STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

Citation	Condition or Requirement
§1932(a)(1)(A)	A. Section 1932(a)(1)(A) of the *Social Security Act*.
	The state of **Virginia** enrolls Medicaid beneficiaries on a voluntary basis into
	managed care entities (managed care organizations (MCOs)
	in the absence of § 1115 or § 1915(b) waiver authority.
	This authority is granted under § 1932(a)(1)(A) of the *Social Security Act*
	(the *Act*). Under this authority, a state can amend its Medicaid state plan to require
	certain categories of Medicaid beneficiaries to enroll in managed care entities without
	being out of compliance with provisions of § 1902 of the *Act* on statewideness
	(42 CFR 431.51) or comparability (42 CFR 440.230).
	This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health
	Plans (PHIPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to
	Mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who
	are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or
	who meet certain categories of "special needs" beneficiaries (see D.2.iii. – vii.
	below).
	B. General Description of the Program and Public Process.
	For B.1 and B.2, place a check mark on any or all that apply.
§ 1932(a)(1)(B)	1. The State will contract with an
§ 1932(a)(1)(B)(ii)	
42CFR 438.50(b)(1)	**X** i. MCO
	ii. PCCM (including capitated PCCMs that qualify as PAHPs)
	iii. Both
42CFR 438.50(b)(2)	2. The payment method to the contracting entity will be:
42CFR 438.50(b)(3)	
	i. fee for service
	X ii. Capitation
	iii. A case management fee
	iv. a bonus/incentive payment
	v. a supplemental payment
	vi. other. (provide description)
1905(t)	3. For states that pay a PCCM on a fee-for-service basis, incentive
42CFR 440.168	payments are permitted as an enhancement to the PCCM's case management fee,
42 CFR 438.6(c)(5)(iii)(iv)	if certain conditions are met.
	If applicable to this state plan, place a check mark to affirm the state has met ***all***

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	Of the following conditions (which are identical to the risk incentive rules for
	Managed care contracts published in 42 CFR 438.6(c)(5)(iv).
	_____ i. Incentive payment to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
	_____ii. Incentives will be based upon specific activities and targets
	_____iii. Incentives will be based on a fixed period of time
	_____ iv. Incentives will not be renewed automatically
	_____v. Incentives will be made available to both public and private PCCMS
	_____vi. Incentives will not be conditioned on intergovernmental transfer agreements
	___**X**__vii. Not applicable to this 1932 state plan amendment.
42CFR438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.
	• **The Department of Medical Assistance (DMAS) convened several public stakeholder meetings. Meetings were held in March 2012 and July 2012. Approximately 200 stakeholders attended the March meeting and approximately 80 stakeholders attended the July meeting. During these meetings, stakeholders learned about the Demonstration and were given the opportunity to provide recommendations and suggestions on the design. Examples include nursing facility parameters (inclusion of any willing provider, Medicaid fee for service payment as the floor for MCO paynment); use of the long-term care state ombudsman program to serve as the ombudsman for the Demonstration; inclusion of Roanoke as a region; and, the exclusion of Medicaid-funded hospice services within the capitated payment.** • **DMAS considered these recommendations and suggestions and incorporated many of them into the DMAS Demonstration proposal that was submitted to CMS on May 31, 2012 (e.g., the need for "high touch" care coordination, 24/7 call lines, maintaining relationships with current providers, etc.).** • **DMAS submitted its Demonstration proposal to the Centers for Medicare & Medicaid Services (CMS) on May 31, 2012 following the two public notice requirements (30 days by the state and 30 days by CMS).** • **DMAS established an Advisory Committee pursuant to a directive in the 2012 Appropriations Act (Item 307 RR.g). Advisory Committee meetings began in November 2012 and will continue on a quarterly basis throughout the Demonstration.** • **DMAS is working with the Advisory Committee to develop program design elements that will assist DMAS with ensuring MCOs will be able to meet the needs of dual eligible individuals. This includes the development of several**

