare and Medicaid beneficiaries (and their families)) with unbiased educational information about their options for participating in CCC+, while the LTC Ombudsman is responsible for protecting all beneficiaries' rights, investigating complaints, empowering beneficiaries to resolve health care problems, and assisting with appeals and grievances for members receiving long term care services.

l. ☒ **On-Site Review**

Activity Details:

The Department follows CMS requirements for managed care programs and utilizes an EQRO to conduct an Operational Systems Review (OSR) every three years. These reviews focus on, but are not limited to, provider licensure, insurance and other legal requirements; credentialing of providers; confidentiality and security; medical records content/retention; member education/prevention programs; cultural competency; enrollment/disenrollment timeliness; grievances and appeals; network monitoring reports; coordination and continuation of care; quality assurance plan; health plan accreditation and audit; consumer and provider survey reports.

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 health plan. These reviews focus on any elements identified in the most recent (EQRO) OSR as needing improvement, or any critical elements of the health plan contract which require more focused attention.

The Department also reserves the right to conduct on-site visits as a part of readiness reviews for program start up, when a new health plan is coming into the market, or there is an expansion into a region.

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

Activity Details:

The health plans are required to conduct performance improvement projects (PIPs) in accordance with 42 C.F.R. § 438.240(a)(2) and in focus areas as directed by the Department.

DMAS MCO contracts require MCOs to measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance improvement projects (PIPs) is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. DMAS requires that contracted Medicaid MCOs conduct PIPs in accordance with 42 CFR §438.330 (d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction. The PIP design requires use of objective quality indicators, implementation of interventions to improve access and quality, evaluation of effectiveness, and activities for increasing or sustaining improvements.

☒ **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 and 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 HEDIS scores on an annual basis.

As part of NCQA requirements, the MCOs will be required to perform all HEDIS measures that meet the minimum criteria for calculation. 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.

DMAS has identified clinical quality, access, and utilization measures for the Cardinal Care Program using the nationally recognized measure sets. 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.

The Department requires MCOs to conduct quality improvement projects or corrective action plans for any measures below the DMAS identified performance measure benchmarks. These improvement projects and corrective action plans are closely monitored by DMAS? quality assurance staff.

☒ **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 are required to continually monitor their networks to ensure adequate coverage of all provider types within required CMS and state guidelines. In accordance with 42 CFR § 438.236, the Contractor shall adopt practice guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
consider the needs of the members;
- Are adopted in consultation with contracting health care professionals; and
- Are reviewed and updated periodically, as appropriate.

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.

The health plans are required to submit reports to Department staff regarding providers who have failed credentialing/re-credentialing. The MCO?s also submit to the Department a quarterly report of abuse, corrective action, overpayment/recovery. This data is shared with the Department's Program Integrity Division for potential provider monitoring activities.

q. ☒ **Provider Self-Report Data**

Activity Details:

Provider self-report data is collected and analyzed annually by the health plans as a part of their NCQA requirements and ongoing monitoring activities and reviewed during OSRs that are conducted every three years.

☒ **Survey of providers**

☐ **Focus groups**

r. ☒ **Test 24/7 PCP Availability**

Activity Details:

As a part of the Managed Care Contract requirements and as required by NCQA the health plans must maintain adequate provider network coverage to serve the entire eligible Cardinal Care population in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days/week (24/7). This coverage requirement is monitored through the CAHPS survey questions, secret shopper studies, and during the EQRO?s evaluations and on-site visits.

In addition to the 24/7 PCP availability requirement, the health plans will be 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. Recipients will be 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 will be provided with treatment advice, or are advised to seek immediate attention through the Emergency Room. Use of the nurse lines not only provides peace of mind for the plan?s member 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 Cardinal Care Program beneficiaries will be conducted by each health plan and is used to determine appropriate use of referrals, authorizations, etc. The plans will look at both over-and under-utilization as well as referral and authorization patterns. The contract will require health plans to operate a Pharmacy Utilization Management Program. The need for this was identified through rising costs and the ability to track abuse of certain recipients, or certain medications.

