Addendum A– Foster Care Specialty Plan Addendum to the Cardinal Care Model Contract

The requirements in this Addendum only apply to the single MCO that, through the DMAS CCMC Request for Proposal (RFP 13330, as amended), was selected to operate the Foster Care Specialty Plan.

1 Foster Care Specialty Plan

This Addendum A contains non-negotiable requirements for the Cardinal Care Managed Care (CCMC) Contractor selected as the Foster Care Specialty Plan. The Foster Care Specialty Plan must demonstrate compliance with these requirements prior to the Operational Start Date, as assessed by the Department during the Readiness Review described in Section 2.7, *Contractor Readiness Reviews*, of the CCMC Contract.

Pending CMS approval, DMAS intends to make the Foster Care Specialty Plan an Addendum to the CCMC Contract awardee that, in the agency's opinion, has made the best Appendix I response as further described in the RFP. In addition to the requirements in the CCMC Contract, this Addendum provides additional requirements for Members within the Foster Care Population, defined as:

1. Members under age twenty-one (21) who are in Foster Care, (designation code 076);
2. Former Foster Care Members under age twenty-six (26) who were Foster Care until their discharge from foster care at age eighteen (18) or older (designation code 070); or
3. Members under age twenty-one (21) who receive Adoption Assistance (designation code 072).

All Contract provisions of the CCMC Contract remain in effect for the Foster Care Population and in addition to the requirements in this Addendum, unless otherwise specified, the Contractor is responsible for meeting all requirements of the CCMC Contract in administering the Foster Care Specialty Plan. The provisions included in this Addendum are in addition to the requirements within the CCMC Contract and are focused exclusively on the Foster Care Population.

The Contractor will participate in regular and ad hoc meetings with the Department, LDSS, VDSS, and other entities as may be determined by the Department in support of the Foster Care Population and for the monitoring and oversight of the Contractor's performance and innovations relative to the Foster Care Population for provisions in both the CCMC Contract and this Foster Care Specialty Plan Addendum. At a minimum, such oversight will include, but is not limited to, review of Member engagement, access to and utilization of covered services and network providers with experience serving the Foster Care Population, and monitoring of quality outcomes. The Contractor must provide reports specific to the Foster Care Specialty Plan as directed by the Department, as described in Section 2.3.5.4, *Foster care/Adoption Assistance Reporting Requirements* of this Addendum, and including ad hoc reports and quality and performance reports. As requested by the Department, the Contractor must participate in stakeholder collaboration workgroups regarding the Foster Care Population. These groups may include, but are not limited to, Department facilitated work groups with external stakeholders serving youth affected by the child welfare system. The Contractor agrees to implement its Appendix I response to the CCMC RFP, including any modifications agreed to by DMAS, identify recommendations for future

innovations, and collaborate with the Department on implementing and refining innovative approaches to achieve improved health and social outcomes for the Foster Care Population.

1.1 Key Personnel Dedicated to Foster Care Specialty Plan

1.1.1 Key Personnel

The Contractor will have a Director of the Foster Care Specialty Plan that is employed by the Contractor and dedicated full time to the Foster Care Population. The Director will work with the Managed Care Project Director required in Section 2.10.1, *Managed Care Personnel,* of the CCMC Contract to ensure that the Contractor complies with all aspects of both the CCMC Contract and this Foster Care Specialty Plan Addendum.

The Contractor will have a Medical Director for the Foster Care Specialty Plan. The Medical Director will provide clinical support to the Foster Care Specialty Plan and coordinate with the Managed Care Clinical Leadership Staff required in Section 2.10.1, *Managed Care Personnel,* of the CCMC Contract to provide comprehensive clinical oversight and comply with all requirements covered under the CCMC Contract and this Foster Care Specialty Plan Addendum. The Medical Director must have experience in behavioral health and with trauma-informed services and working with children and youth in the Foster Care Population. Upon request by the Department, the Contractor must submit to the Department the name, resume, and job description for the Director and the Medical Director of the Foster Care Specialty Plan.