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	vignettes which will be used in the Request for Application and will include the development of education and outreach materials. • **DMAS staff has met, and continues to meet, with provider and advocacy groups on an on-going basis.** • **DMAS created a dedicated website and e-mail address (dualintegration@dmas.virginia.gov).** • **DMAS will continue to convene on-going stakeholder meetings and trainings during the Demonstration's initial implementation. Furthermore, DMAS will consult with the Advisory Committee on an on-going basis during the Demonstration's initial implementation.**
§ 1932(a)(1)(A)	5. The state program will ___/will not __**X**_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___/voluntary __**X**__enrollment will be implemented in the following county/area(s):
	_____ i. county/counties (mandatory)_____
	___**X**__ ii. county/counties (voluntary) **See attachment.**
	_____iii. area/areas (mandatory)
	_____ i. area/areas (voluntary)
	C. State Assurances and Compliance with the Statute and Regulations.
	If applicable to the state plan, place a checkmark to affirm that compliance with
	The following statutes and regulations are met.
§1932(a)(1)(A)(i)(I)	1. ___**X**__ The state assures that all of the applicable requirements of
§1903(m)	§1903(m) of the *Act*, for MCOs and MCO contracts will be met.
42 CFR 438.50(c)(1)	
1932(a)(1)(A)(i)(1)	2. __**N/A**___ The state assures that all the applicable requirements of §1905(t) of the *Act* for PCCMS and PCCM contracts will be met.
1905(t)	
42 CFR 438.50(c)(2)	
1902(a)(23)(A)	
1932(a)(1)(A)	3. __**X**___ The state assures that all the applicable requirements of § 1932 (including subpart (a)(1)(A)) of the *Act*, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
42 CFR 438.50(c)(3)	
1932(a)(1)(A)	4. ___**X**__ The state assures that all the applicable requirements of 42 CFR 431.51
42 CFR 431.51	regarding freedom of choice for family planning services and supplies as
1905(a)(4)(C)	defined in § 1905(a)(4)(C) will be met.

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1932(a)(1)(A)	5. __**X**__ The state assures that all applicable managed care requirements of
42 CFR 438	42 CFR Part 438 for MCOs and PCCMs will be met.
42 CFR 438.50(c)(4)	**Note: Under the Demonstration, enrollees can opt out at any time with or without cause.**
1903(m)	
1932(a)(1)(A)	6. __**X**__ The state assures that all applicable requirements of 42 CFR 438.6(c)
42 CFR 438.6(c)	for payments under any risk contracts will be met.
42 CFR 438.50(c)(6)	
1932(a)(1)(A)	7. __**N/A**__ The state assures that all applicable requirements of 42 CFR 447.362
42 CFR 447.362	For payments under any nonrisk contracts will be met.
42 CFR 438.50(c)(6)	
45 CFR 74.40	8. __**X**__ The state assures that all applicable requirements of 45 CFR 92.36
	for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.
	N/A – no groups will be enrolled on a mandatory basis.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR438.50
	Use a check mark to affirm if there is voluntary enrollment of any of the
	following mandatory exempt groups.
1932(a)(2)(B)	i. __**x**__ Recipients who are also eligible for Medicare. If enrollment is
42 CFR 438(d)(1)	voluntary, describe the circumstances of enrollment.
	Enrollment in the Demonstration will be voluntary. Full-benefit dual eligible individuals age 21 and over who are eligible for the Demonstration will be passively enrolled in the Demonstration. Individuals will be given 60 days to opt out before they are passively enrolled into a managed care organization (MCO). MCOs must pass readiness reviews prior to enrolling beneficiaries. Individuals will be allowed to change MCOs or opt out of the Demonstration and return to fee-for-service at any time. Individuals will also be able to re-enroll at any time; however, there will be two (2) exceptions to this rule. The exceptions include: • **Individuals who are in hospice will be excluded from enrolling in the Demonstration entirely. If an individual is in the Demonstration and then enters hospice, he/she will be disenrolled entirely from the Demonstration; and,** • **Individuals who receive the Medicare end stage renal disease (ESRD) benefit after enrolling in the Demonstration can remain in**

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Citation	Condition or Requirement
	the Demonstration. However, if the individual opts out of the Demonstration, he/she will not be allowed to opt back into the Demonstration.
1932(a)(2)(C)	ii. **N/A** Indians who are members of Federally recognized Tribes except
42 CFR 438(d)(2)	When the MCO or PCCM is operated by the Indian Health Service or an Indian Health
	program operating under a contract, grant or cooperative agreement with the Indian
	Health Service pursuant to the Indian Self Determination Act; or an Urban Indian
	program operating under a contract or grant with the Indian Health Service
	pursuant to Title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i)	iii. **N/A** Children under the age of 19 years, who are eligible for
42 CFR 438.50(d)(3)(i)	Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii)	iv. **N/A** Children under the age of 19 years who are eligible under
42 CFR 438.50(d)(3)(ii)	1902(e)(3) of the *Act*.
1932(a)(2)(A)(v)	v. **N/A** Children under the age of 19 years who are in foster care of other
42 CFR 438.50(3)(iii)	out-of-the-home placement.
1932(a)(2)(A)(iv)	vi. **N/A** Children under the age of 19 years who are receiving foster
42 CFR 438.50(3)(iv)	care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii)	vii. **N/A** Children under the age of 19 years who are receiving services
42 CFR 438.50(3)(v)	through a family-centered, community based, coordinated care
	system that receives grant funds under § 501(a)(1)(D) of title V,
	and is defined by the state in terms of either program participation or
	special health care needs.
	E. Identification of Mandatory Exempt Groups
1932(a)(2)	1. Describe how the state defines children who receive services that are
42 CFR 438.50(d)	funded under § 501(a)(1)(D) of title V.
	N/A-Individuals less than 21 years of age will be excluded from the Dual Eligible Financial Alignment Demonstration (FAD).
	2. Place a check mark to affirm if the state's definition of title V children
	is determined by:
	____ i. program participation
	____ ii. Special health care needs, or
	____ iii. Both
	N/A-Individuals less than 21 years of age will be excluded from the FAD.

