INTERAGENCY AGREEMENT

BETWEEN: Virginia Department of Medical Assistance Services

AND: Virginia Department of Health

It is hereby agreed:

The Department of Medical Assistance Services (DMAS) and the Virginia Department of Health (VDH) do hereby agree to the provisions contained in this document for carrying out the Commonwealth’s responsibilities related to services authorized under the Virginia State Plan for Medical Assistance Services and the State Children’s Health Insurance Plan.

This agreement shall become effective when signed and continue thereafter for a period of 3 years. The agreement may be modified or amended at any time by mutual agreement of the parties in writing. Either party may terminate the agreement or any parts thereof at any time by providing sixty (60) days notice.

This agreement consolidates DMAS-VDH agreements into one document. The agreements are organized into three discrete sections as follows:

Section I: Long-term Care Agreements
Section II: Business Associate Agreement and Data Projects
Section III: Maternal and Child Health Collaborative

This agreement complies with 42 CFR, Subpart M, Section 431.610 (f) regarding the requirement for a written agreement between the state Medicaid agency and the survey agency and with the requirements of 42 CFR, Subpart M, Section 431.615 (d) regarding arrangements between the state Medicaid agency and the state Title V grantee.

If monetary reimbursement is to be made for the performance of services described herein, DMAS will reimburse VDH by one of three methods identified below and defined in the Department of Accounts’ memorandum of May 20, 1998, entitled “Procedures for Identifying and Accounting for Transactions between State Agencies and Institutions.” The method of payment, if any, for each service covered by the Agreement is set forth in the relevant section.

VDH agrees to collect, record and maintain documentation and an audit trail that supports expenses related to carrying out the provisions of this Agreement. VDH shall bill DMAS via Interagency Transfer (IAT) for its monthly costs within forty-five (45) days of the close of each month. The IAT shall reflect the total expenditures incurred (i.e., both the
General and Non-general funds), the project number assigned to each service, and the services performed. Sufficient documentation in the form of accounting or ledger reports shall be submitted with the IAT to support the draw of federal monies. Any indirect costs included in the billings shall be supported by a federally approved cost allocation plan and shall be separately identified on the billing. If sufficient documentation is not presented with the IAT, DMAS shall return the IATR to VDH. Once sufficient documentation has been presented, DMAS will use its best efforts to process the IAT. If the Auditor of Public Accounts or other auditing agents question costs associated with billings by VDH, VDH shall be responsible for providing additional backup documentation and verification. VDH shall reimburse DMAS for any unsupported or disallowed costs. All requests for reimbursement shall be sent to:

Medicaid Grant Supervisor  
Fiscal Unit  
Department of Medical Assistance Services  
Suite 1300  
690 East Broad Street  
Richmond, Virginia 23219

The methods of payment shall be:

**Method 1 – Pass Through Transaction:**
Under this method, DMAS, acting in its capacity as the single state agency, will transfer only federal matching funds to VDH to reimburse VDH for the costs of rendering services to the Medicaid and SCHIP programs. VDH, rather than DMAS, holds the state appropriations from the General Assembly for both the General and Non-General Funds. Under this method, VDH is DMAS’ subrecipient.

DMAS shall:
- Record the transactions using Fund 1000, Transaction Code 497, GLA 989, CFDA number 93.778 and a project number as defined in the applicable section of this agreement;
- Report the pass through on the Schedule of Subrecipient under VDH; and
- Transfer funds from the Medicaid or SCHIP programs to VDH within 30 days of receipt of the IAT.

VDH shall:
- Record the expenditure using the appropriate subobject codes using Fund 1000, Transaction Code 116 and GLA 988;
- Report the expenditures on the Schedule of Pass Through Funds Received from Other Agencies; and Report to the DMAS Grant Supervisor prior to July 15 each fiscal year the total amount of funds transferred through subrecipient activity during the preceding fiscal year. If there are any discrepancies between DMAS and VDH calculations, the DMAS calculation shall be used for final filing of the Schedule of Federal Assistance.
Method 2 – Vendor Transaction:
Under this method, DMAS, acting in its capacity as the single state agency, will reimburse VDH for both the federal and state portions of qualifying expenditures related to services VDH has rendered to the Medicaid or SCHIP programs. DMAS holds the appropriation from the General Assembly.

DMAS shall:
- Record the transactions using Funds 0100 and 1000, Transaction Code 380, CFDA number 93.778, the appropriate subobject codes and a project number as defined in the applicable section of this agreement;
- Process the IAT within 30 days from the date of receipt of the IAT and supporting documentation; and
- Report the vendor expenditure on the Schedule of Federal Assistance under the Medicaid Grant.

VDH shall:
- Record the amount received as revenue under Revenue Source Code 03007, Sale of Good, or Services to State Entities.

Method 3 – Licensure and Certification:
As the designated State Survey Agency for Medicare/Medicaid by DHHS, VDH receives reimbursement directly from CMS for 75% of the total costs (the federal financial participation, or FFP) of Medicaid survey and certification activities. The remaining 25%, (Medicaid State Match) is the responsibility of VDH.

Method 4 – Claims Processing:
Under this method, DMAS acting in its capacity as the single state agency, will reimburse VDH, the State Survey Agency, for the federal match portion (75%) of qualifying expenditures related to completion of pre-admission screening services which VDH has rendered to DMAS. DMAS holds the General Fund appropriation for the Medicaid State Match from the General Assembly.

DMAS shall:
- Execute claims processing of general funds to reimburse VDH for the Medicaid pre-admission screenings submitted by each locality for processing.

VDH shall:
- Have localities submit completed pre-admission screening documentation for processing and adjudication by the Virginia Medicaid Management Information System (VaMMIS).
- Record DMAS’ transfer of the Medicaid State Match amount special fund revenue.

The VDH Budget Office shall submit budget estimates to the DMAS Budget Office for reimbursable activities included in this agreement so that DMAS may include the estimates in the Quarterly Reports furnished to CMS. Estimates shall be submitted to the
DMAS Budget Office no later than January 15, April 15, July 15, and October 15 of each year and shall cover the timeframes specified by CMS. A separate estimate shall be submitted for each service.

VDH shall submit annual budget estimates to the DMAS Budget Office, no later than September 1, for the Medicaid State Match for reimbursable activities included in this agreement, so that DMAS may include the estimates in requests for General Fund Appropriations from the General Assembly.

VDH and DMAS shall undertake an annual review of the intent and provisions of the responsibilities described herein. Each agency shall designate a senior staff individual to serve as its principal contact on questions that arise on these subjects and/or for initiating amendments to this agreement when they are required. The principal contact for each agency is designated as follows:

CONFIDENTIALITY:

- Each party acknowledges that ownership of any data provided by the other party under this agreement remains with the originating party and agrees to return the data to such party when the analysis/activity is completed;
- Each party agrees to use the other party’s data only for the analysis/activity described in each statement of work and for no other purposes unless the party first obtains written permission from the originating party;
- Each party agrees to ensure that access to the data will be limited to its direct employees (including student research assistants) actively engaged in projects and to the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, which administers the survey and certification and MDS/OASIS programs through interagency agreement with VDH; and
- Both parties agree to follow federal and state confidentiality requirements as set forth in 42 CFR Subpart 431.300 and pursuant to Section 32.1-352.3 of the Code of Virginia.

DATA SECURITY PLAN:

VDH agrees to work with the DMAS Division of Internal Audit and DMAS agrees to work with VDH to create a Data Security Plan governing the appropriate use of each agency’s respective data. Both agencies agree to abide by the federal Health Insurance Portability and Accountability Act (HIPAA) Guidelines.

IMPLEMENTATION:

In order to promote the implementation of the intent and provisions of the responsibilities described herein, each agency shall designate a senior staff individual to serve as their principal contact on questions that arise on these subjects and/or for initiation of amendments to this agreement when they are required. Amendments shall be in writing
and executed by signatures of both parties. The principal contact for each agency is designated as follows:

A) The Deputy Commissioner for Administration, Virginia Department of Health
B) The Deputy Director for Operation, Department of Medical Assistance Services

In witness of the foregoing, the parties have caused this agreement to be executed by the following duly authorized officials. Either party may substitute other individuals to serve as the principal contact for their agencies by giving written notice to the other party.

