VIRGINIA'S MEDICAID PROGRAM

DMAS

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The Commonwealth's Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Demonstration

High Needs Supports: Operational Design and Implementation Planning

Thursday, July 23, 2020

Table of Contents

I. Introduction 2

II. High Needs Supports Benefit Overview 2

III. High Needs Supports Delivery System 3

IV. High Needs Supports Roles and Responsibilities High-Level Overview 4

V. High Needs Supports Eligibility Criteria and Services 5

- Eligible Populations 5
- High Needs Supports Services 5

VI. Enrollment Cap and Waitlists 6

VII. High Needs Supports Providers 6

- Contracting and Credentialing of Provider Entities 6
- Provider Staff Qualifications 7
- Network Adequacy 8

VIII. Care Management Roles and Responsibilities 8

- Identification and Referral of Potentially Eligible Enrollees 8
- Eligibility Determination and Redetermination 9
- Assessment and Reassessment 9
- Person-Centered Care Plan Development 10

IX. Care Management Contracting, Qualifications, Staffing, and Training 10

X: Financing and Payment Methodology 11

XI. Coverage Policies 11

XII. Dispute Resolution and Appeals Processes 12

XIII. Program Disenrollment 12

XIV. Systems 12

XV. Quality Improvement 13

XVI. State Monitoring and Oversight 13

XVII. Conclusion 13

Appendix – Attachment G: High Needs Supports Eligibility and Services 15

I. Introduction

On June 7, 2018, Governor Ralph Northam (D-VA) signed the 2018 Special Session I Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act) into law, which authorized Medicaid expansion in the Commonwealth of Virginia.[1] The 2018 Appropriations Act also directed the Department of Medical Assistance Services (DMAS) to seek federal approval of new Medicaid program features, including a supportive housing and employment benefit ("High Needs Supports") targeted to certain high need Medicaid enrollees, through the State's Section 1115 Medicaid demonstration. Once implemented, this benefit will assist Medicaid-enrolled individuals with complex physical or behavioral health needs or who need assistance with activities of daily living (ADLs), and who are at risk for housing and employment instability, in obtaining and sustaining stable housing and employment in order to improve quality of life and health outcomes.

On November 20, 2018, after completing the public notice and comment period, the Commonwealth submitted to the Centers for Medicare and Medicaid Services (CMS) a request to extend its Section 1115 Medicaid demonstration and include the new features. Over the course of several months, the Commonwealth negotiated the demonstration's Special Terms and Conditions (STCs), working towards federal approval. On December 30, 2019, CMS approved the Section 1115 Medicaid demonstration request, inclusive of expanded substance use disorder (SUD) services for all Medicaid enrollees through the Addiction and Recovery Treatment Services (ARTS) benefit package and Medicaid coverage for former foster youth (FFY) up to age 26 who aged out of foster care in another state and now reside in the Commonwealth. CMS delayed its approval of the High Needs Supports benefit, and continued negotiations with the Commonwealth on the benefit design through early July 2020.[2] On July 9, 2020, CMS approved the High Needs Supports benefit.[3]

The Commonwealth's Section 1115 Medicaid demonstration, titled Building and Transforming Coverage, Services, and Supports for a Healthier Virginia, establishes a new opportunity to test the impact of providing evidenced-based interventions to Medicaid enrollees. DMAS will rigorously evaluate the demonstration to assess its effectiveness and determine whether the High Needs Supports program should be continued and integrated permanently into the Medicaid program.

II. High Needs Supports Benefit Overview

The High Needs Supports benefit, which DMAS expects to implement on July 1, 2022, will provide critical housing and employment support services to the Commonwealth's high need Medicaid enrollees. DMAS is committed to addressing the social and environmental needs of Virginians that impact health, wellbeing, and medical expenditures. Existing literature indicates that social determinants of health account for approximately 80 percent of health outcomes, and having unmet social needs is associated with poor health outcomes.[4,5] In particular, housing instability is linked to an increased rate of complex physical and behavioral health problems, hospital admissions/readmissions, and shorter life expectancy.[6] Similarly, unemployment negatively impacts health outcomes, often leading to stress-

[1] HB5002. 2018 Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act), Item 303, Section SS.4. Available here.
[2] Negotiations were delayed in part due to the coronavirus (COVID-19) pandemic.
[3] Building and Transforming Coverage, Services, and Supports for a Healthier Virginia. July, 9, 2020. Available here.
[4] Booske B.C., Athens J.K., Kindig D.A., Park H., Reimington P.L. County Health Ranking Working Paper: Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin, Population Health Institute. February 2010. Available here.
[5] Bachrach D., Pfister H., Wallis K., Lipson M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. Commonwealth Fund, Manatt Health Solutions. May 2014. Available here.
[6] Maness D.L., Khan M. Care of the Homeless: An Overview. American Family Physician. 89.8. April 2014. Available here.

related health conditions such as heart disease and stroke.[7] Therefore, addressing these needs is likely to improve health and reduce healthcare expenditures.[8,9,10]

The purpose of this document is to describe the preliminary operational design for the High Needs Supports benefit for interested stakeholders, including sister agencies, managed care organizations (MCOs), healthcare providers, policymakers, and advocates, among others. This paper also serves as a roadmap for DMAS and the Commonwealth more broadly, identifying the necessary implementation planning still required for 2020 and beyond. While the program design decisions memorialized below reflect substantial input from the Commonwealth's partners, DMAS will continue to engage stakeholders and recognizes that the operational and implementation design of the High Needs Supports program will evolve.

III. High Needs Supports Delivery System

High Needs Supports services are intended to be used by Medicaid enrollees who can benefit most from them and provided in a cost effective manner. To achieve this aim, the Commonwealth will offer the High Needs Supports benefit to enrollees in the State's specialized Medicaid managed care (MMC) program for medically complex individuals, Commonwealth Coordinated Care Plus (CCC Plus).[11] For those who qualify for High Needs Supports through the mainstream MMC program, Medallion 4.0, DMAS will transition them into CCC Plus. To ensure there is no duplication of federal funding and to promote access to the benefit, DMAS will limit the High Needs Supports benefit to individuals who are not receiving services through an existing Home and Community-Based Services (HCBS) Section 1915(c) developmental disability (DD) waiver.[12] Being on a 1915(c) DD waiver waitlist however, will not preclude eligible individuals from receiving the High Needs Supports benefit.

[7] Bachrach D., Pfister H., Wallis K., Lipson M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. Commonwealth Fund, Manatt Health Solutions. May 2014. Available here.