The health plans are permitted to operate a Physician Incentive Plan only if: No single physician is put at financial risk for the costs of treating an member that are outside the physician?s direct control; No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to a member; and The applicable stop/loss protection, member survey, and disclosure requirements of 42 C.F.R. Part 417 are met. Contractually, the plans will be 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 will monitor appropriate utilization through complaints/complaint logs, grievances and appeals, and corresponding monthly or quarterly reports. DMAS will also conduct secret shopper, satisfaction surveys and on site reviews of the health plan records.

t. ☒ **Other**

Activity Details:

The Department, the health plans, EQRO, other state agencies, and stakeholders conduct on-going monitoring activities to ensure compliance to managed care program requirements and the provision of quality of care for all Cardinal Care members. Monitoring mechanisms include but not be limited to: 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 will be done to meet federal and state regulatory compliance, and to fulfill the DMAS managed care goal which is, ?to provide a cost-effective managed care delivery system for eligible Medicaid members that 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). From experience within other programs we?ve found that the health plans as a group readily participate with the Department in formal and ad hoc workgroup meetings and in individual plan meetings.

We continue to seek opportunities to improve access and quality of services through mechanisms such as Behavioral Health Homes, Patient Centered Medical Homes and Value Based Purchasing. 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.

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 State?s 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 2023-2025 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 study data brief; 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.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
ABD Dual	
ABD Non-Dual	
Adoption Assistance	
Foster Care	
ID/DD Dual	
ID/DD Medex	
ID/DD Waivers - Non Duals	
LIFC Adult	
LIFC Child	
MCHIP	
Medicaid Expansion Acute	
Medicaid Expansion Complex	
NF/CCCP Dual	
NF/CCCP Medex	
NF/CCCP Non-Dual	
Tech w/CCCP	
Tech w/CCCP MedEx	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	01/01/2021	12/31/2021	01/01/2022	06/30/2022
Enrollment Projections for the Time Period*	10/01/2023	06/30/2024	07/01/2024	06/30/2025

**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	
Durable Medical Equipment	☒	☐	☒	
Nurse Midwife	☒	☐	☒	
Sterilizations	☒	☐	☒	
Nursing Facility	☒	☐	☒	
Nutritional Counseling for Individuals with Obesity or Chronic Medical Diseases	☒	☐	☒	
Physician Services (includes psych)	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
PT, OT, Speech, Audiology Services	☒	☐	☒	
Early Intervention	☒	☐	☒	
Rural Health Clinic	☒	☐	☒	
Skilled Nursing	☐	☐	☒	
Temporary Detention Orders	☒	☐	☒	
Personal Care	☐	☐	☒	
Lead Investigations	☒	☐	☒	
Targeted Case Management to SMI/ED/MR	☒	☐	☒	
Transplants	☒	☐	☒	
Transportation	☒	☐	☒	
Private Duty Nursing (non EPSDT)	☐	☐	☒	
Community Health Centers	☒	☐	☒	
Home Health Services	☒	☐	☒	
Podiatry	☒	☐	☒	
Community Mental Health Rehabilitation Services	☒	☐	☒	
Substance Abuse	☒	☐	☒	
Other Rehabillitation Services	☒	☐	☒	
Outpatient Hospital (includes psych)	☒	☐	☒	
Family Planning	☒	☐	☒	
Prescribed Drugs, Prosthetic Devices and Eyeglasses	☒	☐	☒	
Residental Treatment	☒	☐	☐	
Transition Services	☐	☐	☒	
Transition Coordination	☐	☐	☒	
Services Facilitation	☐	☐	☒	
Assistive Technologies	☐	☐	☒	
Immunizations	☒	☐	☒	
EPSDT Screening, Diagnosis and Treatment	☒	☐	☒	
Federally Qualified Health Center	☒	☐	☒	
Regular Assisted Living	☒	☐	☒	
Clinic Services	☒	☐	☒	
Vision Services	☒	☐	☒	
Inpatient Hospital (includes psych except for State Psychiatric Hospital)	☒	☐	☒	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Environmental Modifications	☐	☐	☒	
Abortions	☒	☐	☐	
Respite Care	☐	☐	☒	
Case Management Services	☒	☐	☒	
Annual Adult Wellness Exams	☒	☐	☒	
School-based Services	☒	☐	☐	
Lab and Radiology	☒	☐	☒	
Personal Emergency Response System (PERS)	☐	☐	☒	
Individual and Group Smoking Cessation Counseling	☒	☐	☒	
Doula Services	☒	☐	☒	
Adult dental services	☒	☐	☐	
Dental services (<21 years old)	☒	☐	☐	
Community Mental Retardation	☒	☐	☒	
Day Treatment for Pregnant Women	☒	☐	☒	
In-Home Support Services	☐	☐	☐	
Group Day Services	☐	☐	☐	
Individual Supported Employment	☐	☐	☐	
Participant Direction Services Facilitation	☐	☐	☐	
Center-based Crisis Supports	☐	☐	☐	
Companion Services	☐	☐	☐	
Crisis Support Services	☐	☐	☐	
Electronic Home-Based Supports	☐	☐	☐	
Group Supported Employment	☐	☐	☐	
Individual and Family/Caretaker Training	☐	☐	☐	
Shared Living	☐	☐	☐	
Supported Living Residential	☐	☐	☐	
Therapeutic Consultation	☐	☐	☐	
Workplace Assistance	☐	☐	☐	
Adult Day Healthcare	☐	☐	☒	
Community Coaching	☐	☐	☐	
Community Engagement	☐	☐	☐	
Community-based Crisis Supports	☐	☐	☐	