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	3. Place a check mark to affirm if the scope of these title V services
	is received through a family-centered, community-based, coordinated
	care system.
	N/A-Individuals less than 21 years of age will be excluded from the FAD.
	____ i. yes
	____ ii. No
1932(a)(2)	4. Describe how the state identifies the following groups of children who
	Are exempt from mandatory enrollment:
	N/A-Individuals less than 21 years of age will be excluded from the FAD.
	i. children under 19 years of age who are eligible for SSI under title
	XVI;
	N/A-Individuals less than 21 years of age will be excluded from the FAD.
	ii. Children under 19 years of age who are eligible under § 1902(e)(3)
	of the *Act*;
	N/A-Individuals less than 21 years of age will be excluded from the FAD.
	iii. Children under 19 years of age who are in foster care or other
	out-of-home placement;
	N/A-Individuals less than 21 years of age will be excluded from the FAD.
	iv. Children under 19 years of age who are receiving foster care or
	adoption assistance.
	N/A-Individuals less than 21 years of age will be excluded from the FAD.
1932(a)(2)	5. Describe the state's process for allowing children to request an exemption
42 CFR 438.50(d)	From mandatory enrollment based on the special needs criteria as defined
	In the state plan if they are not initially identified as exempt.
	N/A-Individuals less than 21 years of age will be excluded from the FAD.
1932(a)(2)	6. Describe how the state identifies the following groups who are exempt from
	mandatory enrollment into managed care:
	i. Recipients who are also eligible for Medicare.
	Only full-benefit dual eligible individuals will be eligible for the Demonstration (these individuals are included in the Virginia Administrative Code as "Qualified Medicare Beneficiaries (QMB) Plus."). DMAS identifies full benefit dual eligible individuals based on their benefit package; individuals eligible for Medicare Parts A, B and D and full Medicaid benefits.
	ii. Indians who are members of Federally recognized Tribes except
	when the MCO or PCCM is operated by the Indian Health Service or an
	Indian Health program operating under a contract, grant, or cooperative

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	agreement with the Indian Health Service pursuant to the Indian Self
	Determination Act; or an Urban Indian program operating under a
	contract or grant with the Indian Health Service pursuant to title V of
	the Indian Health Care Improvement Act.
	N/A. There are no Federally recognized American Indian tribes in Virginia.
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt
	from mandatory enrollment.
	There will no mandatory enrollment under the Demonstration. Enrollment in the Demonstration will be voluntary. Full-benefit dual eligible individuals age 21 and over who are eligible for the Demonstration will be passively enrolled and will be given the option of opting-out of the Demonstration. Individuals will be given 60 days to opt out before they are passively enrolled into a managed care organization (MCO). MCOs must pass readiness reviews prior to enrolling beneficiaries. Individuals will be allowed to change MCOs or opt out of the Demonstration and return to fee-for-service at any time (individuals not specified above in response to Section D.2.i will also be able to re-enroll at any time).
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary
	basis.
	Individuals age 21 and over who are enrolled in Medicare Parts A, B and D and full-benefit Medicaid ("full-benefit dual eligible individuals"), including those enrolled in the Elderly or Disabled with Consumer Direction (EDCD) home-and-community-based waiver and those residing in nursing facilities will be permitted to enroll on a voluntary basis.
	H. Enrollment process.
1932(a)(4)	1. Definitions
42 CFR 438.50	
	i. An existing provider-recipient relationship is one in which the
	provider was the main source of Medicaid services for the recipient
	during the previous year. This may be established through state
	records of previous managed care enrollment or fee-for-service
	experience, or through contact with the recipient.
	ii. A provider is considered to have "traditionally served" Medicaid
	Recipients if it has experience in serving the Medicaid population.
	2. State process for enrollment by default.
	Describe how the state's default enrollment process will preserve:
	i. the existing provider-recipient relationship (as defined in H.1.i)

