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Notice of Intended Regulatory Action (NOIRA)
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	_12_ VAC_30_-_121__
Regulation title(s)	Medicare-Medicaid Demonstration Waivers
Action title	Commonwealth Coordinated Care
Date this document prepared	April 1, 2015

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Subject matter and intent

Please describe briefly the subject matter, intent, and goals of the planned regulatory action.

This notice concerns the Commonwealth Coordinated Care program (12 VAC 30-121). Persons who are eligible for both Medicare and Medicaid are called 'dual eligible'. The dual eligible population is of particular interest for a managed care program because the participants represent some of the most vulnerable citizens who typically have extensive medical, behavioral health, social, and long-term care needs. In the Commonwealth, dual eligibles are currently excluded from managed care because Medicare, being their first payer of services, covers their acute care services. Also, managed care organizations did not originally cover long term care services (nursing facility services nor home and community based services). These dual eligible persons have been receiving acute and long term care services in Medicaid's fee-for-service system.

As a result of being in the fee-for-service system, no single health care provider or entity is responsible for coordinating all of these individuals' care resulting in an inefficient system that is cumbersome for the individuals with misaligned benefit structures and opportunities for cost shifting. This system has likely led to unnecessary hospital admissions, unnecessary use of nursing facilities, and the mismanagement of medications.

In Virginia, pregnant women and children comprise the majority of managed care organizations' (MCOs') participants and these participants have experienced positive health outcomes together with cost effective management of their health care expenditures. Virginia has also proactively moved individuals with disabilities and seniors who are not Medicare-eligible into managed care. However, compared to children and families who comprise approximately 70 percent of Medicaid beneficiaries, but account for less than one-third of Medicaid spending, the elderly and disabled populations make up less than one-third of Medicaid enrollees, but account for approximately 65 percent of Medicaid spending because of their intensive use of acute and long-term care services.

Integrating primary and acute care services with long-term care services into one delivery system will streamline the delivery of services by offering ongoing access to quality health and long-term care services, care coordination, and referrals to appropriate community resources. This will also empower the Commonwealth's full dual eligible beneficiaries to remain independent, residing in settings of their choice for as long as possible.

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Emergency Regulations

Emergency regulations governing the Commonwealth Coordinated Care program went into effect on December 10, 2014. The authority for the emergency regulations arose from multiple General Assembly mandates: (i) Chapter 806, Item 307 AAAA of the *2013 Acts of the Assembly (*the *Acts)*; (ii) Chapter 806, Item 307 RRRR of the *Acts*, and; (iii) Item 307 RR of the *Acts*.

Chapter 806, Item 307 AAAA (1) directed DMAS to implement a process for administrative appeals of Medicaid/Medicare dual eligible individuals in accordance with the terms of the Memorandum of Understanding between the Department and the Centers for Medicare and Medicaid Services for the Financial Alignment Demonstration. DMAS was directed to promulgate regulations to implement these changes.

Item 307 RR directed DMAS to implement a care coordination program for Medicare- Medicaid Enrollees (dual eligibles). This action included the joint Memorandum of Understanding between DMAS and the Centers for Medicare and Medicaid Services (CMS) as well as three way

contracts between CMS, DMAS, and participating health care plans. This program, to be established in Chapter 121 of the Virginia Administrative Code, is called Commonwealth Coordinated Care.

Item 307 RR of the *Acts* provides for achieving cost savings and standardization of administrative and other processes for providers and also authorized DMAS to promulgate emergency regulations. Emergency regulations for this program were approved by the Governor on December 10, 2014, adopted by the agency and submitted to the Registrar to become effective December 10, 2014.

Current Regulatory Action

The current regulatory action seeks to develop and implement permanent regulations for the Commonwealth Coordinated Care program. The legal authority for this regulatory stage comes from the Code of Virginia and the Social Security Act.

The *Code of Virginia* (1950) as amended, §32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, §32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by §1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The *Social Security Act* §1915 (b) (*SSA*) [42 U.S.C. 1396n(b)] permits the U.S. Secretary of Health and Human Services to waive certain requirements of the *Act* to permit states to implement primary care case management systems or managed care programs which provide for individuals to be restricted to certain providers for their care. These managed care programs are permitted to render services to Medicaid individuals to the extent that they are cost-effective and efficient and are not inconsistent with the purposes of Title XIX.

The *Social Security Act* § 1932(a) permits the combining of Medicare and Medicaid services to dual eligible individuals under the authority of a Financial Administration Demonstration waiver.

Purpose

Please describe the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, please explain any potential issues that may need to be addressed as the regulation is developed.

History

In 2011, CMS announced an opportunity for states to align incentives between Medicare and Medicaid by creating a capitated model of care through which full-benefit dual eligible individuals receive all Medicare and Medicaid covered benefits from one managed care plan and the plan receives a blended capitated rate. In May 2013, DMAS was accepted into the demonstration, along with six other states.