1.1.2 Other Dedicated Staff

The Contractor will have a Care Management Supervisor for the Foster Care Specialty Plan that is dedicated full time to the Foster Care Population. The Care Management Supervisor will be responsible for the Care Management services provided to the Foster Care Population and have direct supervision of the Care Managers for the Foster Care Population. The Care Management Supervisor must have at least two (2) years of experience working directly with foster care populations and must be an RN or LMHP. The Contractor will have sufficient dedicated Care Managers for the Foster Care Population. These Care Managers must be an LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW, have at least one (1) year experience working with children in the Foster Care Population, and be responsible for managing caseloads of individuals within the Foster Care Population, and within the Care Management Ratios identified in Section 8.4.4, *Care Manager Staffing Ratios*, of the CCMC Contract.

2 Enrollment

All Members in foster care, former foster care Members, and Members receiving adoption assistance (designation codes 076, 070 and 072, respectively) will be enrolled in the Foster Care Specialty Plan. Members in foster care (076) will only be served by the Foster Care Specialty Plan. Other populations may opt out of enrollment in the Foster Care Specialty Plan as specified below.

2.1 Adoption Assistance and Former Foster Care Member Health Plan Selection

Former foster care Members and Members in adoption assistance (designation codes 070 and 072, respectively) may opt out of enrollment in the Foster Care Specialty Plan as described below:

1. The adoptive parent is responsible for health plan selection, including changes, for members in adoption assistance and thus can opt their member adoptee(s) out of enrollment in the Foster Care Specialty Plan (AC 072);
2. The former foster care Members (AC 070) are responsible for their health plan selection and any subsequent health plan changes and thus can opt themselves out of enrollment in the Foster Care Specialty Plan; and
3. Former foster care Members and Members in adoption assistance may change their health plan at any time and are not restricted to their health plan selection following the initial ninety (90) calendar day MCO enrollment period. If a Member selects to move from the Foster Care Specialty Plan to another MCO, the Contractor must support the transition of the Member to the new MCO including connecting with the new MCO's Care Management to support continuity of care for the Member.

2.2 Foster Care Covered Services

The Contractor must cover services for Members in foster care, former foster care Members and those in adoption assistance (designation codes 076, 070 and 072, respectively), and adhere to the following:

1. For decisions regarding the foster care Member's medical care, the Contractor must work directly with either the LDSS social worker or the foster care parent (or group home/residential staff person, if applicable), as determined by the locality where the Member resides;
2. For decisions regarding the adoption assistance Member's medical care, the Contractor must work directly with the adoptive parent; and
3. For decisions regarding the medical care of former foster care or Fostering Futures Members (AC 070), the Contractor must work directly with the former foster care Members.

2.3 Care Management

The Contractor must provide Care Management to all Members of the Foster Care Specialty Plan as described below:

1. All Members enrolled in the Foster Care Specialty Plan must be considered Mandatory High Priority, as described in Section 2.3.2, *Priority Populations,* of this Addendum, in the first three (3) months of their enrollment. In addition, these Members will be considered Mandatory High Priority:
    a. Individuals in foster care or former foster care youth for three (3) months after enrollment into the Medicaid program, the child welfare system or a new foster care home;
    b. Individuals in foster care three (3) months prior to aging out of the child welfare system;
    c. Former foster care youth for the first three (3) months after aging out of the child welfare system; and,
    d. For a minimum of the first three (3) months following identification as being part of one of the following populations:
        i. Substance-exposed infants;

ii. Neonatal abstinence syndrome infants (following diagnosis or identification as part of this population, whichever is later);
iii. Infants admitted to the neonatal ICU (NICU Level 3);
iv. Any Member with a SUD diagnosis; and
v. Any Member discharged from a PRTF within the last ninety (90) calendar days.

2. The Contractor must collaborate with the Member's LDSS Care Manager in conducting Health Risk Assessments and determining the Member's specific care management needs, and on an ongoing basis to support whole person care for the Member.
3. Following three (3) months of enrollment, the Contractor will consider whether the Member should remain in the Mandatory High Priority category or whether they can be moved to a less intense level of Care Management (low or moderate).
4. Upon completion of the Readiness Review, as described in Section 2.7, *Contractor Readiness Reviews* of the CCMC Contract, and at the operational effective date of the Foster Care Specialty Plan Addendum, the Contractor will consider all Members to be Mandatory High Priority unless and until the Contractor conducts a review of the Member and determines that that the Member does not meet the Mandatory High Priority Population description and is stratified into either the Mandatory Priority Populations or MCO Determined Priority.