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	Virginia will use a pre-assignment algorithm through its MMIS and an enrollment broker to facilitate the continuity of care of Medicaid recipients by providers that have traditionally served this population.
	ii. the relationship with providers that have traditionally served
	Medicaid recipients (as defined in H.2.ii)
	Virginia will use a pre-assignment algorithm through its MMIS and an enrollment broker to facilitate the continuity of care of Medicaid recipients by providers that have traditionally served this population.
	iii. the equitable distribution of Medicaid recipients among qualified
	MCOs available to enroll them, (excluding those that are
	subject to intermediate sanction described in 42 CFR 438.702(a)(4));
	and disenrollment for cause in accordance with 42 CFR 438.56(d)(2).
	An enrollment broker facilitates the continuity of care of Medicaid recipients by providers that have traditionally served this population and is responsible for an equitable distribution of enrollment.
1932(a)(4)	3. As part of the state's discussion on the default enrollment process, include the
42 CFR 438.50	following information:
	i. The state will ___/**will not** **_X_** use a lock-in for managed care.
	ii. The time frame for recipients to choose a health plan before being
	automatically assigned will be __**60 days**_____.
	iii. Describe the state's process for notifying Medicaid recipients of
	their auto-assignment.
	Eligible individuals will receive a notice that indicates what managed care organization (MCO) they have been assigned to. The notice will have instructions for the individual to contact DMAS' contracted enrollment broker to (1) accept the pre-assigned MCO; (2) select a different MCO that is operating in their region; or, (3) to opt out of the Demonstration altogether and stay in the fee-for-service environment. If an individual does not select an MCO, he/she will be passively enrolled into the pre-assigned MCO.
	iv. Describe the state's process for notifying the Medicaid recipients
	who are auto-assigned of their right to disenroll without cause during the
	first 90 days of their enrollment.
	This will not apply under the Demonstration. Under the Demonstration, individuals can switch MCOs or opt out and return to the fee-for-service environment at any time.

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Citation	Condition or Requirement
	v. Describe the default assignment algorithm used for auto-assignment.
	Enrollees will be assigned to an MCO based on claims going back six (6) months prior to pre-assignment using the rules below in order of priority: • **Individuals in a nursing facility will be pre-assigned to anMCO that includes the individual's nursing facility in its provider network;** • **Individuals in the EDCD Waiver will be assigned to an MCO that includes the individual's current adult day health care provider in its provider network;** • **If more than one MCO network includes the nursing facility or personal care provider used by an individual, they will be assigned to the MCO with which they have previously been assigned in the past six (6) months. If they have no history of previous MCO assignment, they will be randomly assigned to an MCO in which their provider participates.** • **Individuals will be pre-assigned to an MCO (search for Medicare and then Medicaid MCO) with whom they have previously been assigned within the past six (6) months.**
	vi. Describe how the state will monitor any changes in the rate of default assignment.
	Monthly reports generated by the enrollment broker.
1932(a)(4)	I. State assurances on the enrollment process
	Place a check mark to affirm the state has met all of the applicable requirements
	of choice, enrollment, and re-enrollment
	1. **X** The state assures it has an enrollment system that allows recipients
	who are already enrolled to be given priority to continue that
	enrollment if the MCO or PCCM does not have capacity to accept
	all who are seeking enrollment under the program.
	2. **X** The state assures that, per the choice requirements in 42 CFR438.52,
	Medicaid recipients enrolled in either an MCO or PCCM model
	will have a choice of at least two entities unless the area is
	considered rural as defined in 42 CFR 438.52(b)(3).
	Note: Recipients living in rural areas are not a significant percentage of the total Demonstration population. DMAS intends to contract with at least two MCOs in each region, even in areas that meet the definition of rural (and therefore we could only have one MCO).
	3. ___ The state plan program applies the rural exception to choice
	Requirements of 42 CFR 438.52(a) for MCOs and PCCMs.
	X This provision is not applicable to this 1932 State Plan Amendment.