Department of Medical Assistance Services  Virginia Department of Health

Name/Title  Name/Title

Date  Date
Virginia Department of Medical Assistance Services and Virginia Department of Health
Interagency Agreement Components

Section 1: Long-Term Care (Melissa Fritzman)

Licensure and Certification
Pre-Admission Screenings
Assisted Living Facility (ALF) Assessments and Reassessments
Developmental Disabilities (DD) Waiver Screening Assessments

Section 2: Data Sharing (Kim Barnes)

HIPAA
Decedent
Eligibility
Lead Screening

Section 3: Program Collaborations (Alissa Nashwinder)

BabyCare
Children with Special Health Care Needs
Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)
Maternal Outreach (Resource Mothers) Program
Special Supplemental Food Program for Women, Infants, and Children (WIC)
Section I: Long-Term Care Agreements
Nursing Facility Licensure and Certification

**Federal Code Reference:** Title 32.1, Chapter 10, of the *Code of Virginia, 1950, as amended*, and through agreement with the U.S. Secretary of the Department of Health and Human Services (DHHS), to administer the *Virginia State Plan for Medical Assistance Services* and the provisions of Title XIX (Medicaid) of the *Social Security Act*.

The VDH is the official State Survey Agency designated by agreement with the Secretary of DHHS, under sections 1864(a) of the Title XVIII (Medicare) of the *Social Security Act* and section 32.1-137 of the *Code of Virginia, 1950, amended*.

**State Code and Plan Reference:** The VDH is the designated licensing agency responsible for carrying out provisions of Title 32.1, Chapter 5, Article 1 (Hospital and Nursing Home Licensure and Inspection), Article 2 (Rights and Responsibilities of Patients in Nursing Homes), Article 7 (Hospice Program Licensing) of the *Code of Virginia, 1950, as amended*, Article 7.1 (Home Care Organization Licensing) of the *Code of Virginia, 1950, as amended*, and the rules and regulations of the State Board of Health adopted from these statutes.

**DMAS Contact:** Long Term Care and Quality Assurance Division Director

**VDH Contact:** Deputy Commissioner for Administration

**Purpose:**

The purpose of this interagency agreement is to define the contractual responsibilities of the DMAS and the VDH, with respect to the execution of the federal survey and certification requirements, as well as clarify areas of collaboration related to state licensing requirements.

**Description:**

DMAS has contracted with VDH to execute the requirements relating to the on-site survey and certification of providers/suppliers participating in, or requesting participation in the Medicaid program.

**Planning and Coordination:**

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH's program plans and budgets. Similarly, actions of the Department of Health may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.
Responsibilities:

The Department of Medical Assistance Services shall:

- Promptly provide copies to the VDH (the State Survey Agency) of all changes, revisions, and interpretations in the State Plan or federal regulations that affect the certification of providers/suppliers in the Title XIX (Medicaid program, prior to the effective date of implementation;
- Promptly perform the functions required by federal statutes and regulations related to medical review, utilization review, and evaluation of the care of individual recipients for reimbursement purposes;
- Promptly forward to the VDH correspondence relating to approval of Medicaid agreements for each certified provider; correspondence and reports relating to the evaluation of appropriateness of care, medical review, and utilization review visits; and all materials for investigations of complaints on actions by Medicare/Medicaid providers/suppliers that affect the healthcare or life safety of Medicare/Medicaid patients;
- Participate in meetings, training sessions and joint on-site visits that are of mutual benefit to both agencies;
- Designate the Director, Long-Term Care and Quality Assurance Division, as the DMAS' liaison with the VDH for all matters relating to patient care; and
- Designate the Director, Program Operations Division, as the DMAS primary contact with the VDH for all matters relating to provider agreements and enrollment status of Medicaid providers/suppliers of services.

The Virginia Department of Health shall:

- Promptly forward to the DMAS required survey documents for each provider/supplier in the Title XIX (Medicaid) program, surveyed or re-surveyed;
- Promptly forward to the DMAS appropriate licensure and complaint information for Medicaid certified facilities;
- Participate in meetings, training sessions, and on-site visits that the VDH determines are of mutual benefit to both agencies; and
- Designate the Director, Center for Quality Health Care Services and Consumer Protection, as liaison with the DMAS for coordination of licensure and certification issues which affect both agencies.

Areas of Collaboration:

The Department of Medical Assistance Services and the Department of Health agree to:

- Confer regarding the status of nursing facilities and ICF/MR facilities that are out of compliance with Medicare/Medicaid certification requirements as often as necessary to assure timely communication;
• Furnish copies of nursing facility letters with attached survey reports, regarding the status of nursing facilities and ICF/MR facilities that are out of compliance with Medicare/Medicaid certification requirements;
• Work collaboratively to provide information to recipients and their families if a nursing facility or ICF/MR loses its Medicare and/or Medicaid certification. The VDH will be available to explain the survey results as needed to recipients and their families.
• Collaborate on any issues or problems that may arise concerning the effectiveness of this process;

Reimbursement:

As the designated State Survey Agency for Medicare/Medicaid by DHHS, VDH receives reimbursement directly from CMS for 75% of the total costs (the federal financial participation, or FFP) of Medicaid survey and certification activities. The remaining 25%, (Medicaid State Match) is the responsibility of VDH.
Pre-Admission Screenings

Federal Code Reference: Title 42 of the Code of Federal Regulations § 441.302(c)(1) requires a screening of all individuals who, at the time of application for admission to community-based care or an ICF/MR, are eligible for medical assistance.

State Code and Plan Reference: Section 32.1-330 of the Code of Virginia and the Virginia State Plan of Medical Assistance Services require the Department of Medical Assistance Services to evaluate all individuals who will be eligible for institutional or community-based care services to determine their need for nursing facility services as defined in the State Plan.

DMAS Contact: Long Term Care and Quality Assurance Division Director

VDH Contact: Deputy Commissioner for Community Health Services

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services are consistent with the statutory functions and the missions of the participating State departments.

Description:

The pre-admission screening evaluation is done in order to determine if the beneficiary does in fact require long-term care services and, if so, whether the provision of institutional services or community-based services represents the most appropriate response to current medical needs. The individual who is seeking nursing facility placement services, a family member, a physician, a community health services or social services professional or any other concerned individual in a community may initiate requests for pre-admission screening.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH's program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health-related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.
Responsibilities:

The Department of Medical Assistance Services shall:

- Require pursuant to the Code of Virginia, 1950, as amended, §32.1-330, a pre-admission screening of all individuals who, as the time of application for admission to community-based care or a certified nursing facility as defined in §32.1-123 of the Code of Virginia, are eligible for medical assistance or will become eligible within 180 days following admission;
- Require local or district pre-admission screening committees to be available to render decisions on applications to DMAS for admission to nursing facilities;
- Prepare, distribute and maintain a Medicaid Pre-Admission Screening Manual that describes current program procedures and criteria for conducting pre-admission screenings; and
- Provide training as required to ensure that all members of pre-admission screening committees are qualified to conduct the evaluations, and
- Authorize Medicaid reimbursement for institutional care or when more appropriate, alternate services that are available under one of the Medicaid home or community-based care waivers.

The Virginia Department of Health shall:

- Request the District Health Director in whose district the applicant resides to convene a local or district community screening committee in accordance with the requirements of the Medicaid Pre-Admission Screening Manual;
- Ensure that as a condition of payment for pre-admission screenings all local health department personnel who are assigned as members of pre-admission screening teams have been properly trained in the procedure for conducting such screenings;
- Determine the necessity for institutional care or when more appropriate, alternate services which are available under one of the Medicaid community-based care waivers in accordance with procedures and criteria specified by DMAS in the Medicaid Pre-Admission Screening Manual;
- Authorize Medicaid reimbursement for institutional care or when more appropriate, alternate services which are available under one of the Medicaid community-based care waivers in accordance with procedures and criteria specified by DMAS in the Medicaid Pre-Admission Screening Manual;
- Submit required forms, include but not limited to, (UAI, DMAS-96, DMAS-97, MI/MR, and DMAS-101A/B) to:

  First Health Services
  Post Office Box 85083
  Richmond, Virginia 23285-5083
• Inform the applicant, recipient or family member in writing of the decision rendered for authorization of Medicaid services and of the appeal process that is available.

Areas of Collaboration:

The Department of Medical Assistance Services and the Department of Health agree to:

• Collaborate on any issues or problems that may arise concerning the effectiveness of this process;
• Collaborate on various initiatives involving the implementation of Olmstead Recommendations and any other grants and initiatives concerning institutional or home and community-based services; and
• Collaborate to facilitate training as needed regarding new programs/services and existing programs available through the pre-admission screening process.

Reimbursement:

With the implementation of the new Virginia Medicaid Management Information System (MMIS), pre-admission screening packages are now treated as completed claims once all edits for eligibility and service provision have been satisfied.