[8] Srebnik, D. et al. A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services. American Journal of Public Health. 2013. Available here.

[9] Sadowski, L. et al. Effect of a Housing and Case Management Program on Emergency Department (ED) Visits and Hospitalizations Among Chronically Ill Homeless Adults. Journal of the American Medical Association. 301(17):1771-1778. May 2009. Available here.

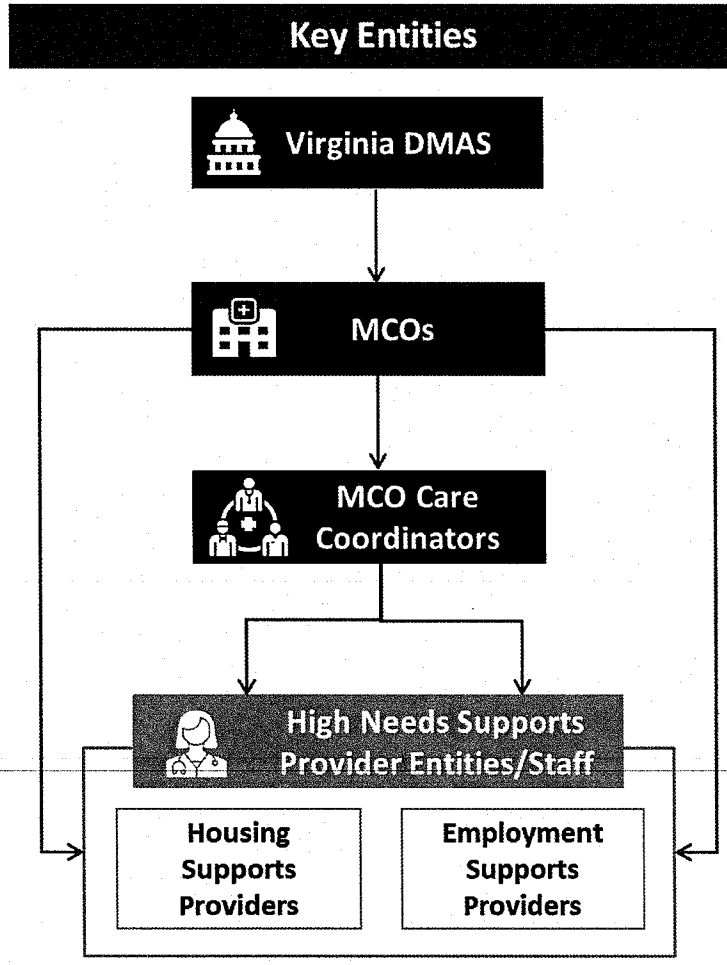
[10] Gruber, K.J. et al. Removing Asthma Triggers and Improving Children's Health: The Asthma Partnership Demonstration Project. Annals of Allergy, Asthma and Immunology. 2016. Available here.

[11] 98 percent of the Commonwealth's Medicaid enrollees receive their benefits through MCOs. (Kaiser Family Foundation. Share of Medicaid Population Covered Under Different Delivery Systems. July 2019. Available here.).

[12] Virginia's Section 1915(c) DD waivers include: Community Living (Available here); Family and Individual Support (Available here); and Building Independence (Available here).

IV. High Needs Supports Roles and Responsibilities High-Level Overview

CCC Plus MCOs will administer the High Needs Supports benefit, with DMAS overseeing the program. A clear delineation of administrative and operational roles and responsibilities among the entities involved will be essential to successful program implementation.



Key Roles and Responsibilities

Virginia DMAS

- Accountable for High Needs Supports program operations, oversight, implementation, monitoring, and evaluation to ensure program integrity, as well as compliance with federal and state requirements and MMC contractual obligations.
- Contract with and pay CCC Plus MCOs for providing approved High Needs Supports services and related activities.

MCOs

- Facilitate the launch of and administer the High Needs Supports program at the plan level, consistent with DMAS requirements.
- Identify and screen potentially eligible members, and manage referrals.
- Oversee MCO care coordinators providing care management.
- Contract with and pay claims for providers of housing and employment supports who deliver services to High Needs Supports enrollees.

MCO Care Coordinators

- Coordinate care for High Needs Supports enrollees, including managing their physical, behavioral, and non-medical care needs.
- Assess and reassess the needs of enrollees determined eligible.
- Develop and maintain person-centered care plans.

High Needs Supports Provider Entities and Staff

- Deliver housing and employment supports services to enrollees.
- Comply with provider requirements as determined by federal regulations, CCC Plus contract requirements, and provider agreements.

V. High Needs Supports Eligibility Criteria and Services

Eligible Populations

The eligibility criteria for High Needs Supports will take into account enrollees' physical and behavioral health status, as well as unmet social and environmental needs. Specifically, the High Needs Supports benefit will be targeted to Medicaid enrollees age 18 or older who are eligible under the Medicaid State Plan and enrolled in the MMC delivery system and individuals who are eligible under the out-of-state FFY component of the Section 1115 Medicaid demonstration age 18 up to 26 and enrolled in the MMC delivery system. Individuals must meet at least one health needs-based criteria, at least one housing or employment specific risk factor, and be expected to benefit from supports necessary to obtain and maintain stable housing or employment, as summarized below and further detailed in the appendix.

High Needs Supports Eligibility

Individual must meet at least one **needs-based criteria:**

- ❑ Behavioral health need (i.e., mental health or SUD)
- ❑ Need for assistance with ADLs
- ❑ Complex physical health need

AND individual must meet at least one **housing risk factor OR employment risk factor:**

Housing Risk Factors

- ❑ At risk of homelessness
- ❑ Homelessness
- ❑ History of frequent or lengthy stays in an institutional setting, assisted living facility, or residential setting
- ❑ History of frequent ED visits and/or hospitalizations
- ❑ History of involvement with the criminal justice system
- ❑ History of frequent moves or housing loss due to behavioral health symptoms

Employment Risk Factors

- ❑ Unable to be employed for at least 90 consecutive days due to mental or physical impairment
- ❑ Unable to obtain or maintain employment resulting from age, disability, or brain injury
- ❑ More than one instance of inpatient or outpatient SUD service in the past two years
- ❑ At risk of deterioration of mental illness and/or SUD

AND be expected to benefit from supports necessary to obtain and maintain employment or stable housing.