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Citation	Condition or Requirement
	4. ___ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in § 1932 (a)(3)(C) of the Act; and the recipient has a choice of at Least two primary care providers within the entity. (CA only)
	__**X**__ This provision is not applicable to this 1932 State Plan Amendment.
	5. __**X**__ The state applies the automatic reenrollment provision in accordance
	With 42 CFR 438.56(g) if the recipient is disenrolled solely be-
	cause he or she loses Medicaid eligibility for a period of 2 months
	or less.
	___ This provision is not applicable to this 1932 State Plan Amendment.
§ 1932(a)(4)	J. Disenrollment
42 CFR 438.50	
	1. The state will____/**will not** __**X**__ use lock-in for managed care.
	2. The lock-in will apply for ____ months (up to 12 months). **N/A.**
	3. Place a check mark to affirm state compliance.
	__**N/A**__ The state assures that beneficiary requests for disenrollment (with
	and without cause) will be permitted in accordance with 42 CFR 438.56(c).
	4. Describe any additional circumstances of "cause" for disenrollment (if any).
	Questions #3 & #4 above do not apply because under the Demonstration, because individuals can opt out at any time and return to the fee-for-service environment with or without cause.
	K. Information requirements for beneficiaries
	Place a check mark to affirm state compliance.
§ 1932(a)(5)	__**N/A**__ The state assures that its state plan program is in compliance with
42 CFR 438.50	42 CFR 438.10(i) for information requirements specific to MCOs and PCCM
42 CFR 438.10	Programs operated under § 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)	L. List all services that are excluded for each model (MCO & PCCM).
1905(t)	**The following services will be excluded (carved out) of the MCO under the Demonstration:** • **Abortions, induced (this services will be provided under limited circumstances through fee-for-service)**

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Citation	Condition or Requirement
	• **Targeted Case Management Services (provided under fee-for-service)**
	• **Dental services (in limited cases, these services will be provided under fee-for-service)**
1932(a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option.
	To respond to items #1 and #2, place a check mark. The third item requires a
	brief narrative.
	1. The state **will** **_X__** /will not ___ intentionally limit the number of entities it
	Contracts under a 1932 state plan option.
	2. **_X___** The state assures that if it limits the number of contracting entities,
	this limitation will not substantially impair beneficiary access to services.
	3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option.
	DMAS will issue a Request for Application (RFA) to solicit applications from qualified managed care organizations (MCOs) to participate in the Demonstration. In addition to the RFA, MCOs must meet all of CMS' requirements for the Demonstration. MCOs will be selected through a joint DMAS and CMS process. The Department and CMS will enter into three-way contracts with a minimum of two, and a maximum of three MCOs, in each Demonstration region.
	4. ____ The selective contracting provision is not applicable to this state plan.

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Citation | Condition or Requirement

[For Section B.5] Regions and Localities for the Medicare-Medicaid Alignment Demonstration

Central Virginia

FIPS	Locality
7	Amelia
25	Brunswick
33	Caroline
36	Charles City
41	Chesterfield
49	Cumberland
53	Dinwiddie
57	Essex
75	Goochland
81	Greensville
85	Hanover
87	Henrico
97	King And Queen
99	King George
101	King William
103	Lancaster
111	Lunenburg
117	Mecklenburg
119	Middlesex
127	New Kent
133	Northumberland
135	Nottoway
145	Powhatan
147	Prince Edward
149	Prince George
159	Richmond Co.
175	Southampton
177	Spotsylvania
179	Stafford
181	Surry
183	Sussex
193	Westmoreland
570	Colonial Heights
595	Emporia
620	Franklin City
630	Fredericksburg
670	Hopewell
730	Petersburg
760	Richmond City

Northern Virginia

FIPS	Locality
13	Arlington
47	Culpeper
59	Fairfax County
61	Fauquier
107	Loudoun
153	Prince William
510	Alexandria
600	Fairfax City
610	Falls Church
683	City of Manassas
685	Manassas Park

Tidewater

FIPS	Locality
1	Accomack (OPTIONAL)
73	Gloucester
93	Isle Of Wight
95	James City County
115	Mathews
131	Northampton (OPTIONAL)
199	York
550	Chesapeake
650	Hampton
700	Newport News
710	Norfolk
735	Poquoson
740	Portsmouth
800	Suffolk
810	Virginia Beach
830	Williamsburg

Western/Charlottesville

FIPS	Locality
3	Albemarle
15	Augusta
29	Buckingham
65	Fluvanna
79	Greene
109	Louisa
113	Madison

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Western/Charlottesville	
125	Nelson
137	Orange
165	Rockingham
540	Charlottesville
660	Harrisonburg
790	Staunton
820	Waynesboro
Roanoke	
FIPS	**Locality**
005	Alleghany
017	Bath
019	Bedford County
023	Botetourt
045	Craig
063	Floyd
067	Franklin County
071	Giles
089	Henry
091	Highland
121	Montgomery
141	Patrick
155	Pulaski
161	Roanoke County
163	Rockbridge
197	Wythe
515	Bedford City
530	Buena Vista
580	Covington
678	Lexington
690	Martinsville
750	Radford
770	Roanoke City
775	Salem