Pre-admission screenings (which may result in a beneficiary being eligible for placement in a nursing facility, or a community-based care waiver program, or placement in an assisted living facility) shall be handled as claims transactions in accordance with procedures set forth in the basic agreement. DMAS will pay a total of $100 for each screening performed, 69% of which will be paid to VDH and 31% percent to DSS.
ALF Assessments and Reassessments

Federal Code Reference: Title 42 of the Code of Federal Regulations § 441.302(c)(1) requires a screening of all individuals who, at the time of application for admission to community based care or an ICF/MR are eligible for medical assistance.

State Code and Plan Reference: Section 32.1-330 of the Code of Virginia requires DMAS to evaluate all individuals who will be eligible for community or institutional long-term care services to determine their need for nursing facility services as defined in the State Plan.

DMAS Contact: Long Term Care and Quality Assurance Division Director

VDH Contact: Deputy Commissioner of Community Health Services

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

Evaluations are done to determine if the beneficiary does require long-term care services and if so, whether the provision of institutional services or community-based services represents the most appropriate response to current medical needs. Under certain circumstances placement of an individual in an Assisted Living Facilities (ALFs) may be an appropriate alternative to placement in an institutional setting.

There are currently two levels of care provided by ALFs in Virginia. They are:

- Residential Living, a level of care provided by an ALF for adults who may have physical or mental impairments and require only minimal assistance with the activities of daily living.
- Regular Assisted Living (RAL), a level of service provided by an ALF for adults who may have physical or mental impairments and require at least a moderate level of assistance with activities of daily living.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH's program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that
could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

The Department of Medical Assistance Services shall:

- Require pursuant to the Code of Virginia, §32.1-330, an Assisted Living Facilities (ALF) initial screening of all individuals who, at the time of application for admission to an assisted living facility as defined in §63.1-172 of the Code of Virginia, are eligible for medical assistance or will become eligible within 180 days following admission;
- Arrange for local or district ALF screening committees to be available to render decisions on applications to DMAS for admission to ALFs;
- Prepare, distribute and maintain a Medicaid Pre-Admission Screening Manual that describes current program procedures and criteria for conducting pre-admission screenings; and
- Provide training as required to ensure that all members of the ALF screening committees are qualified to conduct the evaluations.

The Virginia Department of Health shall:

- Request the District Health Director in whose district the applicant resides to convene a local or district community ALF screening committee in accordance with the requirements of the Medicaid Pre-Admission Screening Manual;
- Ensure that as a condition of payment for ALF screenings all local health department personnel who are assigned as members of the ALF screening teams have been properly trained in the procedures for conducting such screenings;
- Determine the necessity for ALF placement in accordance with procedures and criteria specified by DMAS in the Medicaid Pre-Admission Screening Manual;
- Authorize Medicaid reimbursement for ALF placement in accordance with procedures and criteria specified by DMAS in the Medicaid Pre-Admission Screening Manual;
- Submit required forms (UAI, DMAS-96, and when appropriate, the Eligibility Communication Document) to:

  First Health Services  
  Post Office Box 85083  
  Richmond, Virginia 23285-5083

- Inform the applicant, recipient, or family member in writing of the initial assessment decisions and subsequent reassessment decisions rendered for authorization of Medicaid services and of the appeal process that is available.
Areas of Collaboration:

The Department of Medical Assistance Services and the Department of Health agree to:

- Collaborate on any issues or problems that may arise concerning the effectiveness of this process;
- Collaborate on various initiatives involving the implementation of Olmstead Recommendations and any other grants and initiatives concerning institutional or home and community-based services; and
- Collaborate to facilitate training as needed regarding new programs/services and existing programs available through the pre-admission screening process.

Reimbursement:

VDH shall bill DMAS by initiating a completed pre-admission screening for ALF services. VDH shall bill DMAS by initiating a completed HCFA-1500 claim form for annual reassessments for ALF services.

The ALF assessment process involves an initial, a full reassessment, and a short reassessment and is conducted for all individuals who enter an ALF or regular assisted living. Payment for the initial assessment is $100; the payment for the full reassessment is $75; and the payment for the short assessment is $25.

Assisted Living Facility reassessments shall be handled as Vendor payments in accordance with the procedures set forth in the basic agreement. DMAS shall reimburse VDH $75 for each assessment performed using the long form and $25 for each assessment performed using the short form.
Developmental Disabilities Waiver Screening

Federal Code Reference: Title 42 of the Code of Federal Regulations § 441.302(c)(1) requires a screening of all individuals who, at the time of application for admission to community-based care or an ICF/MR are eligible for medical assistance.


DMAS Contact: Long Term Care and Quality Assurance Division Director

VDH Contact: Deputy Commissioner of Community Health Services

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

The Individual and Family Developmental Disabilities Support Waiver, known as the “DD Waiver,” is a Medicaid waiver that will provide home and community-based care services to Medicaid eligible individuals who would otherwise be eligible for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). This waiver is effective July 1, 2000. Individuals 6 years of age and older with a condition related to mental retardation, but who do not have a diagnosis of mental retardation, and who have been determined to require the level of care provided in an ICF/MR are eligible to receive services. Prior to becoming eligible, the Department of Medical Assistance Services (DMAS) requires that a screening be conducted to determine if the individual meets the diagnostic and functional requirements for admission to the waiver.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH’s program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.
Responsibilities:

The Department of Medical Assistance Services shall:

- Require a screening of all individuals who, at the time of application for admission to community-based care or an ICF/MR are eligible for medical assistance.
- Prepare, distribute, and maintain instructions and forms for waiver screenings.
- Provide training as required to ensure that individuals who conduct the screenings are qualified to conduct the evaluation.
- Provide an updated list of support coordinators.
- On a monthly basis, submit the names of individuals requesting to be screened for the DD Waiver to each clinic.
- Provide technical assistance to screening teams as issues arise.

The Virginia Department of Health shall:

- Ensure that as a condition of payment for all screenings all local health department/clinic personnel who are assigned as members of the screening team have been properly trained in the procedure for conducting such screenings;
- Determine the necessity for institutional care or when more appropriate, alternate services which are available under the DD Waiver in accordance with procedures and criteria specified by DMAS in the Individual and Family Developmental Disabilities Support Waiver Screening Team Resource Guide;
- Refer the individual to DMAS when institutional care is determined to be the appropriate service and the individual chooses institutional care in lieu of home and community-based services through the DD Waiver;
- If the applicant meets the criteria for institutional care and chooses DD Waiver services, provide the applicant with a list of available support coordinators and allow the applicant to choose the coordinator of his/her choice. Once the applicant chooses the coordinator, forward screening materials to the support coordinator;
- Inform the applicant, recipient or family member in writing of the decision rendered for authorization of Medicaid services and of the appeal process that is available; and
- Participate in the appeals process as needed if the applicant requesting the screening decides to appeal the screening decision.

Areas of Collaboration:

The Department of Medical Assistance Services and the Department of Health agree to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process; and
- Provide training as needed regarding screening process and the DD Waiver.
Reimbursement:

The Virginia Department of Health shall bill the Department of Medical Assistance Services by initiating an Interagency Transfer (IAT) and shall reference Project Code # 70082. A First Health Summary Report outlining the screenings performed that month shall support the IAT.

Screenings which may result in a beneficiary being eligible for placement in an ICF/MR or a community-based care waiver program, shall be handled as Pass Through Transactions in accordance with the procedures set forth in the basic agreement. DMAS will pay $300 ($350 in northern Virginia) for each screening performed.
Section II: Business Associate Agreement and Data Projects
MASTER INTERAGENCY / BUSINESS ASSOCIATE AGREEMENT
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

Federal Code Reference:

Title 45 of the Code of Federal Regulations, Parts 160 and 164, establishes standards for the privacy of individually identifiable health information. In addition, Title 42 of the Code of Federal Regulations (CFR 431.300 and Attachment 4.3A of the Virginia State Plan for Medical Assistance) contains requirements for safeguards for restricting the use or disclosure of information concerning Medicaid applicants and recipients.

DMAS Contact: DMAS Privacy Officer
VDH Contact: Director of HIPAA Compliance

Purpose:

This BUSINESS ASSOCIATE AGREEMENT (herein referred to as the “Agreement”) constitutes a non-exclusive agreement between the Covered Entity, which administers Medical Assistance, and the Virginia Department of Health (herein referred to as Business Associate”.

The Covered Entity and Business Associate, as defined in section 160.103 of the Final HIPAA Privacy Rule, have entered into this Business Associate Agreement to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Final Privacy regulation requirements for such an Agreement, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements. Parties shall fully comply with the provisions of the Regulations implementing HIPAA.