2.3.1 Risk Stratification

As described in Section 2.3.2 below, the Contractor will use a risk stratification process to determine the Member's Care Management intensity level assignment (i.e., Low, Moderate or High). The Contractor's risk stratification/scoring methodology should use, as available, the following data sources and must be demonstrated as being fully operational during readiness review, prior to implementation:

1. Assessment and reports from LDSS;
2. Completed MCO Member Health Screening (MMHS) results, including medically complex status;
3. Health Related Social Needs (HRSN) screening;
4. Historical claims analysis;
5. Aid category;
6. Enrollment in the Early Intervention benefit program;
7. Pharmacy data;
8. Immunizations;
9. Lab results;
10. Admission, Discharge, Transfer (ADT) feed information;
11. Provider referrals;
12. Member's zip code;
13. Member's race and ethnicity;
14. Member or caretaker request for care management;
15. Information from a Medical Transition Report;
16. Any relevant information from Complaints, Grievances and Appeals; and
17. Any known involvement from educational or judicial systems.

2.3.2 Priority Populations

Members may be identified as one of three Priority Population groups for assignment to Care Management (or Care Coordination, as appropriate): Mandatory High Priority, Mandatory Priority Populations and MCO-Determined Priority.

1. **Mandatory High Priority Populations:** The Contractor must assign each Member identified in Section 2.3, *Care Management* of this Addendum as Mandatory High Priority to High Intensity Care Management. For Members who are assigned to the Mandatory High Priority population on a time-limited basis, the Contractor may restratify and move those individuals to lower intensity levels of Care Management based on the Member's need/risk and/or at the Contractor's discretion.
2. **Mandatory Priority Populations:** The Contractor must assign a Member with Behavioral Health (MH/SUD), Brain Injuries or Disabilities as a Mandatory Priority Population to either Low, Moderate, or High Intensity Care Management, depending on the Member's needs and risk level. The Contractor is not permitted to assign the Member to Care Coordination. Members with Behavioral Health (MH/SUD), Brain Injuries and Disabilities include:
    a. Members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling);
    b. Members who receive Mental Health Services, as reflected in the CCMC Summary of Covered Benefits Chart, Part 2B (CCMC Contract Attachment E);
    c. Members with intellectual/developmental disabilities (I/DD);
    d. Members with brain injuries; and
    e. Members with physical or sensory disabilities.
3. **MCO-Determined Priority Populations:** The Contractor has discretion to assign MCO-Determined Priority Populations to Care Coordination or Care Management. If the Contractor determines a Member in this population requires Care Management, the Contractor has discretion to assign the Care Management intensity level it deems appropriate based on the Member's needs and risks. The Contractor may use the data sources outlined in Section 2.3.1, *Risk Stratification,* of this Addendum to identify Members for assignment to either Care Management or Care Coordination.

2.3.3 Triggering Events

For the purposes of Health Risk Assessment (HRA), Individualized Care Plan (ICP), and Interdisciplinary Care Team (ICT) requirements, the Department defines a "Triggering Event" as any occurrence that suggests a change in the Member's condition or status that places the Member at a higher risk of harm or jeopardizes their health, safety and welfare, and includes but is not limited to one or more of the following:

1. Inpatient hospitalization or Emergency Department visit for medical and/or behavioral health;
2. Involuntary treatment episode;
3. Use of behavioral health crisis services;
4. Law enforcement involvement;
5. Pregnancy;
6. Transition from a PRTF to the community;
7. Loss of informal supports;
8. Change in functional status;

9. Loss of housing;
10. Child welfare or child protective services involvement; and
11. Critical incident, as defined in Section 16, *Critical Incident Reporting* of the CCMC Model Contract.

In addition to the above Triggering Events, the Contractor must consider additional events that may warrant an HRA reassessment, ICP revision, or ICT meeting. For more information about HRAs after Triggering Events, see Section 8.5.3, *HRA Completion Timeframes* of the CCMC Contract.

2.3.4 HRA Completion Timeframes

Care Managers must complete an initial HRA within thirty (30) calendar days from MMHS completion and/or identification that the Member needs Care Management services. The Contractor must accelerate the HRA completion timeframe, as appropriate, if necessary to effectively manage the Member's condition.

Following the initial HRA, Care Managers must complete an HRA reassessment or update an existing HRA for any individual receiving Care Management:

1. At least every twelve (12) months, and;
2. Within ten (10) calendar days of a Triggering Event as defined in Section 2.3.3 of this Addendum, unless there are extenuating circumstance, and no more than thirty (30) calendar days. If the reassessment takes place beyond the ten (10)-day timeframe, the Contractor must document the reason(s) why this occurred.
    a. HRAs do not need to be completed more frequently than every quarter, unless deemed necessary based on the Member's condition.
    b. The completion of an HRA following a Triggering Event resets the twelve (12) month HRA reassessment timeframe.
3. At any other time between required timeframes if it is deemed necessary based on a change in a Member's condition, need or risk.

HRA reassessment can be completed in parallel or as part of other Care Management processes such as discharge planning and ICT meetings. For foster care or former foster care, the timeframe for responding to the triggering event begins at the time the Contractor is notified that the Member's aid category has changed to a foster care aid category, (i.e., on the end of the month 834 enrollment file).

2.3.5 Foster Care Management

2.3.5.1 General Requirements

The Contractor must provide specialized Care Management to all children and youth in the Foster Care Population according to requirements in Section 2.3, *Care Management* of this Addendum.

The Contractor must document on a case by case basis the reason(s) for assigning a Member to a specific Care Management intensity tier (i.e., Low, Moderate, or High). The Contractor must also document the reason(s) for re-assigning a Member to a different Care Management tier upon restratification or following a triggering event.

In addition to receiving Low, Moderate or High Intensity Care Management, the Contractor must:

1. Support the efforts of the LDSS social worker, LDSS post adoption Care Manager and/or the foster care parents (group homes or LCPAs) during initial outreach to ensure that Members in foster care receive both a PCP and a dental visit within thirty (30) calendar days of enrollment with the Contractor, unless their social worker attests that they have recently seen any provider within three (3) months prior to enrollment;
2. Ensure in the event that the Member has seen an out-of-network PCP and/or an out-of-network dentist prior to enrollment, that the Member is assigned to an in-network PCP and/or an in-network Smiles for Children dentist for future ongoing care;
3. Provide medication management/reconciliation upon enrollment, as expeditiously as the Member's condition requires, on the basis of foster care status or if a Member is known to have entered the foster care system while already enrolled in Medicaid; and,
4. Ensure that Members in Treatment Foster Care Case Management or Therapeutic Group Home Services (TGH) have access to transportation and pharmacy services related to the delivery of these carved-out services, as necessary. In the event that Residential Treatment services consisting of Psychiatric Residential Treatment Facility Services (PRTF) are no longer excluded from CCMC, the Contractor must ensure these members have access to transportation and pharmacy services related to the delivery of these carved-out services, as necessary.

2.3.5.2 Foster Care Transition Planning

The Contractor must develop and maintain transition of care policies and procedures for Members in foster care who are transitioning out of the child welfare system. The policies and procedures must include provisions for convening a comprehensive treatment team meeting prior to Member leaving the child welfare system to discuss the services and supports the Member's needs post-separation. The team must include the LDSS social worker. If the services are not covered by Medicaid, the Contractor must inform the Member, or their authorized representative, of available community programs that may be able to meet their needs and make the necessary referrals, as needed. If the Member has an ICP, the Contractor must include transition needs in the updated ICP.

The Contractor must establish a process to notify youth in foster care who are approaching age seventeen (17) of the programs that provide continued health care coverage, specifically former foster care and Fostering Futures. The Contractor must ensure Care Management continues during this transition period and that there is a focus on supporting LDSS in support of Member efforts to obtain skills to support independence, such as continuing education, support obtaining a driver's license, financial literacy, and obtaining housing.

The Contractor must start transition planning at least eighteen (18) months prior to the expected date upon which an enrollee will age-out of the child welfare system or immediately upon notification that an enrollee has achieved permanency status. The Contractor must assist the Member with all aspects of the eligibility determination process and coordinate with the local Department of Social Services to ensure transition to Aid Category 70, former Foster Care children and youth in Fostering Futures.
The Contractor must provide youth aging out of foster care with a "health summary" consolidating key medical information (e.g., providers, appointments, prescriptions) and providing resources to assist with transitioning to adulthood and managing their own medical decisions.

2.3.5.3 Compliance with Other Federal and State Requirements

The Contractor must work collaboratively with the Department and Department of Social Services in meeting the Federal requirements related to the Virginia Health Care Oversight and Coordination Plan, the provision of health care services as outlined in the VDSS Five Year State Plan for Child and Family Services, and the VDSS Child and Family Services Manuals for children in foster care. Additionally, the Contractor must comply with the following rules:

1. Care Coordination and Care Management
    a. The Contractor must work with LDSS in all areas of Care Management and Care Coordination;
    b. For decisions regarding the foster care child's medical care, the Contractor must work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance child's medical care, the Contractor must work directly with the adoptive parent;
    c. For decisions regarding the medical care of former foster care or Fostering Futures Members (AC 070), the Contractor must work directly with the former foster care Members;
2. Covered Services
    a. The Contractor must provide coverage for all covered services under the CCMC Contract and the Foster Care Specialty Addendum;
    b. Coverage must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, even out of area;
3. Other
    a. The Contractor must participate in child welfare stakeholder collaboration work groups as requested by the Department, including but not limited to Safe and Sound, Commission on Youth, OCS/CSA, and the Child Welfare Advisory Committee. See Section 1.3.2, *Child Welfare Stakeholder Collaboration*, of the CCMC Contract.

2.3.5.4 Foster Care/Adoption Assistance Reporting Requirements

The Contractor must provide reports to the Department on its support for Members covered through the Foster Care Specialty Plan on a regular basis including:

1. The Contractor must report monthly to the Department any barriers identified in contacting and/or providing care to the Foster Care Population. The Department will use the Barrier Report to assist the Contractor in resolving the barriers reported. Refer to the Cardinal Care Technical Manual for Barrier Report specifications.

2. The Contractor agrees to adhere to all additional reporting requirements related to the Foster Care Population, as outlined in the Cardinal Care Technical Manual.

2.3.6.5 Treatment Foster Care Case Management

Treatment Foster Care Case Management (TFCCM) services are covered for Medicaid members under age twenty-one (21) and are administered through the DMAS Service Authorization Contractor. The Contractor must also collaborate with the Member's Treatment Foster Care case management provider to coordinate the provision of Medicaid covered services rendered to the Member, including covered services and carved-out services. This includes, but is not limited to, coordinating step down services for the Member when TFCCM services are no longer deemed medically necessary by the DMAS Service Authorization Contractor. See Attachment E, Cardinal Care Summary of Covered Services, for further description of this service.

2.4 Performance Improvement Project

In accordance with 42 CFR §438.330, the Contractor must collaborate with the External Quality Review Organization (EQRO) on a Foster Care annual study and conduct annual Performance Improvement Projects (PIPs) for validation by the EQRO pursuant to 42 CFR §438.358. The Department will select a specific PIP focused on the Foster Care Population that the Contractor must perform.

2.5 Transition Benefits

The Department encourages the Contractor to provide additional supports for Members, particularly during the transition period prior to Members turning eighteen (18) to support Members becoming independent. These supports may include, but are not limited to, providing support to Members to obtain driver's licenses, obtain housing, identify continuing education including options for college, and supporting Members in financial literacy.

During Readiness Review and by October 1 of each CCMC Contract year, the Contractor must provide to the Department for approval the list of enhanced benefits it would like to offer to all Members in the Foster Care Specialty Plan. The Contractor should include any benefit limits and criteria for each transition benefit.

2.6 Newborn Enrollments

Until such time that a newborn is assigned a Medicaid, FAMIS, or FAMIS Plus identification number, the charges for newborns to mothers enrolled with the Contractor are the responsibility of the Contractor for the birth month plus two (2) months. When a newborn enters foster care during the birth month plus two (2) month time period they may be retroactively assigned to the Foster Care (076) aid category beginning on their date of birth. In these cases the Department will not retroactively enroll the newborn into the Foster Care Specialty Plan. Newborns born to mothers enrolled with another health plan will continue to be covered by that plan, regardless of retroactive foster care aid category assignment, as long as the newborn is enrolled with the health plan. The newborn in foster care will move to the Foster Care Specialty Plan as soon as the system will allow after foster care (076) aid category enrollment.