The Commonwealth of Virginia implemented the Commonwealth Coordinated Care (CCC) program to allow DMAS to combine certain aspects of Medicaid managed care and long-term care and Medicare-covered services into one program. To accomplish its goal, DMAS included certain populations and services previously excluded from managed care into a new managed care program. The CCC was established under authority granted by a *Social Security Act* § 1932(a) state plan amendment and concurrent authority to the relevant existing § 1915(b)/(c) managed care and home-and-community based waivers. The demonstration began in Virginia on March 1, 2014.

The CCC populations include adults (21 years of age and older) who are eligible for both Medicare and Medicaid (full-benefit duals only), including individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver (one of six waivers for home- and community-based services (HCBS) administered by DMAS) and individuals residing in nursing facilities. DMAS estimated in March 2014 that approximately, 78,600 dual eligible individuals were eligible for this program.

The CCC enables these participants to access their primary, acute, behavioral health, and long-term care services through a single managed delivery system, thereby increasing the coordination of services across the spectrum of care. This NOIRA announces the intention of DMAS to promulgate permanent regulations so that the program remains in effect after the emergency regulations expire. As part of this regulatory process, DMAS will seek comments from stakeholders and the public on possible revisions to the program in order to broaden its reach and strengthen its effectiveness.

This proposed regulatory action is essential to protect the health, safety, and welfare of the affected dual eligible individuals because their care will continue to be coordinated across all disciplines (medical, social, long term care) thereby reducing unnecessary, duplicative and inappropriate services.

Substance

Please briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.

Commonwealth Coordinated Care program (CCC) participants includes adult full benefit dual eligible individuals (ages 21 and over), including full benefit dual eligible individuals in the EDCD Waiver and full benefit dual eligible individuals residing in nursing facilities. Individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements will not be eligible. CCC also will not include individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles only) such as: (1) Qualified Medicare Beneficiaries (QMBs); (2) Special Low Income Medicare Beneficiaries (SLMBs); (3) Qualified Disabled Working Individuals (QDWIs); or, (4) Qualified Individuals (QI).

DMAS is considering various options related to how enrollment in the CCC program will be implemented for eligible individuals.

The current CCC program was offered in five (5) regions of the Commonwealth: Central Virginia, Tidewater, Northern Virginia, Charlottesville/Western and the Roanoke region. The program was phased in on a regional basis over the first twelve months of the new program, starting with the Central Virginia and Tidewater regions. Eligible individuals were notified of the opportunity to enroll during March 2014 and the first opportunity for enrollment was effective on April 1, 2014. The remaining three regions were phased in later in 2014.

The CCC program offers dual eligible individuals care coordination, health risk assessments, interdisciplinary care teams, and plans of care, which are otherwise unavailable for this population. Care coordination is essential to providing appropriate and timely services to often-vulnerable participants and it is anticipated that care coordination will improve quality of care.

Under the CCC program, EDCD Waiver participants who receive personal and respite care will continue to have the option of *consumer-direction* as a care delivery model. Consumer direction empowers participants to serve as employers of their personal care attendants. Under consumer direction, participants are responsible for hiring, training, supervising, and firing their attendants. The consumer-directed model of care is freely chosen by participants or their authorized representatives, if the participants are not able to direct their own care.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

If the Commonwealth Coordinated Care program were not implemented, the Commonwealth would not benefit from potential shared Medicare savings that could result from care coordination and the ability to deliver acute and long-term care services under one, streamlined delivery system with a capitation payment rate. Instead, the Department would continue to experience rising expenditures for primary, acute and long-term care costs for these populations.

Public participation

Please indicate whether the agency is seeking comments on the intended regulatory action, including ideas to assist the agency in the development of the proposal and the costs and benefits of the alternatives stated in this notice or other alternatives. Also, indicate whether a public hearing is to be held to receive comments. Please include one of the following choices: 1) a panel will be appointed and the agency's contact if you're interested in serving on the panel is _____; 2) a panel will not be used; or 3) public comment is invited as to whether to use a panel to assist in the development of this regulatory proposal.

The agency is seeking comments on this regulatory action, including but not limited to: the costs and benefits of various alternative, and the potential impacts of the regulation.

The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: projected reporting, recordkeeping, and other administrative costs; the probable effect of the regulation on affected small businesses; and the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (**http://www.townhall.virginia.gov**), or by mail, email, or fax to Matthew Behrens, Senior Policy Analyst, Office of Integrated Care and Behavioral Services, DMAS, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, Matthew.Behrens@dmas.virginia.gov; (804) 625-3673 (office); (804) 786-1680 (fax). Written comments must include the name and address of the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.