This Agreement will have Scope-of-Work Attachments relating to specific informational exchanges.

Covered Entity and Business Associate desire to facilitate the transfer of protected health information in agreed formats and to assure that such transactions comply with relevant laws and regulations.

Responsibilities:

The parties, intending to be legally bound, agree as follows:
I. Definitions.

As used in this contract, the terms below will have the following meanings:

a. Business Associate: A person or organization that performs a function or activity on behalf of the Covered Entity, but is not part of the Covered Entity's workforce. A business associate can also be a covered entity in its own right.

b. Covered Entity: Includes 1) All health care providers who transmit any health information electronically in connection with standard financial or administrative transactions, 2) All health plans, 3) All health care clearinghouses. Covered entities are accountable for PHI. Centers for Medicaid and Medicare Services (CMS) (formerly HCFA), Medicare + Choice and Medicaid State plans are also covered entities.

c. Provider: Any entity eligible to be enrolled and receive reimbursement through Covered Entity for any Medicaid-covered services.

d. MMIS: The Medicaid Management Information System, the computer system that is used to maintain recipient, provider, and claims data for administration of the Medicaid program. This system is currently managed under a contract with First Health Services Corp., which serves as Covered Entity’s fiscal agent.

Terms

The terms of this Agreement are outlined in the Scope-of-Work Attachments. The Scope-of-Work Attachments will define and delineate DMAS and Business Associate’s responsibilities under the conditions of this Agreement.

Special Provisions to General Conditions

1. Use and Disclosure of PHI

1.1 Use of PHI. Business Associate shall not use PHI otherwise than as expressly permitted by this Agreement, or as required by law. However, Business Associate may use PHI for purposes of managing its internal business processes relating to its functions under this Agreement. Business Associate shall be permitted to use and disclose PHI provided by Covered Entity as defined in the “Scope of Work Attachments”.

1.2 Disclosure to Third Parties. Business Associate shall ensure that any agents and subcontractors to whom it provides PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to Business Associate in this Contract. Covered Entity shall have the option to review and approve all such written agreements between Business Associate and its agents and subcontractors prior to their effectiveness.
1.3 Disclosure and Confidentiality. Business Associate must have a confidentiality agreement in place with individuals of its workforce who have access to PHI. A sample Authorized Workforce Confidentiality Agreement is included as Exhibit B. Issuing and maintaining these confidentiality agreements will be the responsibility of the Business Associate. Covered Entity shall have the option to inspect the maintenance of said confidentiality agreements.

1.4 Disclosure to workforce. Business Associate shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI, and who have signed an agreement to hold the information in confidence.

2. Safeguards

2.1 Safeguards. Business Associate shall implement and maintain appropriate safeguards to prevent the use and disclosure of PHI, other than as provided in this Contract. A description of such safeguards may be required of the Business Associate. Covered Entity’s approval of such safeguards and any of Business Associate’s measures to update or add safeguards during the Contract may be required. Upon reasonable request, Business Associate shall give Covered Entity access for inspection and copying to Business Associate’s facilities used for the maintenance or processing of PHI, and to its books, records, practices, policies and procedures concerning the use and disclosure of PHI, for the purpose of determining Business Associate’s compliance with this Agreement.

3. Accounting of Disclosures.

3.1 Accounting of Disclosures. Business Associate shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to, the date made, the name of the person or organization receiving the PHI, the recipient’s address, if known, a description of the PHI disclosed, and the reason for the disclosure). Business Associate shall, within thirty (30) days of Covered Entity’s request, make such log available to Covered Entity, as needed for Covered Entity to provide a proper accounting of disclosures to its patients.

3.2 Disclosure to U.S. Department of Health and Human Services (DHHS). Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) available to the Secretary of DHHS or its designee for purposes of determining Covered Entity’s compliance with HIPAA and with the Privacy Regulations issued pursuant thereto. Business Associate shall provide Covered Entity with copies of any information it has made available to DHHS under this section of this Contract.
4. Reporting

4.1 Reporting Violations. Business Associate shall report to Covered Entity within thirty (30) days of discovery, any use or disclosure of PHI made in violation of this Contract or any law. Business Associate shall implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Contract or the HIPAA privacy regulations. Business Associate shall, as requested by Covered Entity, take steps to mitigate any harmful effect of any such violation of this Contract.

5. Access and Amendment to PHI

5.1 Right of Access. Business Associate shall make an individual’s PHI available to Covered Entity within thirty (30) days of an individual’s request for such information as notified by Covered Entity.

5.2 Right of Amendment. Business Associate shall make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within thirty (30) days of notification by Covered Entity.

6. Termination

6.1 Termination. Covered Entity may immediately terminate this Contract if Covered Entity determines that Business Associate has violated a material term of this Contract. This Agreement shall remain in effect unless terminated for cause by Covered Entity with immediate effect, or until terminated by either party with not less than thirty (30) days prior written notice to the other party, which notice shall specify the effective date of the termination; provided, however, that any termination shall not affect the respective obligations or rights of the parties arising under any Documents or otherwise under this Agreement before the effective date of termination. Within thirty (30) days of expiration or earlier termination of this Contract, Business Associate shall return or destroy all PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form and retain no copies of such PHI. Business Associate shall provide a written certification that all such PHI has been returned or destroyed, whichever is deemed appropriate. If such return or destruction is infeasible, Business Associate shall use such PHI only for purposes that make such return or destruction infeasible and the provisions of this Contract shall survive with respect to such PHI.

7. Amendment

7.1 Amendment. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, Covered Entity may, by written notice to the Business Associate, amend this Agreement
in such manner as Covered Entity determines necessary to comply with such law or regulation. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within thirty (30) days of Covered Entity's notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, either of them may terminate this Agreement by written notice to the other.
Decedent Information
Scope of Work Attachment

Purpose:

The assignments as stated herein are intended to result in improved use of state government resources by providing for the sharing of official decedent data between the Virginia Department of Health (VDH) and the Virginia Department of Medical Assistance Services (DMAS).

Description:

In 1997 an audit test conducted by the DMAS Division of Internal Audit & Contract Evaluation determined that, because of untimely notice of recipient mortality, the Medicaid program was paying approximately $100,000.00 per annum in claims and capitation payment (primarily for pharmacy claims and to HMOs) for recipients who were deceased. Such payments require DMAS staff to attempt recoupment upon eventual DMAS receipt of official notice of death from the Virginia Department of Health. The recoupment of such monies can be difficult because recoupment sometimes starts many months after the original payment.

Statutory Reference:

§ 32.1-272 entitled “Certified copies of vital records; other copies” reads in part:
D. Other federal, state and local, public or private agencies in the conduct of their official duties may, upon request and payment of a reasonable fee, be furnished copies or other data from the system of vital records for statistical or administrative purposes upon such terms or conditions as may be prescribed by the Board. Such copies or other data shall not be used for purposes other than those for which they were requested unless so authorized by the State Registrar.

Responsibilities:

The Virginia Department of Medical Assistance Services shall:

- Provide a key contact within DMAS whose responsibility will be to ensure a secure data transfer process and establish proper data use safeguards.
- Use data for the purpose of verification of a recipients’ status on the Eligibility File and to check for payments made on behalf of deceased recipients either through error or as the result of fraudulent activities.
- Upon receipt of such data, DMAS will acknowledge the receipt of the information to VDH by e-mail.
The Virginia Department of Health shall:

- Provide a key contact within VDH, Office of Vital Records, whose responsibility will be to ensure a secure data transfer process and proper data use safeguards.
- Provide mortality data on a quarterly basis for all death reported during the prior six months.
- The data exchange will be initiated by VDH by sending a CD with data in Microsoft Excel format to DMAS by regular mail. The CD will be clearly labeled “Contains Confidential Protected Health Information”.
- The data will include all decedents for a period of six months and include the following data fields:
  
  Social Security Number  
  Name  
  Address  
  Date of birth  
  Sex  
  Date of death
Eligibility Information
Scope of Work Attachment

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources by providing for the sharing of official enrollment and eligibility data between the Virginia Department of Medical Assistance Services (DMAS) and the Virginia Department of Health (VDH).