High Needs Supports Services

MCOs will provide federally-approved housing and employment supports services, summarized in the table below and included in full in the appendix.[13] DMAS and its state agency partners developed the list of services through facilitating multiple working sessions, conducting an assessment of the Commonwealth's Medicaid enrollees' needs, reviewing best practice models in other states, and iterating with CMS. The approved list included in Attachment G: High Needs Supports Eligibility and Services to the demonstration's STCs reflects those services that will allow individuals to secure and sustain housing and employment, thereby meaningfully impacting health outcomes.

[13] Self-direction is not applicable for High Needs Supports services.

Housing Supports Services	▪ **Individual Housing and Pre-Tenancy Services** (e.g., assisting in budgeting for housing/living expenses, identifying and securing resources to obtain housing). ▪ **Individual Housing and Tenancy Sustaining Services** (e.g., providing assistance with securing and maintaining entitlements and benefits, providing education on roles/responsibilities of the tenant and landlord). ▪ **Community Transition Services*** (i.e., supports that cover expenses necessary to enable individuals to obtain independent, community-based living).
Employment Supports Services	▪ **Pre-Employment Services** (e.g., training to improve executive functioning skills, individualized job development and placement, mentoring and career coaching). ▪ **Employment Sustaining Services** (e.g., financial and health literacy, follow-along services, payment for public transportation, assistance with linking to high quality child care and after-school programs).

**Community Transition Services are only available to High Needs Supports enrollees transitioning out of an institutional setting and/or provider-owned and operated congregate living arrangement.*

VI. Enrollment Cap and Waitlists

The Commonwealth's High Needs Supports program will include an enrollment cap established by the General Assembly, as well as separate waitlists for housing supports and employment supports with "slots" to receive services allocated annually. DMAS will manage both of these statewide processes and has begun establishing transparent prioritization criteria for the allocation of initial program enrollment slots. The prioritization criteria will be flexible, allowing DMAS to quickly implement changes (e.g., to respond to COVID-19 or other unforeseen circumstances), and will prioritize individuals based on level of need (as required by state and federally-funded programs that serve homeless individuals) as well as predetermined emergency prioritization criteria (e.g., institutional transfer, compromised homeless situation). Prioritization will occur during the High Needs Supports eligibility determination and/or as enrollment slots are assigned.

VII. High Needs Supports Providers

Contracting and Credentialing of Provider Entities

To deliver high-quality services for High Needs Supports enrollees, DMAS will require MCOs to contract with a network of housing and employment supports provider entities, which will be achieved by leveraging existing providers in the community (i.e., Community Services Boards (CSBs)[14], Continuum of Care (CoC) providers[15], Employment Service Organizations (ESOs))[16] that are experienced and qualified to address the health-related needs of the population.[17] Provider entities will be enrolled in Medicaid and expected to meet DMAS-determined standards (e.g., National Committee for Quality Assurance (NCQA)). While some of these providers already contract with Medicaid, the majority have limited exposure to MMC and will need initial and ongoing support from DMAS and the MCOs.

[14] In their current capacity, CSBs serve as the single point of entry into publicly funded mental health, SUD, and developmental services. Some CSBs act as ESOs in their region/area.

[15] In their current capacity, CoCs organize and deliver housing services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency.

[16] In their current capacity, ESOs are approved by the Department for Aging and Rehabilitative Services (DARS) to provide employment and vocational rehabilitation services to individuals with disabilities.

[17] DMAS does not intend to limit the provider type.

DMAS and the MCOs (contingent upon DMAS review and approval) also will impose credentialing (i.e., licensure/certification/accreditation) requirements on provider entities beyond the minimum provider staff qualifications outlined in the section below. For employment supports, DMAS plans to leverage Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation and may require provider entities to meet Individual Placement and Support (IPS) requirements. Because the Commonwealth's existing housing/homeless providers do not hold national accreditation or state licensure, DMAS will need to determine the credentialing approach, looking to its sister agencies and other states for appropriate models. DMAS may require providers of housing supports to meet Permanent Supportive Housing (PSH) requirements. MCOs will have the ability to enhance the credentialing requirements once minimum standards are met.

Provider Staff Qualifications[18]

To participate in High Needs Supports, staff employed by certified provider entities (listed above) who deliver housing and employment supports services must maintain the minimum qualifications negotiated with and approved by CMS (see table below) in order to effectively serve enrollees.

Staff providing High Needs Supports services will receive DMAS-approved housing and employment supports trainings on evidence-based principles and practices, as well as other applicable trainings in accordance with the CCC Plus contract. Provider training and education may include topics such as compliance with the HCBS Settings Rule, contractual obligations (e.g., reporting, billing, data collection/submission), and the special needs of the High Needs Supports population. DMAS will retain the ability to require trainings specific to the High Needs Supports program at any time, and MCOs will conduct/ensure the provision of ongoing High Needs Supports training for providers.

Provider Staff Type	Education and Experience	Skills	Services
Housing Supports	▪ Education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field; and/or ▪ At least one year of relevant professional experience and/or training in the field of service.	Knowledge of principles, methods, and procedures of services included under housing supports services, or comparable services meant to support an individual's ability to obtain and maintain stable housing.	▪ Individual Housing and Pre-Tenancy Services. ▪ Individual Housing and Tenancy Sustaining Services. ▪ Community Transition Services.
Employment Supports		Knowledge of principles, methods, and procedures of services included under employment supports services, or comparable services meant to support an individual's ability to	▪ Pre-Employment Services (individual and small group). ▪ Employment Sustaining Services (individual and small group).

[18] Credentialing is an industry-standard, systemic approach to the collection and verification of professional qualifications. Credentialing includes a review of relevant training, licensure, accreditation, certification and/or registration to practice in a healthcare field as well as academic background.

Provider Staff Type	Education and Experience	Skills	Services
		obtain and maintain stable employment.	

Network Adequacy

To ensure successful program implementation, MCOs will need to understand community dynamics and build partnerships with community based organizations (CBOs), identifying provider entities and staff with a range of expertise and experience. DMAS will require MCO networks to meet the CCC Plus access to care standards, which specify that MCOs must include in their networks or otherwise arrange for care by providers who are specialized in and have demonstrated competency in meeting the unique needs of the MMC population (which will include High Needs Supports enrollees).

DMAS will also leverage existing network adequacy contractual requirements to ensure the High Needs Supports population receives needed services, which may entail describing the required provider types and new time and distance standards for providers of housing and employment supports. MCOs' networks may change over the course of the demonstration, as long as MCOs comply with network standards. DMAS will hold MCOs accountable for identifying gaps and assessing the adequacy of their provider networks, including periodically conducting network adequacy reviews for the High Needs Supports benefit.