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 State?s 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 State?s submitted CMS-64 forms.

Signature:	Matt Behrens
	State Medicaid Director or Designee
Submission Date:	Nov 17, 2025

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:

Nick Merciez

c. Telephone Number:

(804) 225-4269

d. E-mail:

Nick.Merciez@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:

MEGs have been revised from those utilized in the original waiver application to include MEGs previously utilized under the Medallion 4 waiver. Medallion 4 members will be included in the new Cardinal Care program effective October 1, 2023. In addition, projections for P1 have been adjusted to reflect expected reductions associated with the end of the PHE and the maintenance of effort (MOE) requirements.

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

Projected enrollment was modeled using time series analysis of historical member months by MEG in the base period adjusted to reflect MOE requirements associated with the public health emergency for COVID 19. The variance is due to continued enrollment and increase in membership for the MEGS, inclusion of Medallion 4 MEGs and recognition of expiring MOE requirements.

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

Calendar years.

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:

- ☐ **[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).

a. ☐ **[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
Durable Medical Equipment	☒	☐	☐	☐	☐	☐	☐
Nurse Midwife	☒	☐	☐	☐	☐	☐	☐
Sterilizations	☒	☐	☐	☐	☐	☐	☐
Nursing Facility	☒	☐	☐	☐	☐	☐	☐
Nutritional Counseling for Individuals with Obesity or Chronic Medical Diseases	☒	☐	☐	☐	☐	☐	☐
Physician Services (includes psych)	☒	☐	☐	☐	☐	☐	☐
PT, OT, Speech, Audiology Services	☒	☐	☐	☐	☐	☐	☐
Early Intervention	☒	☐	☐	☐	☐	☐	☐
Rural Health Clinic	☒	☐	☐	☐	☐	☐	☐
Skilled Nursing	☐	☒	☐	☐	☐	☐	☐
Temporary Detention Orders	☒	☐	☐	☐	☐	☐	☐
Personal Care	☒	☐	☐	☐	☐	☐	☐
Lead Investigations	☒	☐	☐	☐	☐	☐	☐
Targeted Case Management to	☒	☐	☐	☐	☐	☐	☐