Description:

Staff of the DMAS Division of Cost Settlement and Reimbursement provided VDH with an analysis of total denied claims from VDH operating units by specific reasons of denial for SFY 2000 and SFY 2001. This analysis was provided in order to furnish VDH with specific information that could lead to improvements in the billing processes thereby producing a cost savings to DMAS. The volume of VDH claims denied for payment from DMAS based on reasons related to accurate eligibility, led to the initiation of a basic efficiency and productivity survey of VDH operating units. The results of this survey document that: 1) VDH operating units devote considerable staff time to the acquisition of eligibility information that can only be garnered through a telephonic queuing process; 2) Mistakes are made in the billing process due to the lack of or inaccurate eligibility information; and 3) The VDH WebVision system, used by VDH operating units for billing purposes, can be easily modified to provide electronic on-line DMAS eligibility information.

Statutory Reference:

§ 32.1-127.1:04 requires the agencies of the Secretary of Health and Human Resources to establish a secure system for sharing protected health information that may be necessary for the coordination of prevention and control of disease, injury or disability.

Title 45 of the Code of Federal Regulation, Parts 160 and 164, establishes standards for the privacy of individually identifiable health information.

Responsibilities:

The Virginia Department of Medical Assistance Services shall:

- Provide a key contact within DMAS whose responsibility will be to ensure a secure data transfer process and proper data use safeguard.
- Provide VDH representative with selected Eligibility File data on a biweekly basis.
- DMAS will upload data to a secure state owned and operated Internet web site. The site and transfer software will meet all security and encryption standards required by both HIPAA and the Commonwealth.
The data provided will be in Microsoft Excel format and not HIPAA X12 standard transaction format.
The data will include all active Medicaid enrollees and contain the following data fields:

- Recipient ID number
- Recipient name
- Social Security Number
- Sex
- Date of birth
- Medicaid program enrolled in
- Beginning and end dates for current and previous two enrollment periods
- Third party payor to include type of insurance and policy number
- Policy effective begin and end dates
- HMO provider ID
- Lockin program provider and effective dates

The Virginia Department of Health shall:

- Provide a key contact within VDH whose responsibility will be to ensure a secure data transfer process and proper data use safeguard.
- Use the data only for the purpose of eligibility verification.
Childhood Lead Poisoning Prevention
Scope of Work Attachment

Federal Code Reference: (Title 42 of the Code of Federal Regulations (CFR), 440.40 (b) and 441, Subpart B)

State Code and Plan Reference: The Virginia EPSDT Program is a Medicaid Program that provides services for children as defined in Title 42 of the Code of Federal Regulations (CFR), 440.40 (b) and 441, Subpart B. In addition, §32.1-46.1 of the Code of Virginia requires blood-lead level testing at appropriate ages and frequencies when indicated as at risk.

DMAS Contact: Supervisor of Maternal and Child Health Services

VDH Contact: Supervisor, Lead Safe Virginia Program Lead-Safe Virginia Program Director

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

The Code of Virginia, section 32.1-46.1 requires all children determined to be at risk (which includes Medicaid eligible children) to be screened for elevated blood lead levels at the age of one year, at the age of two years, and between the ages of three and six years if never tested previously. All laboratories are required to report the results electronically within ten days to the Department of Health/Lead Safe Virginia Program. A statewide database for children screened for elevated lead levels has been established with the ability to provide timely data and statistics. In addition, lead poisoning is considered a reportable disease and completion of the Epi-1 Form is required for all positive test results.

Based on the Centers for Disease Control and Prevention (CDC) predictor model, Virginia ranks 14th among the 50 states in the estimated number of children with elevated blood lead levels. It is estimated that 13,800 children under the age of six have elevated blood levels. The purpose of this agreement is to forge an agency partnership working towards the elimination of lead poisoning in children under six years of age by the year 2010.
Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH’s program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

The Department of Medical Assistance Services shall:

- Develop an informational package that will include the a revised EPSDT Brochure to include current Virginia lead screening guidelines, Lead Screening Brochure and cover letter which will encourage participation in Well Child physician visits to be mailed to recipient households with children under six years of age that reside in high-risk zip code areas.
- Create a DMAS Web site hotlink to the Lead Safe Virginia Web site.
- Coordinate with the Lead-Safe Virginia Program for a data exchange of DMAS enrolled children under 6 years of age.
  - **Data Exchange Frequency**: The data exchange will occur quarterly for the periods July 1-September 30, October 1-December 31, January 1-March 31, and April 1-June 30. A summary year-end match will also occur to assure complete matching for Lead-Safe Virginia grant requirements.
  - **Data Exchange Media**: Transfer of data on a password protected CD will occur by regular mail or hand delivered. The CD carrier will clearly be labeled “Confidential”. The data provided by DMAS from the subsequent data match will include the following fields:
    - Child’s Last Name
    - Child’s First Name
    - Social Security Number if available
    - Street Address
    - City
    - State
    - ZIP Code
    - Race
    - Sex
    - Sample Type from billing if available
    - Medicaid Number

- **LeadTrax ID Number**

- DMAS will provide to VDH the total number of children enrolled by age categories of under 12 months, 12-23 months, 24-35 months and 36-72 months for each quarter above and also the annual number for each category. If possible
the counts should be broken down by ZIP Codes and/or FIPS Codes for screening rate evaluation.

- Using the data match, mail to providers of patients with Elevated Blood Lead (EBL) levels treatment inquiry letters if treatment claims are not submitted within 120 days of case identification.
- Participate in a Lead Poisoning Prevention workgroup that shall meet at a minimum of biannually to establish further joint initiatives and develop recommendations to the Joint Subcommittee Studying Lead Poisoning Prevention.
- Disseminate a provider memo regarding the proper and improper use of the Division of Consolidated Labs in regards to proper process of blood samples with collaborative input from the Lead-Safe Virginia Program.

The Virginia Department of Health shall:

- Provide semiannually a listing of high-risk ZIP Codes to facilitate targeted mailing efforts of informational brochures.
- Provide information on screening and testing patterns in relationship to high-risk ZIP Code areas. Coordinate with the DMAS for a data exchange of all children under 6 years of age screened for lead poisoning. The data provided by the Lead-Safe Virginia Program will include the following fields:
  - Child's Last Name
  - Child's First Name
  - Social Security Number if available
  - Street Address
  - City
  - State
  - ZIP Code
  - Sample Date
  - Lead Level
  - Sample Type
  - Date of Birth
  - Race
  - Sex
  - Lab Name
  - Test Reason
  - Date Analyzed
  - Medicaid Number
  - Provider Name
  - Provider Address if available

LeadTrax ID Number
- Create a VDH Web site hotlink to the DMAS Provider Information Web site.
- Participate in a Lead Poisoning Prevention workgroup that shall meet at a minimum of biannually to establish further joint initiatives and develop
recommendations to the Joint Subcommittee Studying Lead Poisoning Prevention.

Areas of Collaboration:

The Department of Medical Assistance Services and the Department of Health agree to:

- Collaborate in continued education and training initiatives for providers on lead testing and management protocols.
- Evaluate training initiatives by annual review of screening rates by high-risk ZIP Code.

Reimbursement:

There shall be no reimbursement to the Department of Health for services rendered in support of the administration of the EPSDT Program. Payment for medical services provided under the Medicaid and FAMIS Programs is made to local health departments who have provider agreements with DMAS and at rates established by DMAS. Reimbursement for these services shall be made via the DMAS claims submission and payment process.
Section III: Maternal and Child Health Collaborative
BabyCare

Federal Code Reference: The federal grants administration procedures detailed in Title 43 of the Code of Federal Regulations (CFR), part 74 and the provisions of Title 42 of the CFR 431.300 and Attachment 4.3A of the Virginia State Plan for Medical Assistance with regard to requirements for safeguards for restricting the use or disclosure of information concerning Medicaid applicants and recipients. Compliance with these requirements for such safeguards is recognized to be an obligation of each participating department during all handling and every exchange of information with any other parties concerning eligibility, income, and other personal data of Medicaid applicants and recipients and under all other circumstances and regulations on the privacy of individuals. Page 5240 of the State Medicaid Manual, which allows for cooperative agreements with other agencies for administrative functions such as outreach; and 42 CFR 433.15(b)(7), which provides for fifty (50) percent federal matching payment for activities the Secretary finds necessary for the efficient administration of the State Plan. Title V of the Social Security Act, Section 501 (42 USC 701) requires that the state agency administering the state’s program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.


DMAS Contact: Supervisor of Maternal and Child Health Services

VDH Contact: BabyCare Coordinator, Division of Women’s and Infant’s Health

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

In 1987 the Department of Medical Assistance Services, with the Departments of Health and Social Services developed a plan for care coordination and other expanded services called BABYCARE. The new services that BABYCARE provides for pregnant women include education in childbirth, smoking cessation, parenting, nutrition assessment, and counseling and homemaker services. BABYCARE also covers care coordination for pregnant women and infants who are identified by their physicians to be at high risk.
Such management is usually provided by a registered nurse or a social worker with experience in health care.