VIII. Care Management Roles and Responsibilities

Identification and Referral of Potentially Eligible Enrollees

DMAS will leverage multiple pathways (outlined in the table below) to ensure a "no wrong door" approach to identifying enrollees who may be eligible for High Needs Supports. Information regarding CCC Plus enrollees identified as potentially eligible for High Needs Supports will be referred by DMAS to MCOs to confirm eligibility for the benefit. Enrollees who are identified as potentially eligible for High Needs Supports but not yet enrolled in Medicaid or MMC will need to enroll in CCC Plus and select an MCO or be auto-assigned before they can enroll in and use the High Needs Supports benefit.

Entity	Sources of Identification
State Agencies	▪ **Claims/Encounter Data Review.** The Commonwealth's data review will include individuals found to be medically complex and enrolled in or slated for enrollment in CCC Plus; individuals participating in a state-certified drug court program; individuals with a disability determination based on Social Security Act (SSA)[19]; and individuals with frequent ED visits.[20] ▪ **Other State Agency Processes.** In addition to DMAS, other state agencies will identify enrollees who may be eligible for High Needs Supports through various mechanisms.
MCOs	▪ **High Needs Supports Screening Tool.** Once developed, MCOs will use the High Needs Supports Screening Tool to identify potentially eligible individuals.

[19] To meet the SSA definition of disability, an individual must not be able to engage in any substantial gainful activity because of a medically-determinable physical or mental impairment(s) that is expected to result in death, or that has lasted or is expected to last for a continuous period of at least 12 months.

[20] Frequent is defined as more than four ED visits and/or hospitalizations in the past 12 months.

Entity	Sources of Identification
	▪ **Member Screening.** MCOs will use the adapted MCO Member Health Screening (MMHS) tool to identify potentially eligible individuals.[21] ▪ **Risk Stratification.** MCOs will leverage and enhance existing risk stratification processes in CCC Plus to identify members who require High Needs Supports.
MCO Care Coordinators	▪ **Care Coordination.** Care coordinators providing care coordination to CCC Plus enrollees will identify Medicaid enrollees who may be eligible for High Needs Supports.
Providers	▪ **Provider Attestations.** Providers (contracted and non-contracted) will attest to individuals meeting certain needs-based criteria and risk factors (particularly when MCOs have limited claims history). ▪ **Workforce Centers and CBOs Processes.** Workforce centers (that already refer enrollees to DARS) and CBOs will identify and refer high need enrollees to DMAS. ▪ **Local Agency Processes.** Local agencies (e.g., local public health agencies, CSBs/the Behavioral Health Authority, CoCs) will identify enrollees who may be eligible for High Needs Supports through local referral networks.
Individual	▪ **Self-Referrals.** Individuals will self-refer to providers, MCOs/MCO care coordinators, and state agencies. ▪ **Consumer Advocacy Organizations.** Advocacy organizations will identify enrollees who may be eligible for High Needs Supports through consumer engagement.

Eligibility Determination and Redetermination

To determine High Needs Supports eligibility, MCOs will screen new members, CCC Plus members currently receiving care management, and CCC Plus members referred to them using a one-page High Needs Supports eligibility screening tool, to be developed by DMAS. MCOs will use the information gathered through the screening to determine and document an enrollee's eligibility for High Needs Supports as well as whether/how they should be prioritized for the waitlists. The documentation will provide the rationale for the enrollee meeting the needs-based criteria and risk factors for housing and employment supports. Because the benefit will be capped, MCOs will be required to track the number of enrollees determined eligible by sharing screening/prioritization information with DMAS. DMAS will ultimately confirm eligibility and waitlist prioritization. MCOs may redetermine High Needs Supports eligibility for members on the waitlist(s) when a program slot becomes available. DMAS will develop requisite rescreening timeframes for members on the waitlist(s). MCOs will redetermine eligibility for High Needs Supports for members immediately following the member's annual Medicaid eligibility redetermination. MCOs will also conduct ongoing data surveillance/identification of members to monitor any changes to the member's High Needs Supports status.

Assessment and Reassessment

Once notified of the High Needs Supports slot allocation, MCO care coordinators will provide to enrollees determined eligible for the benefit a standardized assessment of their housing and employment supports needs, goals, and preferences, which will be documented in and monitored through a person-centered care plan. To develop the statewide, standardized assessment, DMAS will

[21] The MMHS is used to determine medical complexity for CCC Plus enrollees; enrollees deemed as non-medically complex are screened by their MCOs in Medallion 4.0 to verify the determination.

develop a supplement to the CCC Plus Health Risk Assessment (HRA). At minimum, the assessment will address:

- Enrollees' immediate support needs and current services;
- Enrollees' support goals and preferences;
- Other state or local services currently used;
- Health conditions;
- Physical, intellectual or developmental disabilities (I/DDs);
- Medications;
- Informal caregiver or social supports, including peer supports;
- Current and past mental health and substance use status and/or SUD; and
- Social determinants of health.

MCOs will have the flexibility to modify the assessment at their discretion (with DMAS review and approval) to collect additional information related to High Needs Supports. Depending on the timing of eligibility for the benefit, the enrollee may receive a High Needs Supports assessment separate from their comprehensive assessment, the CCC Plus HRA. Over time, however, the timing for the delivery of the assessments will be aligned to the extent possible. MCO care coordinators will reassess enrollees for High Needs Supports every 365 calendar days at minimum or upon an enrollee's request/change in circumstances. Person-centered care plans will be updated accordingly.

Person-Centered Care Plan Development

As noted above, MCO care coordinators will develop and monitor the High Needs Supports person-centered care plan that reflects enrollees' housing and employment-related needs, goals, and preferences. The High Needs Supports person-centered care plan will be integrated, to the extent appropriate, with an enrollee's comprehensive care plan for their other Medicaid covered services. MCO care coordinators will use the High Needs Supports person-centered care plan to connect enrollees to services authorized by the MCO; refer them to providers; and monitor/track enrollees' access to services and progress against their goals.

To mitigate the administrative burden on MCO care coordinators, updating the High Needs Supports person-centered care plan will not require a simultaneous update to the comprehensive care plan; however, MCO care coordinators may need to meet in-person with providers and members to make changes. The High Needs Supports person-centered care plan will be reviewed and revised upon reassessment of functional need, as required by 42 CFR 441.725(c), at least every 365 calendar days, when the enrollee's circumstances or needs change significantly, or at the request of the enrollee. Once a High Needs Supports slot has been allocated, providers will work closely with interdisciplinary care teams, led by the MCO care coordinator and the enrollee. Interdisciplinary care teams for High Needs Supports will be person-centered, and members will be encouraged to identify individuals for participation on the team.