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
SMI/ED/MR							
Transplants	☒	☐	☐	☐	☐	☐	☐
Transportation	☒	☐	☐	☐	☐	☐	☐
Private Duty Nursing (non EPSDT)	☐	☒	☐	☐	☐	☐	☐
Community Health Centers	☒	☐	☐	☐	☐	☐	☐
Home Health Services	☒	☐	☐	☐	☐	☐	☐
Podiatry	☒	☐	☐	☐	☐	☐	☐
Community Mental Health Rehabilitation Services	☒	☐	☐	☐	☐	☐	☐
Substance Abuse	☒	☐	☐	☐	☐	☐	☐
Other Rehabillitation Services	☒	☐	☐	☐	☐	☐	☐
Outpatient Hospital (includes psych)	☒	☐	☐	☐	☐	☐	☐
Family Planning	☒	☐	☐	☐	☐	☐	☐
Prescribed Drugs, Prosthetic Devices and Eyeglasses	☒	☐	☐	☐	☐	☐	☐
Residental Treatment	☐	☒	☐	☐	☐	☐	☐
Transition Services	☒	☐	☐	☐	☐	☐	☐
Transition Coordination	☒	☐	☐	☐	☐	☐	☐
Services Facilitation	☒	☐	☐	☐	☐	☐	☐
Assistive Technologies	☒	☐	☐	☐	☐	☐	☐
Immunizations	☒	☐	☐	☐	☐	☐	☐
EPSDT Screening, Diagnosis and Treatment	☒	☐	☐	☐	☐	☐	☐
Federally Qualified Health Center	☒	☐	☐	☐	☐	☐	☐
Regular Assisted Living	☒	☐	☐	☐	☐	☐	☐
Clinic Services	☒	☐	☐	☐	☐	☐	☐

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	☒	☐	☐	☐	☐	☐	☐
Inpatient Hospital (includes psych except for State Psychiatric Hospital)	☒	☐	☐	☐	☐	☐	☐
Environmental Modifications	☒	☐	☐	☐	☐	☐	☐
Abortions	☒	☐	☐	☐	☐	☐	☐
Respite Care	☒	☐	☐	☐	☐	☐	☐
Case Management Services	☒	☐	☐	☐	☐	☐	☐
Annual Adult Wellness Exams	☒	☐	☐	☐	☐	☐	☐
School-based Services	☐	☒	☐	☐	☐	☐	☐
Lab and Radiology	☒	☐	☐	☐	☐	☐	☐
Personal Emergency Response System (PERS)	☒	☐	☐	☐	☐	☐	☐
Individual and Group Smoking Cessation Counseling	☒	☐	☐	☐	☐	☐	☐
Doula Services	☒	☐	☐	☐	☐	☐	☐
Adult dental services	☐	☒	☐	☐	☐	☐	☐
Dental services (<21 years old)	☐	☒	☐	☐	☐	☐	☐
Community Mental Retardation	☒	☐	☐	☐	☐	☐	☐
Day Treatment for Pregnant Women	☒	☐	☐	☐	☐	☐	☐
In-Home Support Services	☐	☒	☐	☐	☐	☐	☐
Group Day Services	☐	☒	☐	☐	☐	☐	☐
Individual Supported Employment	☐	☒	☐	☐	☐	☐	☐
Participant Direction Services Facilitation	☐	☒	☐	☐	☐	☐	☐
Center-based Crisis Supports	☐	☒	☐	☐	☐	☐	☐
Companion Services	☐	☒	☐	☐	☐	☐	☐

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
Crisis Support Services	☐	☒	☐	☐	☐	☐	☐
Electronic Home-Based Supports	☐	☒	☐	☐	☐	☐	☐
Group Supported Employment	☐	☒	☐	☐	☐	☐	☐
Individual and Family/Caretaker Training	☐	☒	☐	☐	☐	☐	☐
Shared Living	☐	☒	☐	☐	☐	☐	☐
Supported Living Residential	☐	☒	☐	☐	☐	☐	☐
Therapeutic Consultation	☐	☒	☐	☐	☐	☐	☐
Workplace Assistance	☐	☒	☐	☐	☐	☐	☐
Adult Day Healthcare	☒	☐	☐	☐	☐	☐	☐
Community Coaching	☐	☒	☐	☐	☐	☐	☐
Community Engagement	☐	☒	☐	☐	☐	☐	☐
Community-based Crisis Supports	☐	☒	☐	☐	☐	☐	☐

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:

   The State operates a prescription drug reinsurance pool. The pool aggregates the claims experience of members with prescription drug claims in excess of $200,000 in a fiscal year. The State then allocates 90% of member claims in excess of $200,000 to each of the MCOs in proportion to their capitation revenue. The pool is designed to be budget neutral to the State.