BABYCARE is a Medicaid Program that provides targeted case management services to high-risk pregnant women and infants (Maternal and Infant Care Coordination) and expanded prenatal services to assist recipients in gaining access to medical, social, educational and other services. In 1988, the Virginia General Assembly gave the Department of Medical Assistance Services authority to implement BABYCARE services as allowed by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Public Law 99-272).

BABYCARE services encompass:

1. Outreach or case finding and risk screening, which initiate the referral for services and identify a woman and infant as needing care coordination. Outreach is conducted through medical clinics, physicians’ offices, and hospitals. Plans are developed locally in conjunction with community partners.
2. Assessments and Service Planning, which is a process that outlines services and resources needed to meet the needs of the client and provides assistance in accessing resources.
3. Education and counseling or expanded prenatal services which include classes on smoking cessation, preparation for parenting and childbirth, nutritional counseling, and homemaker services.
4. Follow-up and monitoring to assess the ongoing progress and ensure that services are delivered through accurate record keeping.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) impacts other program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor can affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

The Department of Medical Assistance Services and the Virginia Department of Health shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process; and
- Provide training as needed regarding new programs or services and existing programs.
Responsibilities:

The responsibility for the administration of the BABYCARE program is a collaborative effort between the Department of Medical Assistance Services and the Virginia Department of Health.

The Department of Medical Assistance Services shall:

- Provide overall administration of the BABYCARE Program.
- Collect data and evaluate the effectiveness of the BABYCARE Program for pregnant women and children; maintain data for program evaluation and improvement.
- Manage and monitor Maternal and Infant Care Coordination providers in local health departments, private provider practices and in community and migrant health centers.
- Maintain the BABYCARE outreach and case management data tracking system and develop a data system for collecting and evaluating the Medicaid expansions for services to high-risk pregnant women and children.
- Maintain the BABYCARE Provider Manual and other policies, procedures, forms and instructional materials developed in conjunction with the Virginia Department of Health in response to federal and state statutory or regulatory requirements.
- Maintain the Virginia Medicaid Management Information System subsystem files so that they remain sufficient to accomplish BABYCARE claims processing, provider enrollment, and recipient enrollment.
- Authorize the Virginia Department of Health to apply to the federal Department of Health and Human Services for special grants or waivers or to any source of special funding as may be made available in the future for further development expansion of the Medicaid BABYCARE program.
- Develop and produce outreach and program orientation materials and oversee the implementation of outreach campaigns to encourage high-risk pregnant women and infants to apply for Medicaid coverage, and to refer recipients to participating Medicaid maternal and child health providers.

The Virginia Department of Health shall:

- Provide BABYCARE services in each health district where programs exist. This includes the identification of high-risk pregnant women, infants and children eligible to participate and to refer potential pregnant women and children to the Department of Social Services for eligibility determination.
- Ensure that all Medicaid eligible high-risk pregnant women and children who are identified to health departments and are receptive to receipt of BABYCARE services receive prenatal care including support services such as appointment scheduling, transportation assistance, assessment of health needs Risk Screns, expanded prenatal services and tracking and care coordination to ensure initiation and continuation of treatment for identified problems.
• Provide maternal and child health expertise in the development of outreach and educational materials such as brochures and public relation campaigns.
• Work in conjunction with DMAS to develop presentations to professional and community groups on maternal and child health issues that promote improved access to care.
• Establish and maintain working relationships with local Medicaid participating providers of pediatric and obstetric services to BABYCare Program eligible recipients.
• Develop standards and procedures for quality assurance for maternal and child health providers in cooperation with DMAS.
• Assure that all local health department staff working with pregnant women and children are aware of participating Medicaid providers for maternal and child health services.
• Encourage local health departments to develop partnerships with private maternal and child health providers to facilitate access to care for pregnant women and children and to assist in identifying high-risk clients.
• Provide clinical consultation and technical assistance to local health department professional staff in the development of health care standards, guidelines, and administrative procedures for providers in the delivery of prenatal and postpartum services.
• Recommend modifications, as appropriate, for the BABYCare subsystem of the Medicaid Management Information System to improve the quality of its reported statistical data and its responsiveness to user’s information needs.
• Support the Department of Medical Assistance Services’ efforts to obtain sufficient state appropriations to maintain provider reimbursement at a level that can assure that BABYCare services are as accessible to Medicaid recipients as they are to the general population.
• Designate a Virginia Department of Health BABYCare Program Manager who will provide program support and ascertain local health department BABYCare training needs as well as participate in any planning and implementation of training indicated.
• Follow the budgetary procedures presented in section E and section F of the ‘GENERAL’ statement at the beginning of this interagency agreement.

Areas of Collaboration:

The Department of Medical Assistance Services and the Virginia Department of Health shall:

• Develop materials to be included in the BABYCare Manual and other provider notices as may be required.
• Share data and participate in planning efforts to develop joint training to improve the delivery of services to high-risk pregnant women and children.
• Develop training and education programs for Medicaid providers, local professional staff, and recipients of BABYCare services.
• Keep each other apprised at all times of those services available to eligible individuals pursuant to federal law and state regulations and guidelines.

• Collaborate in the development of program objectives and outcome criteria including data needs in order to evaluate program effectiveness.

• Designate a liaison from their staff whose responsibilities shall include regular and periodic communication about programs and operations described in this agreement.

• Convene a study group to review BABYCare policies and procedures for documentation with the intent of program improvement.

Reimbursement:

There shall be no reimbursement to the Department of Health for services rendered in support of the administration of the BABYCare Program. Reimbursement for Maternal/Infant Care Case Management services shall be made to local health divisions who have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

VDH agrees to collect, record and maintain documentation and an audit trail that supports expenses related to carrying out the provisions of this Agreement.

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.
Children with Special Health Care Needs Program

**Federal Code Reference:** The federal grants administration procedures detailed in Title 43 of the Code of Federal Regulations (CFR), part 74 and the provisions of Title 42 of the CFR 431.300 and Attachment 4.3A of the Virginia State Plan for Medical Assistance with regard to requirements for safeguards for restricting the use or disclosure of information concerning Medicaid applicants and recipients. Compliance with these requirements for such safeguards is recognized to be an obligation of each participating department during all handling and every exchange of information with any other parties concerning eligibility, income, and other personal data of Medicaid applicants and recipients and under all other circumstances and regulations on the privacy of individuals. Page 5240 of the State Medicaid Manual, which allows for cooperative agreements with other agencies for administrative functions such as outreach; and 42 CFR 433.15(b)(7), which provides for fifty (50) percent federal matching payment for activities the Secretary finds necessary for the efficient administration of the State Plan. Title V of the Social Security Act, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

**State Code and Plan Reference:**

Section 32.1-77 of the Code of Virginia authorizes the Board of Health to prepare, amend, and submit to the appropriate federal authority, a state plan for maternal and child health services and children's specialty services pursuant to Title V of the United States Social Security Act and any amendments thereto. The Commissioner is authorized to administer such plans and to receive and expend federal funds.

Section 32.1-89 of the Code of Virginia authorizes the Board of Health to establish a program for the care and treatment of persons suffering from hemophilia and other related bleeding diseases.

Section 32.1-90 of the Code of Virginia authorizes the Board of Health to provide health services for persons suffering from epilepsy and cystic fibrosis.

**DMAS Contact:** Supervisor of Maternal and Child Health Services

**VDH Contact:** Director of Children with Special Health Care Needs Program

**Purpose:** The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the
provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

Special needs populations require more diverse and intense services than do individuals without special health care needs. This population includes children with special health care needs (CSHCN) who receive services through the health department’s CSHCN Program funded by Title V of the Social Security Act and state funds. CSHCN have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition(s) and who need health and related services of a type or amount over and above the usual for the child’s age. The CSHCN Program administers the Care Connection for Children Program, Child Development Services Program, and the Virginia Bleeding Disorders Program that serve these children.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) impacts other program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor can affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

The Department of Medical Assistance Services and the Virginia Department of Health shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process; and
- Provide training as needed regarding new programs or services and existing programs.
Responsibilities:

The Department of Medical Assistance shall:

- Collaborate and coordinate on an ongoing basis with VDH on CSHCN issues, share resources, and disseminate information of mutual interest.
- Provide an upper management liaison between DMAS and the Care Connection for Children (CCC) Inter-Center Work Group to:
  - Serve as a point of contact for regular communication between DMAS and CCC
  - Facilitate education so that CCC staff learns about Medicaid and FAMIS and DMAS staff learns about CCC
  - Participate in problem solving with CCC about CSHCN issues
  - Seek CCC input on DMAS policies related to CSHCN
  - Attend the CCC Inter-Center Work Group meeting a minimum of once per year

The Virginia Department of Health shall:

- Provide feedback to DMAS on the impact of managed care on CSHCN, managed care contracts, identification of CSHCN, quality assurance and other issues that impact CSHCN.
- Collaborate and coordinate on an ongoing basis with DMAS on CSHCN issues, share resources, and disseminate information of mutual interest.