IX. Care Management Contracting, Qualifications, Staffing, and Training

Many case managers/care coordinators in the community, including those providing targeted case management for Section 1915(c) waiver enrollees, have long-term expertise in connecting individuals to housing and employment supports. DMAS will require MCOs to ensure that High Needs Supports care coordinators have specific expertise in housing and/or employment supports. DMAS will allow MCOs the flexibility to use their own staff as care coordinators and/or hire existing community-based care coordinators with expertise (in accordance with the CCC Plus contract, which includes provisions to comply with federal conflict of interest requirements). As outlined in the CCC Plus contract, DMAS will

also permit MCOs to leverage care coordinator "extenders" – or staff who assist care coordinators with their responsibilities – to play a role without requiring these individuals to meet the required qualification standards. DMAS will avoid duplication of care coordination efforts through requiring robust communication between care coordinators/case managers.

With respect to qualifications for care coordinators, DMAS will leverage the qualifications described in the CCC Plus contract. High Needs Supports care coordinators will have at minimum a Bachelor's degree in a health or human services field or be a Registered Nurse (RN) or Licensed Practical Nurse (LPN); and care coordinators will have at least one year of experience directly working with individuals who meet the target population criteria. DMAS will similarly build upon care coordinator staffing requirements included in the CCC Plus contract (e.g., submitting to DMAS the staffing structure, identifying the function of each care coordinator and the relevant experience, reporting compliance) to ensure the care coordinator's experience in coordinating access to housing and employment supports is taken into consideration. Contingent upon sufficient funding, DMAS may consider implementing care coordinator staffing ratios for High Needs Supports enrollees.

Following current practice, High Needs Supports care coordinators will be required to complete a comprehensive training curriculum. The curriculum will (at least initially) be developed by DMAS and may include new content on social determinants of health and the impact of housing and employment instability on enrollees' health and wellbeing.

X: Financing and Payment Methodology

DMAS will establish a payment approach – based on clearly defined housing and employment supports service definitions – that is transparent, fair, and sustainable for High Needs Supports providers and MCOs alike. Together with the State's actuary, DMAS will establish a payment floor for housing and employment supports services. Rather than pricing each service individually, DMAS will consider a hybrid approach: establishing a minimum payment floor for DMAS-determined groupings of select housing and employment supports services (based on the Washington Foundational Community Supports Model). The services will be priced based on factors such as the intensity of services, duration of services, geography, contracted provider per unit cost, and comparable fee-for-service (FFS) service costs. MCOs will have the ability to negotiate provider payment rates above the floor.

Once the High Needs Supports program is fully implemented in a manner envisioned by the Commonwealth, DMAS may consider revising the approach to remove the payment floor and allow MCOs to negotiate payment rates. This will allow for DMAS, MCOs, and new providers to gain program experience – ensuring all parties involved are equipped to negotiate sufficient, actuarial sound capitation rates – and create a smooth transition into the benefit for members.

XI. Coverage Policies

To ensure quality, DMAS will apply its existing coverage policies in CCC Plus to the High Needs Supports program. Specifically, the MCO medical necessity criteria for High Needs Supports will be consistent with federal, state, and DMAS guidelines. MCOs will be required to provide services at least in equal amount, duration, and scope as available under Medicaid FFS, and any service limits will be placed in a manner that is no more restrictive than FFS. Additionally, utilization management policies will reflect the standards from the most current NCQA accreditation standards. MCOs will be required to use licensed healthcare professionals to make utilization management decisions. Cost-sharing requirements will not apply to the High Needs Supports benefit.

XII. Dispute Resolution and Appeals Processes

DMAS will require MCOs to adopt a dispute resolution process for High Needs Supports to mitigate issues raised by enrollees. This process will follow the dispute resolution process included in the CCC Plus contract, which requires parties involved to make good faith efforts to resolve internally any dispute by escalating it to higher levels of management. Additionally, the Commonwealth's MCOs are currently required to have in place systems and processes to respond to standard and expedited appeals. High Needs Supports enrollees will therefore have the ability to appeal adverse benefit determinations in accordance with federal regulations and the CCC Plus contract.

XIII. Program Disenrollment

Under certain circumstances, DMAS will permit enrollees to disenroll from the High Needs Supports program. These circumstances include: the individual requests the disenrollment; the individual is deceased; the individual loses Medicaid eligibility; or the individual no longer meets the High Needs Supports eligibility criteria. Non-use of services after a DMAS-specified timeframe (e.g., 30 days) will result in disenrollment, a redetermination of eligibility, or other action (still to be determined and operationalized by DMAS).

XIV. Systems

Successful implementation of the High Needs Supports program will require leveraging existing mechanisms and sub-systems, as well as changing/updating the Virginia Case Management System (VACMS) and the Medicaid Enterprise System (MES). To oversee and monitor the High Needs Supports program, the Commonwealth envisions creating highly automated processes. DMAS will also closely coordinate/communicate with MCOs who will administer the program, as well as new providers of housing and employment supports. Key systems implications include, but are not limited to the following.

Key VACMS, MES, and Sub-Systems Implications
Identification and Eligibility Determination. ▪ Identify individuals eligible for the High Needs Supports benefit through mechanisms such as claims and encounter data analysis. ▪ Modify systems to collect and store eligibility determinations/redeterminations and waitlist prioritizations based on the High Needs Supports eligibility screening. ▪ Accept and process referrals for eligibility determinations. ▪ Transition Medallion 4.0 enrollees eligible for High Needs Supports into CCC Plus. ▪ Track DMAS' distribution of High Needs Supports slots to enrollees determined eligible. ▪ Leverage systems to trigger the dissemination of consumer notices to enrollees regarding their eligibility, waitlist status, available benefits, appeals rights, disenrollment, etc.
Assessments and Person-Centered Care Plans. ▪ Monitor enrollees' needs identified by the High Needs Supports assessment. ▪ Track person-centered care plan development, implementation, adequacy; and progress against goals. ▪ Support the ability for MCO care coordinators to connect enrollees to providers of housing and employment supports through the development of a referral platform. ▪ Track referrals and whether enrollees access the services to which they are referred.
Information Exchange and Reporting. ▪ Design, develop, and implement information sharing channels between DMAS, sister agencies, MCOs, and providers.