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.**

   1.25% of capitation payments is withheld as a quality withhold.
   MCO Plans earn back these quality withhold amounts as they meet quality measures set by DMAS.
   DMAS also has an incentive program for MCOs to earn payments for transitions to the community.

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 State?s 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:

   Please document how that trend was calculated:

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 State?s 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 2018 through September 2021. 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, DMAS?s Certified Actuary 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. Also, see Cardinal Care Waiver ? Narrative Support_20230914.

ii. ☒ **National or regional factors that are predictive of this waiver?s future costs.**

Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver?s future costs. Finally, please note and explain if the State?s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

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 by major aid categories. The MCO MEG service categories were hospital inpatient, hospital outpatient, professional (physician and other providers), outpatient pharmacy, other, ARTS, community behavioral health, emergency room, community LTSS (LTSS Only) and nursing facility (LTSS Only). For P1, the major service category trend relied upon analysis of 45 months of historical FFS and encounter data from January 2018 through September 2021. 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 for the items listed and described in Section IV below 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. Also see Cardinal Care Waiver ? Narrative Support_20230914.

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.

Please see attached document entitled "Cardinal Care Waiver ? Narrative Support_20230914" in Section III which list the benefit changes which result in a specific program adjustment.

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

Please see attached document entitled "Cardinal Care Waiver ? Narrative Support_20230914", Section IV.

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 isPMPM size of adjustment

0.00

Please describe:

D. ☐ Other

Please describe:

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.

In P1 (10/1/2023-6/30/2024) administrative expenses projection of historic costs for R1 projected 5%
in P2 (7/1/2024-6/30/2025) administrative expenses projection 4%
in P3 (7/1/2025-6/30/2026) administrative expenses projection 3%
in P4 (7/1/2026-6/30/2027) administrative expenses projection 3%
8in P5 (7/1/2027-6/30/2028) administrative expenses projection 3%

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
1/1/2022 - 6/30/2022
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 State?s 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
0.00

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 State?s 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 State?s 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 State?s 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 State?s 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 contractor?s 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.

Descriptions of adjustments described above in Sections D.I.I and D.I.J, and Cardinal Care Waiver ? Narrative Support_20230914 as referenced.

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.

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.

P2 Weighted Average PMPM Casemix for P1 (P1 MMs) - 6.2%
P2 Weighted Average PMPM Casemix for P2 (P2 MMs) - 7.6%

Overall BY to P2 Change (annualized)
ABD Dual - 5.1%
ABD Non-Dual - 6.0%
Adoption Assistance - 4.9%
Foster Care - 5.0%
ID/DD Waivers Dual - 4.3%
ID/DD MedEx - 6.6%
ID/DD Non-Dual - 6.6%
LIFC Adult - 7.3%
LIFC Child - 4.6%
MCHIP - 4.7%
Medicaid Expansion Acute - 7.1%
Medicaid Expansion Complex - 7.9%
NF/CCCP Dual - 3.5%
NF/CCCP MedEx - 3.7%
NF/CCCP Non-Dual - 3.7%
Tech w CCCP - 3.1%
Tech w CCCP MedEx - 3.1%

The variance is because of the enrollment population growth and case mix between different Medicaid eligibility groups - NF/CCCP, LIFC, ABD, Tech, and Medicaid Expansion.

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:

The case load changes are based on the population growth and case mix between Medicaid Eligibility Groups (MEGs).

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 State?s explanation of cost increase given in Section D.I.I and D.I.J:

There are hospital inpatient, nursing facility, home health, outpatient rehab and other COS service unit cost increase adjustments that have been incorporated.
These have been described as adjustments to the capitated portion of the 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 State?s explanation of utilization given in Section D.I.I and D.I.J:

Utilization changes included behavioral health service changes, addition of adult dental, ramp up of expansion population utilization from base data, expanded use of high cost drugs, adjustments of increased utilization due to the COVID-19 pandemic, and changes to coverage of newborn care under managed care.

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