Reimbursement:

Reimbursement for services shall be made to the Children with Special Health Care Needs Program and local health divisions who have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

VDH agrees to collect, record and maintain documentation and an audit trail that supports expenses related to carrying out the provisions of this Agreement.

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.
EPSDT

Federal Code Reference: The federal grants administration procedures detailed in Title 43 of the Code of Federal Regulations (CFR), part 74 and the provisions of Title 42 of the CFR 431.300 and Attachment 4.3A of the Virginia State Plan for Medical Assistance with regard to requirements for safeguards for restricting the use or disclosure of information concerning Medicaid applicants and recipients. Compliance with these requirements for such safeguards is recognized to be an obligation of each participating department during all handling and every exchange of information with any other parties concerning eligibility, income, and other personal data of Medicaid applicants and recipients and under all other circumstances and regulations on the privacy of individuals. Page 5240 of the State Medicaid Manual, which allows for cooperative agreements with other agencies for administrative functions such as outreach; and 42 CFR 433.15(b)(7), which provides for fifty (50) percent federal matching payment for activities the Secretary finds necessary for the efficient administration of the State Plan. Title V of the Social Security Act, Section 501 (42 USC 701) requires that the state agency administering the state’s program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:

DMAS Contact: Supervisor of Maternal and Child Health Services

VDH Contact: Policy Analyst, Office of Family Health Services

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

The Virginia EPSDT Program is a Medicaid Program that provides services for children as defined in Title 42 of the Code of Federal Regulations (CFR), 440.4O (b) and 441, Subpart B. These preventive health services encompass:

1. Screening and diagnostic services to determine physical or mental defects in recipients under age 21, and
2. Health care, treatment, and other necessary measures to correct or ameliorate any defects and chronic conditions discovered.
The administration of the EPSDT program is a collaborative effort among three state agencies: the Department of Medical Assistance Services, the Virginia Department of Health, and the Virginia Department of Social Services.

The Virginia EPSDT Program is a Medicaid Program that provides services for children as defined in Title 42 of the Code of Federal Regulations (CFR), 440.40(b), and 441, Subpart B. These preventive health services encompass:

1. Screening and diagnostic services to determine physical or mental defects in recipients under age 21 and
2. Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH’s program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

The Department of Medical Assistance Services shall:

- Consult with the Virginia Department of Health regarding recommendations for modifications to the EPSDT subsystem of the Medicaid Management Information System (VAMMIS). Should federal reporting requirements change, the Department of Medical Assistance Services will coordinate with the Department of Health in developing subsystem and data collection modifications that are necessary to meet new federal data requirements;
- Disseminate the EPSDT Supplement and other policies, procedures, forms, and instructional materials developed in conjunction with the Department of Health in response to federal and state statutory or regulatory requirements; DMAS no longer mails/distributes manuals.
- Maintain the VAMMIS EPSDT subsystem files so that they remain sufficient to accomplish EPSDT claims processing and report statistics required by the Centers for Medicare and Medicaid Services (CMS) and by other federal and state agencies.
- Authorize the Virginia Department of Health to apply to the federal Department of Health and Human Services for special grants or waivers or to any other source of special funding as may be made available in the future for further development and expansion of the Medicaid EPSDT program.
The Virginia Department of Health shall:

- Assign Virginia Department of Health Program Staff to survey, as needed, local coordinators to ascertain their training needs and participate in any planning and implementation of training indicated.
- Appoint EPSDT Coordinators at selected local health departments who shall be responsible for planning, promoting, and coordinating the delivery of EPSDT services, as well as attending, when requested, state sponsored EPSDT meetings.
- Maintain, in cooperation with the Department of Social Services and DMAS, the current EPSDT program information brochures and other materials that are needed to communicate information about and promote EPSDT to the target population;
- Recommend modifications, as appropriate, for the EPSDT subsystem of the VAMMIS to improve the quality of its reported statistical data and its responsiveness to users’ information needs.
- Support the Department of Medical Assistance Services’ efforts to obtain sufficient State appropriations to maintain physician reimbursement at a level that can assure that services are available to Medicaid recipients at least to the extent that those services are available to the general population.
- Collaborate with the Department of Medical Assistance Services and the Department of Social Services in the development of screening standards and procedure guidelines for EPSDT providers.
- Develop materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required.

Areas of Collaboration:

The Department of Medical Assistance Services and the Department of Health agree to:

- Collaborate in the development of screening standards and procedure guidelines for EPSDT providers.
- Collaborate with the Department of Social Services, Head Start, Early Intervention, Department of Education, and other appropriate organizations to increase the annual number of screenings statewide.
- Provide training and technical assistance on EPSDT policies/procedures to local Public Health personnel on an as needed basis.
- Share data pursuant to a properly executed Scope of Work under requirements of the Data Sharing component of the global agreement of which the current component is a part.

Reimbursement:

There shall be no reimbursement to the Department of Health for services rendered in support of the administration of the EPSDT Program. Payment for medical services provided under the Medicaid and FAMIS Programs is made to local health departments
who have provider agreements with DMAS and at rates established by DMAS. Reimbursement for these services shall be made via the DMAS claims submission and payment process.
Resource Mothers

Federal Code Reference: The federal grants administration procedures detailed in Title 43 of the Code of Federal Regulations (CFR), part 74 and the provisions of Title 42 of the CFR 431.300 and Attachment 4.3A of the Virginia State Plan for Medical Assistance with regard to requirements for safeguards for restricting the use or disclosure of information concerning Medicaid applicants and recipients. Compliance with these requirements for such safeguards is recognized to be an obligation of each participating department during all handling and every exchange of information with any other parties concerning eligibility, income, and other personal data of Medicaid applicants and recipients and under all other circumstances and regulations on the privacy of individuals. Page 5240 of the State Medicaid Manual, which allows for cooperative agreements with other agencies for administrative functions such as outreach; and 42 CFR 433.15(b)(7), which provides for fifty (50) percent federal matching payment for activities the Secretary finds necessary for the efficient administration of the State Plan. Title V of the Social Security Act, Section 501 (42 USC 701) requires that the state agency administering the state’s program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:

DMAS Contact: Supervisor of Maternal and Child Health Services

VDH Contact: Resource Mothers Program Coordinator, Division of Women’s and Infants’ Health

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

The Resource Mother Program is one of the programs of the Virginia Department of Health to reduce the Commonwealth’s infant mortality and low birth weight rates, to prevent school dropouts and repeat pregnancies, and to facilitate good health practices and utilization of health care services. While the current target population for the program is the teenager pregnant with her first child, some sites also serve other high-risk pregnant woman on a limited basis and through other funding sources. Services continue through the infant’s first birthday.
The Resource Mother program recruits laywomen from the community and provides them with intensive training to serve as a “resource mother” for pregnant and parenting teens. The resource mother becomes a support person for the teenager and her family and, through a plan of scheduled home visits, carries out the following duties:

- Identifying pregnant teenagers and getting them into prenatal care early.
- Assisting teenagers in obtaining Medicaid, WIC, family planning, education, and other community services.
- Ensuring that teenagers and infants keep health care appointments by providing help with arranging for transportation and babysitting if needed.
- Reinforcing recommendations of health care providers and giving basic health information and advice in areas such as physical activity, nutrition, avoidance of smoking, drugs, and alcohol, infant development and infant care.
- Promoting a family-centered approach to maternal and child health services that encourages participation of the teenager’s family and the infant’s father.

The Department of Medical Assistance Services and the Virginia Department of Health agree that the Resource Mother Program serves as a vehicle for expanding maternal outreach efforts as a service under Medicaid.

Planning, Coordination, and Collaboration:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH’s program plans and budgets. Similarly, actions of the Department of Health to offer health care services to the poor may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to:

- Coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency.
- Consider responses concerning potential impacts before changes are adopted.
- Provide training as required to ensure that all members are qualified to conduct the evaluations.

