

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

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**ALTERNATIVE BENEFITS**

**DISEASE MANAGEMENT**

1937(a),   X   / The State elects to provide alternative benefits under Section  
1937(b) 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

a.    / Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

\_\_\_\_\_  
\_\_\_\_\_

b.   X   / Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

All individuals in fee-for-service (except SCHIP enrollees, those who have third party insurance coverage or those who reside in institutional settings) who are determined to have asthma, congestive heart failure, coronary artery disease, and/or diabetes.

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

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Individuals are encouraged to participate in the program through mailings and telephonic outreach by the disease management program administrator. Individuals who choose to participate in the opt-in program maintain eligibility for the regular Medicaid benefits at all times. The opt-in program adds additional care management services for individuals diagnosed with one of the covered conditions.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

In addition to all regular Medicaid program benefits, the alternative benefit package includes disease management services such as condition specific education, access to a 24 hour nurse call line, regularly scheduled telephonic care management and support. The package also includes monitoring patient health activity and providing informational feedback to primary care physicians to help facilitate changes to patients' plans of care pursuant to the provision of disease management services.

c. \_\_\_/ Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

Services under this alternative benefit package are available statewide.

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

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B. Description of the Benefits

X / The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1. X / Benchmark Benefits

a. \_\_\_ / **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

b. \_\_\_ / **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State’s employee benefits plan package.

c. \_\_\_ / **Coverage Offered Through a Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO’s benefit package.

d. X / **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State’s plan. Provide a full description of the benefits package including the benefits provided and any applicable limits:

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This alternative benefits package includes all Medicaid State Plan services plus disease management services for the covered conditions. Disease management services include care management, a 24-hour nurse call line, and on-going condition specific education. Virginia's disease management program is designed to help patients better understand and manage their condition(s) through prevention, education, lifestyle changes, and adherence to prescribed plans of care (POCs). The purpose of the program is not to offer medical advice, but rather to support providers in reinforcing patients' POCs.

The covered State Plan services are those as already specified and limited in Attachment 3.1-A, Attachment 3.1-B, and Supplement 1 to Attachment 3.1A&B.

2. \_\_\_/ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan:

\_\_\_\_\_.

- a. \_\_\_/ The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

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b. \_\_\_/ The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. \_\_\_/ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) \_\_\_/ **Inclusion of Basic Services** – This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

\_\_\_/ Inpatient and outpatient hospital services;

\_\_\_/ Physicians' surgical and medical services;

\_\_\_/ Laboratory and x-ray services;

\_\_\_/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices

\_\_\_/ Other appropriate preventive services, as designated by the Secretary.

\_\_\_/ Clinic services (including health center services) and other ambulatory health care services.

\_\_\_/ Federally qualified health care services

\_\_\_/ Rural health clinic services

\_\_\_/ Prescription drugs

\_\_\_/ Over-the-counter medications

\_\_\_/ Prenatal care and pre-pregnancy family services and supplies

\_\_\_/ Inpatient Mental Health Services not to exceed 30 days in a calendar year

\_\_\_/ Outpatient mental health services furnished in a State-operated facility and including community-based services

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/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)

/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.

/ Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year

/ Dental services

/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year

/ Outpatient substance abuse treatment services

/ Case management services

/ Care coordination services

/ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders

/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.

/ Premiums for private health care insurance coverage

/ Medical transportation

/ Enabling services (such as transportation, translation, and outreach services)

/ Any other health care services or items specified by the Secretary and not included under this section

**(2) Additional benefits for voluntary opt-in populations:**

/ Home and community-based health care services

/ Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

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3. Wrap-around/Additional Services

- a.  / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wraparound benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).
- b.  / The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1.  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.
2.  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated as a primary care case management system consistent with section 1915(b)(1).
3.  / The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.

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4.    / Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

5.   X   / Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

Alternative benefit services for disease management will be offered through a Prepaid Ambulatory Health Plan, under contract with the State. All other Medicaid State Plan services shall be provided fee-for-service.

D. Additional Assurances

a.   X   / The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b.   X   / The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

  X   / The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

  X   / The State will implement this State Plan amendment on October 1, 2006.