Key VACMS, MES, and Sub-Systems Implications
▪ Enable care coordinators to access/exchange information on enrollees' needs to better coordinate care. ▪ Update systems to ensure MCOs and providers are able to report to the Commonwealth on various aspects of the High Needs Supports program (e.g., the number of substantiated instances of abuse, neglect, exploitation and death; the actions taken regarding the incidents and how they were resolved). ▪ Enable the reporting of DMAS-specified data to support evaluation and oversight efforts to promote program integrity. ▪ Collect and maintain up-to-date program information (e.g., resources, services, providers) and provide access to various stakeholders.
Coverage Policies and Payment. ▪ Coordinate data exchange between DMAS, MCOs, and providers for utilization management. ▪ Monitor and collect data on services rendered, provider performance, service utilization (including to ensure non-duplication of services), and other topic areas (as required by CMS). ▪ Establish processes to collect and report measures (as required by CMS). ▪ Send and receive invoices and payments for High Needs Supports services, and track payments for services delivered to enrollees. ▪ Track and address High Needs Supports-related dispute resolutions and appeals.

XV. Quality Improvement

The Commonwealth is committed to ensuring quality and enrollee protections for High Needs Supports enrollees. Through STC negotiations, DMAS and CMS agreed upon a High Needs Supports quality strategy, which will encompass specific measures and assess program performance. Performance measures will track that: all new enrollees receive an evaluation for High Needs Supports eligibility prior to receiving services; providers meet licensure/certification/accreditation standards; non-certified providers are monitored to assure adherence to demonstration requirements; and training is given to providers in accordance with the demonstration, among others.

DMAS will monitor and oversee the High Needs Supports benefit. In addition, DMAS will design and implement an effective system for assuring HCBS participants' health and welfare. DMAS will also submit a report to CMS that accompanies the quarterly and annual monitoring reports and that will include evidence of compliance at or above 86 percent with the HCBS quality assurances and measures. Where issues are identified, DMAS will intervene through corrective action or other mechanisms.

XVI. State Monitoring and Oversight

As noted above, DMAS will retain responsibility for oversight of the High Needs Supports program, including monitoring and tracking MCOs' delegated activities to ensure the highest standards of program integrity throughout the program. The Commonwealth's standards and requirements to uphold program integrity will leverage and adapt the rigorous compliance, oversight, and program integrity requirements for MCOs in the CCC Plus program, which extend requirements to network providers.

XVII. Conclusion

The Commonwealth's High Needs Supports program included in the Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Demonstration presents an opportunity for the State to invest in the health and wellbeing of Medicaid-enrolled Virginians with high needs by

addressing their social and environmental needs. The program represents a significant step towards the Commonwealth developing an innovative, whole-person centered and well-coordinated system of care. DMAS will continue to seek public input in the operational design and implementation planning for the High Needs Supports benefit. This will require convening stakeholders on a regular basis to identify issues related to implementation, develop solutions, and share best practices.

Appendix – Attachment G: High Needs Supports Eligibility and Services[22]

Target Group: Housing and employment supports eligibility is targeted to Medicaid beneficiaries age 18 or older who are enrolled under the Medicaid State Plan and is also targeted to those in the Medicaid 1115 waiver former foster care youth (FFCY) eligibility group age 18 up to 26 who aged out of foster care in another state.

DMAS will limit the High Needs Supports benefit to individuals who are not receiving housing or employment support services through an existing 1915(c) developmental disability (DD) waiver. Being on a 1915(c) DD waiver waitlist will not preclude eligible individuals from receiving the High Needs Supports benefit.

Needs-Based Criteria and Risk Factors: The Department of Medical Assistance Services (DMAS) assures there are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria below for receipt of High Needs Supports home and community-based services (HCBS).

Individual meets at least one of the following health needs-based criteria and is expected to benefit from housing or employment supports:

1. Individual has a behavioral health need, which is defined as one or more of the following criteria:
   a. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a serious mental illness or developmental or cognitive disability.
   b. Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria (or equivalent assessment) would indicate that the individual would meet at least ASAM level 1. 0, indicating the need for outpatient Substance Use Disorder (SUD) treatment.
2. Individual assessed to have a need for assistance, demonstrated by the need for assistance with two or more activities of daily living (ADLs); or hands-on assistance with one or more ADLs, defined in Virginia's Administrative Code (VAC) as "personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding."
3. Individual assessed to have a complex physical health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a continuing, progressive, or indefinite physical condition, developmental or cognitive disability, or an emotional medical condition.

AND The individual meets at least one of the following sets of risk factors:

1. **The individual has at least one or more of the following risk factors and is expected to benefit from housing support services:**
   a. At risk of homelessness.
      i. At risk of homelessness is defined as an individual who will lose their primary nighttime residence.
   b. Homelessness.
      i. Homelessness is defined as lacking a fixed, regular, and adequate nighttime residence, meaning:

[22] Building and Transforming Coverage, Services, and Supports for a Healthier Virginia. July, 9, 2020. Available here.

1) Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (e.g., a car, park, abandoned building, bus or train station, airport, or camping ground).
2) Living in a place not meant for human habitation, in an emergency shelter, in transitional housing (including congregate shelters, transitional housing, and hotels and motels) or exiting an institution where they temporarily resided in one of the aforementioned situations.
3) Fleeing domestic violence or another dangerous situation related to violence. Or
4) An individual living with children or unaccompanied youth unstably housed. Unstably housed is defined as an individual living with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, who have had two or more moves in the last 60 days, and who are likely to continue in such a state.

c. History of frequent or lengthy stays in an institutional setting (as defined in 42 CFR 435. 1010), assisted living facility (as defined in 22VAC30-80-10), or residential setting (consistent with those settings noted in 12VAC35-105-20 for residential services and residential treatment settings).
   i. Frequent is defined as more than one time in the past 12 months.
   ii. Lengthy is defined as at least 28 or more consecutive days within an institutional setting, assisted living facility, or residential setting.
d. History of frequent emergency department (ED) visits and/or hospitalizations.
   i. Frequent is defined as more than four ED visits and/or hospitalizations in the past 12 months.
e. History of involvement with the criminal justice system.
   i. History of involvement with the criminal justice system is defined as an individual who has been confined to a prison, jail, halfway house, boot camp, weekend program, and other justice-involved facilities in which individuals are locked up overnight, for at least 24 hours over the past 12 months.
f. History of frequent moves or loss of housing as a result of behavioral health symptoms (e.g., lapsed rent payments due to psychiatric hospitalization).
   i. Frequent is defined as more than once in the past six months.

OR

2. **The individual has at least one or more of the following risk factors and is expected to benefit from employment support services:**
   a. Unable to be gainfully employed for at least 90 consecutive days in the past 12 months due to a mental or physical impairment.
   b. Unable to obtain or maintain employment resulting from age, physical/sensory disability, or moderate to severe brain injury.
   c. More than one instance of inpatient or outpatient SU D service in the past two years.
   d. At risk of deterioration of mental illness and/or SU D, including one or more of the following:
      i. Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness.
         1) DMAS will apply the same definition of homelessness as required for the housing supports risk factors, as described above.
      ii. Care for mental illness or SU D requires multiple provider types, including behavioral health, primary care, long-term services and supports, or other supportive services.
      iii. Past psychiatric history, with ongoing treatment and supports necessary to ensure functional improvement.
      iv. Dysfunction in role performance, including one or more of the following:

1) Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension.
2) A history of multiple terminations from work or suspensions/expulsions from school.
3) Cannot succeed in a structured work or school setting without additional support or accommodations.
4) Performance significantly below expectation for cognitive/developmental level.

Housing and Employment Supports Services

Housing Supports: Housing supports services are determined to be necessary for an individual to obtain and reside in an independent community setting and are tailored to the goal of maintaining an individual's personal health and welfare in a home and community-based setting. Housing supports services may include one or more of the following components:

Individual Housing and Pre-Tenancy Services:

1. Conducting an assessment to identify the individual's needs and preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other preferences).
2. Assisting in budgeting for housing/living expenses, including financial literacy education on budget basics.
3. Assisting individuals with finding and applying for housing, including filling out housing, utility, and rental assistance applications and obtaining and submitting appropriate documentation.
4. Assisting individuals with completing reasonable accommodation requests as needed to obtain housing.
5. Developing an individualized housing support plan that identifies short and long-term measurable goals, how goals will be achieved and how barriers to achieving goals will be addressed.
6. Assisting with identifying and securing resources to obtain housing.
7. Ensuring the living environment is safe (including the assessment of health risks to ensure the living environment is not adversely affecting the occupants' health) and accessible for move-in.
8. Assisting in arranging for and supporting the details and activities of the move-in.

Individual Housing and Tenancy Sustaining Services:

1. Coordination with the individual to plan, participate in, review, update and modify their individualized housing support plan on a regular basis, including at redetermination and/or revision plan meetings, to reflect current needs and preferences and address existing or recurring housing retention barriers.
2. Providing assistance with securing and maintaining entitlements and benefits (including rental assistance) necessary to maintain community integration and housing stability (e.g., assisting individuals in obtaining documentation, assistance with completing documentation, navigating the process to secure and maintain benefits, and coordinating with the entitlement/benefit assistance agency).
3. Assistance with securing supports to preserve the most independent living.
4. Monitoring and follow-up to ensure that linkages are established and services are addressing community integration needs.
5. Providing supports to assist the individual in the development of independent living skills to remain in the most integrated setting (e.g., skills coaching to maintain a healthy living environment, develop and manage a household budget, interact appropriately with neighbors or roommates, reduce social isolation, utilize local transportation).
6. Providing supports to assist the individual in communicating with the landlord and/or property manager.
7. Education and training on the role, rights, and responsibilities of the tenant and landlord.

8. Providing training and resources to assist the individual with complying with his/her lease.
9. Assisting in reducing the risk of eviction by providing services to prevent eviction (e.g., to improve conflict resolution skills; coaching; role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicating with landlords and neighbors to reduce the risk of eviction; addressing biopsychosocial behaviors that put housing at risk; providing ongoing support with activities related to household management; and linking the tenant to community resources to prevent eviction).
10. Providing early identification and intervention for actions or behaviors that may jeopardize housing.
11. Providing a pest eradication treatment no more than one time per year that is necessary for the individual's health and safety as documented by a health care professional. This service is not intended for monthly, routine or ongoing treatments. This service is coverable when the individual is living in their own home, when not already included in a lease, and when the pest eradication is for the management of health and safety as identified in the person-centered service plan. The service is not otherwise provided under this waiver (except as part of Community Transition Services for individuals transitioning out of institutional settings and provider-owned and operated congregate living arrangements) and the Medicaid state plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
12. Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health, and when modification is not covered by another entity as required by law.
13. Assistance with connecting the enrollee to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions.
14. Shared living support services that provide for the payment for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the individual. Payment will not be made when the individual lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

Community Transition Services:

1. Supports designed to assist individuals transitioning out of institutional settings and provider-owned and operated congregate living arrangements, not to exceed $5,000 per member per lifetime, regardless of the number of services. Supports cover expenses necessary to enable individuals to obtain an independent, community-based living setting. Specifically, allowable expenses may include: security deposits required to obtain a lease on an apartment or home; essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; moving expenses; necessary home accessibility adaptations; and activities to assess need, arrange for, and procure needed resources.

Services Not Included in the High Needs Supports Housing Benefit:

1. Payment of rent or other room and board costs.
2. Capital costs related to the development or modification of housing.
3. Expenses for utilities or other regular occurring bills.
4. Goods or services intended for leisure or recreation.
5. Duplicative services from other state or federal programs.
6. Services to individuals in a correctional institution or an Institution of Mental Disease (IM D) (other than services that meet the exception to the IM D exclusion).

7. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and only when the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

Employment Supports: Employment supports services are determined to be necessary for an individual to obtain and maintain employment in the community. Employment supports services will be individualized and may include one or more of the following components:

Pre-Employment Services *(individual and small group):*

1. Pre-vocational/job-related discovery or assessment.
2. Assessment of workplace readiness (e.g., people skills, technology knowledge).
3. Person-centered employment planning.
4. Individualized job development and placement (e.g., job fairs, interviews).
5. Mentoring (e.g., on how to change cultural behavior, re-entry from incarceration).
6. Career coaching (e.g., resume coaching, interview coaching).
7. Job carving.
8. Benefits education, planning, and training.
9. Transportation (provided either as a separate transportation service to employment services or to the individual's job, or services included in the rate paid to the provider of employment services).
10. Soft skill training (e.g., interpersonal skills, customer service, answering the phone, workplace culture).
11. Volunteer work and paid internships.
12. Job preparation training (e.g., coaching on appropriate personal hygiene and attire, timeliness, workplace behavior and communication, reliability).
13. Training to improve executive functioning skills (e.g., sustaining attention, organizing, and task prioritization).
14. Behavioral modification (e.g., to increase emotional maturity, to developed alternative coping mechanisms for adverse behaviors such as alcohol/drug use).
15. Coordination with other care providers to address behavioral health needs that impact an individual's ability to secure and maintain employment.

Employment Sustaining Services *(individual and small group)*:

1. Job coaching (including situational assessments).
2. Career advancement services.
3. Negotiation with employers.
4. Job analysis.
5. Training and systemic instruction
6. Benefits education and planning.
7. Financial and health literacy.
8. Transportation (provided either as a separate transportation service to employment services or to the individual's job, or included in the rate paid to the provider of employment services).
9. Payment for public transportation (e.g., bus passes, mass transit vouchers) to support the enrollee's ability to participate in work/community engagement and to gain access to community services, activities, and resources.
10. Account credits for cost-effective private forms of transportation (e.g., taxi, ridesharing) in areas without access to public transit in order to enable individuals to participate in work/community engagement and to gain access to community services, activities, and resources.

11. Transportation education assistance in gaining access to public or mass transit, including access locations, pilot services available via public transportation, and how to purchase transportation passes.
12. Assistance with linking to high quality child care and after-school programs and programs that increase adults' capacity to participate in work/community engagement activities.
13. Asset development.
14. Follow-along supports.
15. Peer supports for employment provided by a co-worker or other job site personnel, provided that the services furnished (e.g., emotional support, connections to resources) are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the pertinent qualifications for the provider of service.

Services Not Included in the High Needs Supports Employment Benefit:

1. Generalized employer contacts that are not connected to a specific enrolled individual or an authorized service.
2. Employment support for individuals in sub-minimum wage, or sheltered workshop settings.
3. Facility-based habilitation or personal care services.
4. Wage or wage enhancements for individuals.
5. Duplicative services from other state or federal programs.
6. Medicaid funds to defray the expenses associated with starting up or operating a business.

Provider Qualifications: Contracted High Needs Supports providers must assure staff providing housing and employment supports services maintain appropriate qualifications in order to effectively serve enrollees. Staff providing High Needs Supports services must receive DMAS-approved housing and employment supports trainings in accordance with evidence-based principles and practices, as well as other applicable trainings in accordance with the Commonwealth Coordinated Care (CCC) Plus contract. Below are the minimum provider staff qualifications. DMAS and the managed care organizations (MCOs) (contingent upon DMA S review and approval) may also impose licensure/certification/accreditation requirements beyond the minimum provider qualifications outlined below.

Provider Type	Education and Experience	Skills	Services
Housing Supports	• Education (e.g., Bachelor's degree, Associate's degree, (certificate) in a human/social services field or a relevant field; and/or • At least one year of relevant professional experience and/or training in the field of service	Knowledge of principles, methods, and procedures of services included under housing supports services, or comparable services meant to support an individual's ability to obtain and maintain stable housing.	• Individual Housing and Pre-Tenancy Services. • Individual Housing and Tenancy Sustaining Services. • Community Transition Services.

Provider Type	Education and Experience	Skills	Services
Employment Supports	• Education (e.g., Bachelor's degree, Associate's degree, (certificate) in a human/social services field or a relevant field; and/or • At least one year of relevant professional experience and/or training in the field of service.	Knowledge of principles, methods, and procedures of services included under employment supports services, or comparable services meant to support an individual's ability to obtain and maintain stable employment.	• Pre-Employment Services (individual and small group). • Employment Sustaining Services (individual and small group).

Administrative Approach: The state will provide a set of housing and employment supports to certain high need Medicaid beneficiaries enrolled in the managed care delivery system by contracting with Commonwealth Coordinated Care Plus (CCC Plus) MCOs to provide the approved High Needs Supports services and related activities. The state will maintain authority, accountability, oversight, and evaluation of the High Needs Supports program, including oversight of delegated activities to CCC Plus MCOs and any other contracted entities, as well as oversight of the High Needs Supports quality strategy described in STCs 23 – 26.

The state will leverage multiple pathways to ensure a "no wrong door" approach to identifying enrollees who may be eligible for High Needs Supports. Multiple entities, including MCOs, state agencies, community organizations, and providers, will play a critical role in identifying individuals for the High Needs Supports benefit. The state will send information it receives regarding potentially eligible enrollees to the MCOs to determine eligibility for the benefit. The state will develop standardized High Needs Supports screening questions that MCOs will use to determine High Needs Supports eligibility. The state will validate the eligibility determination provided by the MCOs.

The state will develop standardized elements for a High Needs Supports assessment to be performed by MCO care coordinators, and review/approve any changes to the assessment proposed by the MCOs. The state will require the MCOs to ensure their care coordinators develop the High Needs Supports person-centered care plan that reflects enrollees' housing and employment-related needs, goals, and preferences, and to connect enrollees to providers and services authorized by the MCO. The state will require that MCOs, in collaboration with providers, track and report the services provided to High Needs Supports enrollees, ensuring accountability for service delivery and payment. The state will conduct periodic audits of payments to verify accurate reporting and spending.

The following activities will be delegated to MCOs; the state will monitor and ensure MCO compliance and performance with respect to these functions:

- Develop, manage, and contract with a network of High Needs Supports providers to deliver and pay claims for High Needs Supports services.
- Screen members to identify those potentially eligible for High Needs Supports.
- Conduct the High Needs Supports eligibility screening to determine High Needs Supports eligibility based on the eligibility criteria set forth above.
- Perform ongoing data surveillance/identification of members to monitor any changes to the member's High Needs Supports status.

- Oversee the provision of the standardized High Needs Supports assessment and the development/maintenance of the High Needs Supports person-centered care plan by the MCO care coordinators.
- Authorize High Needs Supports services and care plan modifications.
- Work with MCO care coordinators to ensure care management and monitor/track enrollees' access to services and progress against their goals.

Payment Methodology: The state will demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the High Needs Supports program. Working closely with the state's contracted actuary, the state will establish a payment floor for the federally-approved High Needs Supports services. The services will be priced based on factors such as the intensity of services, duration of services, geography, contracted provider per unit cost, and comparable fee-for-service (FFS) service costs. The state will allow MCOs to negotiate High Needs Supports payment rates above the payment floor. Once the High Needs Supports program is fully implemented in a manner envisioned by the state, DMAS may consider revising the payment methodology approach to remove the payment floor and allow MCOs to negotiate provider payment rates. The state will require MCOs to reimburse network providers authorized to deliver High Needs Supports services based on the standards and requirements set forth by the state. The state will conduct periodic audits of payments to verify accurate reporting and spending. The state will demonstrate actuarial soundness on an annual basis pursuant to 42 CFR Part 438.