The Department of Medical Assistance Services and the Virginia Department of Health shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process.
- Provide training as needed regarding new programs or services and existing programs.
- Develop program objectives and outcome criteria in order to evaluate program effectiveness.
- Take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS
or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

- Promote the implementation of the intent and provisions of the responsibilities, herein described, by the designation of a senior staff individual to serve as the principal contact for each department on questions that arise on these subjects and/or for initiating amendments to this agreement when required. Amendments shall be in writing and executed by signatures of both parties.
- Participate in meetings, training sessions, and joint on-site visits that are of mutual benefit to both agencies.

Programmatic Responsibilities:

The Department of Medical Assistance Services shall:

- Claim as an administrative expense in Federal reports the cost of the Resource Mothers Program from the Medicaid Grant in accordance with federal regulations and grant procedures.
- Keep abreast of federal regulations, policies, or directives that may affect the program.
- Designate a staff member to serve as DMAS' liaison for the Resource Mother Program.
- Up to the dollar limit set forth herein and subject to available appropriations, reimburse the Virginia Department of Health for the Federal share of the cost of the Maternal Outreach Program via Interagency Transfer invoice prepared by Virginia Department of Health within thirty (30) calendar days of receipt of the billing invoice.
- Track Maternal Outreach Program expenditures and prepare a report quarterly for the Virginia Department of Health of the expenditures against allotted funds to ensure that expenditures do not exceed appropriations.

The Virginia Department of Health shall:

- Ensure that qualified resource mothers are recruited as necessary to meet program needs.
- Ensure that newly hired resource mothers receive appropriate training in prenatal care, health-related topics, infant development, parenting, communication skills, and community resources. A Major objective of the training program must be a thorough familiarization with Medicaid programs, with special emphasis on the application process and covered services.
- Provide program consultation and technical assistance to the program sites.
- Evaluate the program through site visits, reports, and statistical reviews and provide a copy of this evaluation to the Department of Medical Assistance Services. The evaluation should include any comparative statistics that show the impact of the program.
- Provide to the Department of Medical Assistance Services not later than thirty (30) days after the end of each calendar quarter a report that specifies for the quarter:
  - The number of pregnant teenagers entering the program.
  - The number of infants entering the program.
  - The percent of teenagers entering program on first trimester of pregnancy.
  - Give credit to the role of Title XIX funding in the Program in any statements, press releases, requests for proposal, bid solicitations, educational materials, educational sessions or conferences prepared by the Department of Health on activities resulting from this agreement.
- Provide to the Department of Medical Assistance Services not later than forty-five (45) days after the end of each state fiscal year, a summary report to Department of Medical Assistance Services describing the population served and program outcomes during that fiscal year. The report should include an assessment of unmet needs, the number of participants on Medicaid, the number of infant deaths, the number of low-weight births, and the number and percent of postpartum teenagers returning to school.
- Maintain personnel, expenditure, and other fiscal records necessary to document the use of funds and its performance of responsibilities under the agreement, and make such records available to federal officials or Department of Medical Assistance Services staff on request. Documented expenditures allowable as Medicaid administrative expenditures as part of the Resource Mothers Program include:
  - Coordinators’ salaries and benefits
  - Resource mothers’ wages
  - Coordinators’ training costs
  - Travel/transportation - coordinators and resource mothers
  - Telephone charges
  - Program educational supplies
  - Brochures and posters
  - Teenage group activities
  - Recognition ceremonies
  - Mailing expenditures

- Limit Resource Mother Program expenditures during each State Fiscal Year to the amount appropriated in the annual Appropriation Act.

Reimbursement:

The Virginia Department of Health will follow the budgetary procedures as specified in sections B and F and the GENERAL statement at the beginning of this interagency agreement as appropriate for this appendix.

VDH agrees to collect, record and maintain documentation and an audit trail that supports expenses related to carrying out the provisions of this Agreement. VDH shall bill DMAS
via Interagency Transfer (IAT) for its monthly costs within forty-live (45) days of the close of each month. The IAT shall reflect the total computable expenditures incurred (i.e., both the General and non-general funds, even though DMAS will only be requested to transfer the Federal share), the project number assigned to each (as set forth in the applicable Appendix), and the services performed. Sufficient, adequate documentation in the form of accounting or ledger reports shall be submitted with the IAT to support the draw of federal monies. Any indirect costs included in the billings shall be supported by a federally approved cost allocation plan and shall be separately identified on the billing. If sufficient documentation is not presented with the IAT, DMAS shall return the IAT to VDH.

If the Auditor of Public Accounts or other auditing agents question costs associated with billings by VDH, VDH shall be responsible for providing additional backup and verification. VDH shall reimburse DMAS for any unsupported or disallowed costs. Under this method, DMAS, acting in its capacity as the single state agency, will transfer federal matching funds only to VDH to reimburse VDH for the costs of rendering services for Medicaid and FAMIS programs. VDH, rather than DMAS, holds the state appropriations from the General Assembly for both the general and non-general funds. Under this method, VDH is DMAS’ Subrecipient.

DMAS shall:

- Record the transactions using Fund 1000, Transaction Code 497. GLA 989, CFDA number #93.778 (93.767 for FAMIS) and a project number set forth in the applicable Appendix to this agreement (70072).
- Report the pass through on the Schedule of subrecipient under VDH.
- Transfer funds from the Medicaid or FAMIS programs to VDH within 30 days of receipt of the IAT.
- Process the IAT within 30 days from date of receipt of the IAT and supporting documentation.
- Report the vendor expenditure on the Schedule of Federal Assistance under the Medicaid Grant. (VDH will not have to report the expenditure on any year-end federal schedules.)

VDH shall:

- Record the amount received as revenue under Revenue Source Code 03007, Sale of Goods, or Services to State Entities.
- Record the expenditure using the appropriate subobject codes using Fund 1000, Transaction Code 116, and GLA 988;
- Report the expenditures on the Schedule of Pass-Through Funds Received from Other Agencies;
- Report to the DMAS Grant Supervisor prior to July 15 each fiscal year the total amount of funds transferred through subrecipient activity during the preceding fiscal year. If there are any discrepancies between DMAS and VDH calculations,
the DMAS calculation shall be used for final filing of the Schedule of Federal Assistance.

- Record the transactions using Funds 0100 and 1000, Transaction Code 380, CFDA number #93378, the appropriate subobject codes, and a project number set forth in the applicable Appendix to this agreement.

Under this method, DMAS, acting in its capacity as the single state agency, will reimburse VDH for the Federal portion of qualifying expenditures related to services VDH has rendered to the Medicaid or FAMIS programs. VDH holds the appropriation from the General Assembly.

Budget Estimates:

The VDH Budget Office shall submit budget estimates to the DMAS Budget Office for reimbursable activities included in this agreement so that DMAS may include the estimates in the Quarterly CMS-37 Reports furnished to the Centers for Medicare and Medicaid (CMS). Estimates shall be submitted to the DMAS Budget Office no later than January 15, April 15, July 15, and October 15 of each year and shall cover the timeframes specified by CMS. A separate estimate shall be submitted for each service. By separate correspondence DMAS and VDH shall designate contacts within their respective Budget Offices to coordinate the preparation and transmittal of the estimates.
WIC

**Federal Code Reference:** The federal grants administration procedures detailed in Title 43 of the Code of Federal Regulations, part 74 and the provisions of Title 42 of the Code of Federal Regulations (CFR) 431.300

**State Code Reference:** 12VAC30-10-770. Required coordination between the Medicaid and WIC Programs.

**State Plan Reference:** The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with §1902(a)(53) of the Act.

**DMAS Contact:** Coordinator of Maternal and Child Health Services

**VDH Contact:** Policy Analyst, Division of WIC and Community Nutrition Services

**Purpose:**

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources, more effective service delivery, and improved and documented outcomes by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State agencies.

**Description:**

The Omnibus Budget Reconciliation Act of 1989 mandated the coordination and referral of services with the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Program and other maternal and child health programs. Through the EPSDT program administered by the Virginia Department of Medical Assistance Services, children from birth through 20 years of age may receive medically necessary services identified through screening exams conducted by a medical professional. The WIC program provides low income pregnant, postpartum, and breastfeeding women, infants and children up to their fifth birthday with nutritious supplemental food, infant formula, and nutrition education.

**Scope of Services:**

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH’s program plans and budgets. Similarly, actions of the Department of Health to offer health care services to low income individuals may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.
Responsibilities:

The Department of Medical Assistance Services shall:

This section of the MOA is currently under negotiation and will be added at a later date as an addendum: