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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-120- 500 through 600
Regulation title(s)	Definitions; CCC Plus Mandatory Managed Care Enrollees, Enrollment Process; Covered Services, Flexible Benefits; Payment Rate for CCC Plus Contractors, Emergency Care by Out-of-Network Providers; Sanctions; State Fair Hearing Process; Appeal Timeframes; Prehearing Decisions; Hearing Process and Final Decision; Division Appeal Records; Provider Appeals
Action title	CCC Plus
Date this document prepared	January 8, 2018

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.*

Brief summary

Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

Commonwealth Coordinated Care Plus (CCC Plus) is a new statewide Medicaid managed long term services and supports program that serves approximately 214,000 individuals with complex care needs through an integrated delivery model across the full continuum of care. Care management is at the heart of the CCC Plus high-touch, person-centered program design. CCC Plus focuses on improving quality, access and efficiency. CCC Plus launched in August 2017 and enrollment into CCC Plus is required for qualifying populations.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

CCC Plus = Commonwealth Coordinated Care Plus
DMAS = Department of Medical Assistance Services
LTSS – Long-Term Services and Supports
MLTSS = Managed Long-Term Services and Supports

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.

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 2016 *Acts of the Assembly*, Chapter 780, Item 306.JJJ (3) and the 2017 *Acts of Assembly*, Chapter 836, Item 306.JJJ (3) directed the agency to "include all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems… DMAS shall promulgate regulations to implement these provisions within 280 days of its enactment."

DMAS promulgated emergency regulations which are currently in place and these proposed stage regulations follow the emergency regulations.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The General Assembly directed DMAS to transition individuals from the Fee-For-Service delivery model into the managed care model to achieve high quality care and budget

predictability. Managed care offers better care coordination and integration of care, which can address rising health care costs and the growing population eligible for Medicaid.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

Under the policy that was in effect prior to the CCC Plus emergency regulations, individuals receiving LTSS were served primarily under the fee-for-service system. The fee-for-service system lacks comprehensive care coordination, the flexibility to provide innovative benefit plans and value based payment strategies, and budget predictability. Spending trends for LTSS were unsustainable.

Consistent with Virginia General Assembly and Medicaid reform initiatives, DMAS is transitioning individuals from fee-for-service delivery models into managed care.

The CCC Plus program includes many of the core program values from the Commonwealth Coordinated Care Program (CCC). CCC launched in March 2014 and is a CMS Medicare-Medicaid Financial Alignment Demonstration. CCC operates as a voluntary managed care program with three health plans and includes a strong, person-centered care coordination component, integration with an array of provider types for continuity of care, ongoing stakeholder participation, outreach and education, and the ability for innovation to meet the needs of the population. The CCC demonstration operated through December 31, 2017. CCC populations will transition to CCC Plus effective January 1, 2018.

DMAS has worked collaboratively with stakeholders over the past two years on every aspect of the CCC Plus program development including, the program design, model of care, CMS waiver, the request for proposal (RFP) content, and the CCC Plus managed care contract development.

CCC Plus launched in phases across six regions of the Commonwealth as shown in the table below. The final implementation phase occurs in January 2018 and will include individuals transitioning from CCC as well as *aged, blind, and disabled* (ABD) populations from Medallion 3.0. The third column of the table below reflects the population totals by month of implementation. The far right column of the table reflects the populations enrolled in CCC Plus by region as of January 2018, including populations transitioning from CCC and Medallion 3.0.

CCC Plus Enrollment By Region and Launch Date

Date	Regions	Enrolled Regional Launch Populations as of 12/8/17	Total Populations by Region as of Jan 2018 (Includes CCC and ABD)

August 1, 2017	**Tidewater**	**20,422**	**46,811**
September 1, 2017	**Central**	**23,027**	**52,698**
October 1, 2017	**Charlottesville/Western**	**16,634**	**30,114**
November 1, 2017	**Roanoke/Alleghany**	**11,214**	**26,014**
November 1, 2017	**Southwest**	**12,207**	**21,767**
December 1, 2017	**Northern/Winchester**	**25,799**	**39,447**
January 2018	**CCC Demonstration**	**22,586**	
January 2018	**ABD from Medallion 3.0)**	**79,191**	
Total	**All Regions**	**211,080**	**216,851**

**** Represents the total anticipated population by region including CCC Demo and ABD Transition from Medallion 3.0***

Virginia's managed long term services and supports (MLTSS) efforts are consistent with National trends. Many states are moving LTSS into managed care programs and towards payment/outcome driven delivery models because (i) LTSS spending trends are unsustainable; (ii) managed care offers flexibility not otherwise available through fee-for-service; and (iii) there is an emphasis on care coordination/integration of care.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

This regulatory action is essential to protect the health, safety, and welfare of citizens who are receiving Medicaid long-term services and supports (LTSS), by enabling them to receive high quality care and care coordination services. The primary advantages to Medicaid members and

the Commonwealth are achieving high quality long term services and supports and budget predictability. Managed care offers better care coordination and integration of care, which can address rising health care costs and the growing population eligible for Medicaid. There are no disadvantages to the public, the agency, or the Commonwealth.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements in this regulation that are more restrictive than applicable federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No localities will be particularly affected, as these regulations will apply statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, phone, or email to Matthew Behrens, DMAS, 600 Broad Street, Richmond VA 23219; 804-625-3673; matthew.behrens@dmas.virginia.gov. Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including: **a) fund source / fund detail; and** **b) a delineation of one-time versus on-going expenditures**	By federal rule, all programs authorized under 1915(b) waiver authority, which this program is, must at least be budget neutral (no new costs). To comply with this rule, the Department implemented various cost controls during the design of CCC Plus to ensure no new costs would be incurred. Therefore, there are no additional projected costs related to implementing this regulation.
Projected cost of the new regulations or changes to existing regulations on localities.	There is no projected cost to localities.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	DMAS has contracted six Managed Care Organizations (MCO) to implement CCC Plus. These MCO's are: Aetna Better Health of Virginia Anthem Health Keepers Plus Magellan Complete Care of Virginia Optima Health Community Care UnitedHealthCare Virginia Premier Elite Plus These MCO's have contracted with qualified providers (qualification standards are the same or reasonably similar as currently required to be a Medicaid provider in other programs) of medical, long-term care (Nursing Facilities, Personal Care, etc.) and behavioral health services. Individuals enrolled in CCC Plus shall be: eligible for Medicaid (no new Medicaid eligibility standards have been created through this regulation), roughly half will also have Medicare, most will utilize long-term care services, most will be over 21, and most will be considered aged, blind or disabled. This population typically makes up roughly 30 percent of the current Medicaid population.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or	No small businesses are expected to be affected by this program.

has gross annual sales of less than $6 million.	
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.	Administrative costs for providers related to this regulation are expected to be minimal. MCO's will have additional administrative costs but they are compensated for these costs through monthly capitation payments. There will be no costs related to development of real estate.
Beneficial impact the regulation is designed to produce.	The Program is projected to incur savings to the Department and the Commonwealth while at the same time providing better care for our members.

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.

No other alternatives satisfy the General Assembly mandate.

Regulatory flexibility analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

This regulatory action does not establish any compliance or reporting requirements or performance standards for small businesses.

Family Impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and

one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, and do not increase or decrease disposable family income.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

Commenter	Comment	Agency Response
Moms in Motion/At Home Your Way	The commenter proposes inquiry for further interdisciplinary and interagency discussion with input from people utilizing services within CCC Plus managed care. Regarding 12VAC30-120-610, during the initial enrollment of all CCC plus managed care program eligible individuals beginning July 1st through January 1st, there is a 90 day continuity of care period with an initial 90 days to change plans. During the initial 90 days, individuals are allotted the ability to change their plans, yet there is no system established for service providers to be able to accurately check eligibility and managed care enrollment. Waiver service providers are accountable for assuring eligibility prior to submitting any service authorization to the managed care organization. However, the VAMMIS portal is only updated by the 18th of each month for the month for up to 10 individuals at a time. This is an ineffective system for providers that causes lapses in service, difficulty in submitting clean claims, and the ability to honor the start date of initial service authorizations. Changes outside of open enrollment will present the same challenges. Data reported to the Department of	The commenter proposes inquiry for further interdisciplinary and interagency discussion with input from people utilizing services within CCC Plus managed care. DMAS has established a CCC Plus Stakeholder Advisory Committee which is composed core provider association representatives and is open to the public including providers and members. The Advisory Committee meets quarterly. DMAS, along with the CCC Plus Managed Care Organizations (MCO), host weekly provider calls and member calls where DMAS and the MCO's provide critical updates, receive input from the callers and answer questions. For further information on how and when to attend the provider calls go here. Member call information can be found here and selecting "Schedule for CCC Plus Member Question and Answer Calls". FAQ's from these calls can be found here. DMAS, along with the MCO's, are hosting a series of town hall style meetings across the state for members and provides. Members and providers are afforded the opportunity to ask questions and voice concerns. Provider town hall information can be found here and selecting "Provider Town Hall Schedule with Registration Links". Member town hall information can be found here and selecting "Member Town Hall Schedule – Registration Required". Additionally, DMAS has established a CCC Plus email box (CCCPlus@dmas.virginia.gov) and a member help-line (1-844-374-9159). The MCO's are also required to operate a member help-line

	Medical Assistance Services, the Attorney General of Virginia or his authorized representative, or the State Medicaid Fraud Control Unit should be publicized to inform provider choice and stakeholder knowledge of the managed care process and quality of the MCO organizations. Information in public reports of managed care contracting should include items such as data, claims reports, and quality studies performed by the MCOs. The commenter supports the condition that MCO requirements not be less restrictive than what DMAS has set forth. Consumer directed service authorizations in the Tidewater region require immediate attention to prevent disruptions in service. Some service authorizations were ended due to the switch from KePro to individual MCOs. The regulations state that MCOs may deny service due to moral or religious objections but this conflicts with the condition that MCO requirements not be less restrictive than what the Department has set forth. Referenced Commentary by VAC Section 12VAC30-120-620. MCO responsibilities; sanctions A.3. –States that the contracted MCOs shall "maintain record of written policies and procedures". As a contracted consumer directed service facilitation company the commenter has been unable to identify these records through communication with the MCOs or their websites. A. 8. –"Cost sharing" obligations shall not be set forth on enrollees except as designated by regulation "set forth in 12VAC30-20-150 and 12VAC30-20-160 and as described in the CCC Plus contract". What potential "cost sharing" is there? (For example, as discussed in conference with DMAS representatives there is concern that	from 8:00 am to 8:00 pm seven days a week. Finally, in accordance with 42 CFR §438.110, the MCO's are required to establish a Member Advisory Committee that will provide regular feedback to the Contractor on issues related to CCC Plus program management and member care. Member Advisory Committees must meet at least quarterly beginning the second quarter of CY 2018 and be comprised of a reasonably representative sample of the LTSS members, or other individuals representing members including family members, independent advocates and other caregivers that reflect the diversity of the CCC Plus program population, including individuals with disabilities and individuals residing in NFs. If the commenter believes further avenues of communication from people utilizing services within CCC Plus is necessary specific examples or ideas would be helpful and can be submitted to the CCC Plus email box (CCCPlus@dmas.virginia.gov). Regarding 12VAC30-120-610, during the initial enrollment of all CCC plus managed care program eligible individuals beginning July 1st through January 1st, there is a 90 day continuity of care period with an initial 90 days to change plans. During the initial 90 days, individuals are allotted the ability to change their plans, yet there is no system established for service providers to be able to accurately check eligibility and managed care enrollment. Waiver service providers are accountable for assuring eligibility prior to submitting any service authorization to the managed care organization. However, the VAMMIS portal is only updated by the 18th of each month for the month for up to 10 individuals at a time. This is an ineffective system for providers that causes lapses in service, difficulty in submitting clean claims, and the ability to honor the start date of initial service authorizations. Changes outside of open enrollment will present the same challenges. All providers are required to check eligibility at least monthly but prior to submitting service authorization requests or claims. Providers may check the DMAS portal after the 21st of each month to determine which MCO the member will be in for the following month. During the implementation period when members can change MCOs, service authorization requests must be

	PCP visits necessitated by the simultaneous designation of EPSDT services for PCA for those under the DD waiver, CL and FIS, may require exceptional medical visits outside of what is covered by EPSDT covered well visits and coordinated costs for PCP appointments to complete the DMAS 7 and associated documentation for this service or to receive copies of records.) D. - "The MCO's coverage rules for contract covered services shall also ensure compliance with federal EPSDT [FPA1] coverage requirements for enrollees younger than 21 years of age." As this section states in cooperation with applicable CMS EPSDT rules, it is presumed that all HCBS waivers with consumer directed PCA services would be affected. At this time, there has been an adjustment to the DD waivers (CL and FIS) regarding personal care attendant supports following the guidelines of the June 30th Medicaid memo. However, this has not yet been applied to the CCC Plus waiver (combined EDCD and TA effective July 1). At what time will EPSDT rules be implemented upon the CCC Plus waiver and what estimated time for prior notice will be given to providers and medical professionals? Time to prepare operationally and inform those that will be affected is necessary to maintain quality care, responsible provision of service facilitation and trustworthy relationships. Further concern has been expressed to DMAS and continues as the EPSDT criteria is more restrictive toward children and waiver services are less applicable or available to children so that they may maintain their medically necessary waivers. Additionally, there is an identified lack of service providers available to children or disability even when the potential for waiver service is extended to the child population. A lack of providers that cater to children should be taken into consideration under the exceptional criteria for "individual consideration"	submitted to the MCO that the member is enrolled with on the date the service will be provided. All claims must be submitted to the MCO the member was enrolled with on the date the service was provided. Regardless of whether it happens during the initial 90-day continuity of care period when a member moves from one health plan to another, or from fee-for-service to a CCC Plus MCO, the new MCO is required to honor the existing authorization(s) for the duration of the service authorization or for ninety calendar days from enrollment. Existing authorization(s) are transferred from the current plan to the future plan automatically prior to the service begin date. For members effective on or after April 1, 2018, the continuity of care time period will change to a minimum of thirty (30) calendar days. The MCO's are required to extend this time frame as necessary to ensure continuity of care pending the provider's contracting with the Contractor or the Member's safe and effective transition to a contracted provider. VAMMIS always displays the member's current health plan, eligibility information for the upcoming month is available through the DMAS portal on the 21st of each month, just as it is for fee-for-service Medicaid. Since VAMMIS displays the member's current health plan and because existing authorizations are automatically transferred to the new MCO, providers do not need to submit authorization requests or claims to the future health plan for the continuity of care period. Data reported to the Department of Medical Assistance Services, the Attorney General of Virginia or his authorized representative, or the State Medicaid Fraud Control Unit should be publicized to inform provider choice and stakeholder knowledge of the managed care process and quality of the MCO organizations. Information in public reports of managed care contracting should include items such as data, claims reports, and quality studies performed by the MCOs. In accordance with Section §438.334 of the Medicaid Managed Care Final Rule DMAS is in the process of developing a managed care quality rating system. Once complete the rating system will be published and open to public consumption.

	while the Commonwealth departments should continue to actively encourage and establish provision of services and an array of provider choice across all demographics of the Commonwealth (disability, economics, culture, geography, etc.). 12VAC30-120-640. State fair hearing process. As the MCOs begin to establish relationships with enrollees and service providers it is hoped that the enrollee and their planning team, including the individual, family, medical professionals, paid and unpaid supports and service providers, are regarded as experts. Any denial of waiver and medical services managed by the MCOs should be reviewed by DMAS to ensure quality care of medically necessary services, equal standards and support of 12VAC30-120-620 wherein MCOs are stipulated to not be less restrictive than the department. Data reports on denials, absent of identifying information, should also be made public for stakeholder review to ensure consistency of services that are not less restrictive than the department and to support informed provider choice of those MCOs that are abiding by the department's contractual agreement. B. "It is presumed that appellants will receive the MCOs final internal appeal decision 5 days after the MCO mails it." & J.2. "For continuation of benefits for an internal appeal with the MCO, the enrollee or representative must file the appeal before the effective date of action or within 10 calendar days of the mail date of the MCO's notice of action." This proposed time for enrollees to initiate an appeal following denial is extremely limited and should be extended to 30 days after the MCO mails the denial. While enrollees have a time frame of 120 days to appeal final decisions of the MCO and initiate a state fair hearing process. 30 days from the mailing of an initial denial from the MCO allows the enrollee enough time to consider action, become familiar with the appeal process, collect	The commenter supports the condition that MCO requirements not be less restrictive than what DMAS has set forth. The commenter says the requirements is "less restrictive" but the actual requirements is "no more restrictive". 12VAC30-120-620(C) requires MCO's medical necessity criteria to be no **more** restrictive than DMAS' criteria not no **less** restrictive. This is a requirement of federal managed care regulations 42 CFR §438.210 (a)(5(i), and ensures CCC Plus MCO's provide services at least in equal amount, duration, and scope as available under Medicaid fee-for-service program. Consumer directed service authorizations in the Tidewater region require immediate attention to prevent disruptions in service. Some service authorizations were ended due to the switch from KePro to individual MCOs. DMAS is working with the appropriate vendors (PPL or the MCO's) to ensure this issue is resolved. If a provider has a specific example and needs assistance they can contact DMAS using the CCC Plus email box (CCCPlus@dmas.virginia.gov). All service authorizations generated by KePRO are end-dated the last day of the month prior to the MCO effective date. Letters are generated to members and providers informing them that the authorization was ended due to entering a CCC Plus benefit plan. The MCOs automatically generate new authorizations, and send the consumer-directed service authorization information to PPL The regulations state that MCOs may deny service due to moral or religious objections but this conflicts with the condition that MCO requirements not be less restrictive than what the Department has set forth. This provision is required through 42 CFR §438.102 of the federal managed care regulations. Based on this rule, MCO's are required to notify potential enrollees before and during the enrollment period. When a change in coverage is made by the MCO outside of the enrollment period the MCO is required to notify current enrollees within thirty calendar days before the effective date of change. If their current MCO makes a coverage change based on this rule the enrollee can change MCO's even if it is outside

	supportive documentation and establish representation from professionals or support groups that can provide experienced direction in appeals. Enrollees and families are often their own advocates and unfamiliar with the appeal process. To support self-advocacy and determination the enrollees and their families should be afforded a reasonable amount of time to prepare and initiate appeals. J.5."If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's adverse benefit determination, the MCO may recover the costs of services furnished to the enrollee while the appeal and the state fair hearing was pending[FPA4] , to the extent they were furnished solely because of the pending appeal." This regulation is potentially exploitative of people with disabilities and minimal financial resources who necessitate the support of waiver services for their health, safety and inclusion at home, work, school and in their community alternative to institutional care. 12VAC30-120-650. Appeal timeframes. G. "An extension of the 120-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include the following situations:" As the Commonwealth of Virginia contains a large military community, an additional "good cause" grant should be extended to military families, single or dual parent, that may be deployed or otherwise ordered to serve and subsequently be delayed in receiving denial notices with appeal time frame restrictions. I. 4. "Following a hearing, the hearing officer orders an independent medical assessment as described in 12VAC30-120-670 H 1". 12VAC30-120-670 H 1 we are unable to identify this section of the Va Code	the open enrollment period. 12VAC30-120-620. MCO responsibilities; sanctions A.3. –States that the contracted MCOs shall "maintain record of written policies and procedures". As a contracted consumer directed service facilitation company the commenter has been unable to identify these records through communication with the MCOs or their websites. The complete language for this section is: "The MCO shall maintain records, including written policies and procedures, as required by the CCC Plus contract." Most records, including policies and procedures, that the MCO's are required to maintain in the contract are specific to MCO's internal process. For example, IM Systems requirements for processing claims, IM Systems requirements for ensuring quality measure validity, etc. Much of this would be considered proprietary and the MCO's cannot be compelled to make them available to a provider. DMAS reviews required policies and procedures to ensure they are complying with contract requirements. Any policies and procedures that MCO's are required to make available to providers (e.g., grievance and appeals process, submission of authorizations and claims, using the provider portal, etc.) is covered in the MCO Provider Manual. All CCC Plus MCO's Provider Manuals are on their CCC Plus specific website. If there is a specific policy or procedure record that a provider has requested but are not getting from a MCO, the provider should contact DMAS using the CCC Plus email box (CCCPlus@dmas.virginia.gov). DMAS staff will work with the provider to ensure they have all the information necessary to operate. A. 8. –"Cost sharing" obligations shall not be set forth on enrollees except as designated by regulation "set forth in 12VAC30-20-150 and 12VAC30-20-160 and as described in the CCC Plus contract". What potential "cost sharing" is there? (For example, as discussed in conference with DMAS representatives there is concern that PCP visits necessitated by the simultaneous designation of EPSDT services for PCA for those under the DD waiver, CL and FIS, may require exceptional medical visits outside of what is covered by EPSDT covered well visits and coordinated costs for PCP appointments to

	for cross walk review between this emergency regulation and established state code. 4. 12VAC30-120-660. Prehearing decisions. A. 2.c. "The action being appealed was not taken by the MCO" We are requesting clarification of this reasoning. Does this mean that the appeal process will be dismissed when the MCO never acted upon a denial?	complete the DMAS 7 and associated documentation for this service or to receive copies of records.) See section 11.6 of the CCC Plus contract here. The MCO cannot impose any cost sharing obligations on enrollees for covered and non-covered services. The MCO may not impose co-payments on prescription drugs covered under CCC Plus. CCC Plus program enrollee will be exempt from cost sharing other than for any Patient Pay established by DSS towards LTSS services, including skilled and custodial nursing facility and CCC Plus Waiver services. The allowable Patient Pay is described in section 4.7.5 of the CCC Plus contract. (The cost sharing language is required per 42 CFR 438.108.) D. - "The MCO's coverage rules for contract covered services shall also ensure compliance with federal EPSDT [FPA1] coverage requirements for enrollees younger than 21 years of age." As this section states in cooperation with applicable CMS EPSDT rules, it is presumed that all HCBS waivers with consumer directed PCA services would be affected. At this time, there has been an adjustment to the DD waivers (CL and FIS) regarding personal care attendant supports following the guidelines of the June 30th Medicaid memo. However, this has not yet been applied to the CCC Plus waiver (combined EDCD and TA effective July 1). At what time will EPSDT rules be implemented upon the CCC Plus waiver and what estimated time for prior notice will be given to providers and medical professionals? Time to prepare operationally and inform those that will be affected is necessary to maintain quality care, responsible provision of service facilitation and trustworthy relationships. The CCC Plus MCO's are required to cover EPSDT services in accordance with current State and Federal guidelines and regulations. DD waiver services are carved out of CCC Plus and are reimbursed through Fee-For-Service. A Medicaid Memo regarding the delay in implementation of EPSDT service authorizations in DD waivers was issued in September and can be found here. Further concern has been expressed to DMAS and continues as the EPSDT criteria is more restrictive toward children and waiver services are less applicable or available to children so that they may maintain their medically necessary waivers. Additionally, there is an identified lack

		of service providers available to children or disability even when the potential for waiver service is extended to the child population. A lack of providers that cater to children should be taken into consideration under the exceptional criteria for "individual consideration" while the Commonwealth departments should continue to actively encourage and establish provision of services and an array of provider choice across all demographics of the Commonwealth (disability, economics, culture, geography, etc.). As stated previously, MCO medical necessity criteria must be no more restrictive than DMAS'. This also applies to EPSDT; However, since DMAS is applying this criterion under FFS with the DD Waivers, the MCOs are in compliance with DMAS requirements and are not applying more restrictive criteria. MCO's are able to enroll providers that are not currently Medicaid enrolled providers this may result in more providers participating than we traditionally have. 12VAC30-120-640. State fair hearing process. As the MCOs begin to establish relationships with enrollees and service providers it is hoped that the enrollee and their planning team, including the individual, family, medical professionals, paid and unpaid supports and service providers, are regarded as experts. Any denial of waiver and medical services managed by the MCOs should be reviewed by DMAS to ensure quality care of medically necessary services, equal standards and support of 12VAC30-120-620 wherein MCOs are stipulated to not be less restrictive than the department. Data reports on denials, absent of identifying information, should also be made public for stakeholder review to ensure consistency of services that are not less restrictive than the department and to support informed provider choice of those MCOs that are abiding by the department's contractual agreement. From the comment it is unclear what benefit it would be to the enrollee during the State Fair Hearing Process if the cohorts mentioned were to be considered "experts" since "expert" is not a term used in the regulation package. 12VAC30-120-670(F) allows "the appellant or his representative shall have the right to bring witnesses…" therefore, the cohorts mentioned are all eligible to serve as the enrollee's witnesses regardless of their professional status. Do note, 12VAC30-120-670(G) gives the hearing officer

		the authority to determine the probative weight of the evidence and therefore the officer may determine that some witness's testimony is not relevant to the proceedings. As noted above the requirement in 12VAC30-120-620(C) is to be **no more** restrictive not **no less** restrictive. As to DMAS reviewing all denial of medical and waiver services, DMAS will perform routine monitoring of MCO operations including the denial of service authorizations. MCO's cannot determine an individual's eligibility for waiver services. DMAS will retain that authority. B. "It is presumed that appellants will receive the MCOs final internal appeal decision 5 days after the MCO mails it." & J.2. "For continuation of benefits for an internal appeal with the MCO, the enrollee or representative must file the appeal before the effective date of action or within 10 calendar days of the mail date of the MCO's notice of action." This proposed time for enrollees to initiate an appeal following denial is extremely limited and should be extended to 30 days after the MCO mails the denial. While enrollees have a time frame of 120 days to appeal final decisions of the MCO and initiate a state fair hearing process. 30 days from the mailing of an initial denial from the MCO allows the enrollee enough time to consider action, become familiar with the appeal process, collect supportive documentation and establish representation from professionals or support groups that can provide experienced direction in appeals. Enrollees and families are often their own advocates and unfamiliar with the appeal process. To support self-advocacy and determination the enrollees and their families should be afforded a reasonable amount of time to prepare and initiate appeals. The federal regulations at 42 CFR 438.420 provides that timely filing of a request for continued coverage while an appeal of an MCO action is pending requires that the request for continued coverage be made on or before the later of either: (i) Within 10 calendar days of the MCO sending the notice of adverse benefit determination, or (ii) The intended effective date of the MCO's, proposed adverse benefit determination. This requirement for requesting and being eligible for continued coverage does not impact (restrict or expand) the time granted for an individual to file

		an appeal of an adverse benefit determination as provided in 42 CFR 438.402(c)(1)(ii) and (c)(2)(ii). Additionally, the federal regulations extended the timeframe for filing a state fair hearing to 120 days to give members additional time to prepare for and file an appeal with DMAS. J.5."If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's adverse benefit determination, the MCO may recover the costs of services furnished to the enrollee while the appeal and the state fair hearing was pending[FPA4] , to the extent they were furnished solely because of the pending appeal." This regulation is potentially exploitative of people with disabilities and minimal financial resources who necessitate the support of waiver services for their health, safety and inclusion at home, work, school and in their community alternative to institutional care. This provision is consistent with 42 CFR 438.420 and 42 CFR 431.230. Notice of the potential for recovery of the cost of services provided during an appeal when the action of the MCO is upheld must be provided with the denial notice. Therefore, the member can make an informed decision regarding requesting continued coverage. 12VAC30-120-650. Appeal timeframes. G. "An extension of the 120-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include the following situations:" As the Commonwealth of Virginia contains a large military community, an additional "good cause" grant should be extended to military families, single or dual parent, that may be deployed or otherwise ordered to serve and subsequently be delayed in receiving denial notices with appeal time frame restrictions. DMAS believes that 120 days is generally sufficient time to file an appeal, there may be some unique circumstances where an individual may actually have "good cause" for not filing an appeal within 120 days. Special provisions are often made for those individuals who are active armed service members. DMAS is reviewing this provision to determine if more flexibility is needed and will take these comments into consideration. I. 4. "Following a hearing, the hearing officer orders an independent medical assessment as

		described in 12VAC30-120-670 H 1". 12VAC30-120-670 H 1 we are unable to identify this section of the Va Code for cross walk review between this emergency regulation and established state code. According to 12 VAC 30-110-200, an independent medical assessment may be ordered by a Hearing Officer if: 1. The hearing involves medical issues such as a diagnosis, an examining physician's report, or a medical review team's decision; and 2. The hearing officer determines it necessary to have an assessment by someone other than the person or team who made the original decision, for example, to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence. This assessment becomes part of the record and is at the expense of DMAS. 4. 12VAC30-120-660. Prehearing decisions. A. 2.c. "The action being appealed was not taken by the MCO" We are requesting clarification of this reasoning. Does this mean that the appeal process will be dismissed when the MCO never acted upon a denial? This section provides that an appeal may be administratively dismissed if it is determined that the action being appealed was not taken by the CCC Plus contractor. Additionally, administrative dismissal does not apply to actions that were not taken by an MCO but should have been (such as failing to make a determination within the required timeframe).
Individual	The commenter opposes the mandated managed care program called CCC Plus. The commenter states that causing individuals to leave their existing doctors and choosing a new provider from a limited list limits choice and is not person centered. The commenter states that not enough information and data has been released to determine if CCC Plus will save the Commonwealth money, and that more research is needed before implementation.	The commenter opposes the mandated managed care program called CCC Plus. The commenter states that causing individuals to leave their existing doctors and choosing a new provider from a limited list limits choice and is not person centered. Individuals enrolled into CCC Plus will be assigned a health plan using an intelligent assignment process, which will assign members to a health plan based on their previous managed care enrollment. As providers often agree to participate with the same health plan across multiple lines of business using this process

	The commenter states that the privatization of Medicaid in the Southwest Virginia Region has created unrealistic rules and regulations aimed at reclaiming funds during audits and has added more forms and documentation requirements that limit the face-to-face care a professional can provide to an individual. The commenter states that person centered care is based on the needs of the people rather than the bottom line.	reduces the instances of members needing to switch providers. Additionally, if the member's provider(s) do not participate in the plan they have been assigned to the member is able to switch health plans. Individuals in a Nursing Facility will be assigned to a MCO that includes the individual's Nursing Facility in its network In addition, half of our CCC Plus members are duals meaning they also have Medicare. These members will not have disruption in their physician coverage or other coverage where Medicare is primary. The commenter states that not enough information and data has been released to determine if CCC Plus will save the Commonwealth money, and that more research is needed before implementation. While one of the benefits we hope to gain through CCC Plus is a reduction in the rate at which Medicaid costs are increasing the primary focus is to improve care for our members. As MLTSS programs are relatively new across the country several states have reported success. Virginia has realized similar success through our Commonwealth Coordinated Care (CCC) program. The report, which can be found here, provides an annual update on CCC and incudes cost savings and success stories. The commenter states that the privatization of Medicaid in the Southwest Virginia Region has created unrealistic rules and regulations aimed at reclaiming funds during audits and has added more forms and documentation requirements that limit the face-to-face care a professional can provide to an individual. During the design phase, DMAS worked with the contracted health plans and numerous provider associations to standardize rules, regulations, processes and forms across all health plans. While some processes and forms cannot be standardized providers can ask for exceptions during contract negotiations that may alleviate administrative burden. The commenter states that person centered care is based on the needs of the people rather than the bottom line. DMAS agrees with this statement. As stated previously, we hope cost avoidance is achieved

		but it is not the foundation of the program. Over the past several years DMAS has researched best practices in person centered care and worked with state provider associations to develop a program that we believe will work for Virginia. If the commenter has specific examples or suggestions on how DMAS can make CCC Plus more person centered they can contact DMAS using the CCC Plus email box (CCCPlus@dmas.virginia.gov).
Individual	The CCC Plus program has caused chaos due to uncertainty surrounding differences in coverage. During the CCC pilot program, enrollees could choose from one of 3 different insurance companies and that choice has been removed in CCC Plus, and removing that choice is not person-centered. The argument for the emergency regulation is that long term services and supports are not sustainable as the number of individuals requiring Medicaid rises. There is no indication as to how the quality of services will be improved. This is an attempt to save money by ensuring that funds aren't allocated if it isn't permitted by an MCO. Public participation is encouraged in relation to cost and benefit alternatives, impacts and ideas on the development of CCC Plus but no one has left a comment. The CCC Plus program is happening whether or not there are comments. It is ironic that this action seeks to provide a higher quality of care but also incorporates more control on budget predictability. CCC Plus individuals do not have much in the way of disposable funds. Individuals must stay in the network to avoid being charged costs. The mandated change is not person-centered, limits vulnerable populations, provides more stringent guidelines on in-network healthcare and takes advantage of marginalized populations	The CCC Plus program has caused chaos due to uncertainty surrounding differences in coverage. DMAS is conducting an exhaustive outreach and education campaign to help members and providers understand CCC Plus. Member specific educational information, including how to attend one of our town hall meetings, can be found here. Provider specific educational information, including how to attend one of our provider focused town hall meetings, can be found here and here. DMAS and the MCO's also host conference calls for members and providers to ask and get answer to their questions. Member call information can be found here under "Schedule for CCC Plus Member Question and Answer Calls – NEW" and provider call information can be found here under "CCC Plus Provider Q and A Conference Call Schedule – NEW". Additionally, if individuals or providers have unanswered questions they can contact their assigned health plan using the contact information provided in their Member Handbook or they can reach DMAS using the CCC Plus email box (CCCPlus@dmas.virginia.gov). During the CCC pilot program, enrollees could choose from one of 3 different insurance companies and that choice has been removed in CCC Plus, and removing that choice is not person-centered. Enrollees have the choice of six health plans for CCC Plus. The argument for the emergency regulation is that long term services and supports are not sustainable as the number of individuals requiring Medicaid rises. There is no indication as to how the quality of services will be improved. This is an attempt to save money by ensuring that funds aren't allocated if it isn't permitted by an MCO. Agencies may use an emergency regulation when Virginia statutory law or the appropriation act or federal law or federal regulation requires that a

	by forcing them to seek out-of-network care using their own funds.	regulation be effective in 280 days or less from its enactment. In this instance, DMAS was required to promulgate regulations 280 days from the enactment of the 2016 appropriation act. Following the conclusion of the Emergency Regulation review and approval process DMAS is required to promulgate permanent regulations. The permanent regulations will also have public comment period. It is ironic that this action seeks to provide a higher quality of care but also incorporates more control on budget predictability. Thank you for your comment. CCC Plus individuals do not have much in the way of disposable funds. Individuals must stay in the network to avoid being charged costs. CCC Plus plans are required to maintain a robust provider network that will accommodate all the enrollees service needs. If a health plan's network does not meet adequacy requirements they will not be allowed to enroll individuals into their product. CCC Plus network adequacy standards surpass federal requirements and are the most comprehensive and demanding DMAS has required to date. Furthermore, if a health plan's network is unable to meet a member's needs in-network, that member can see an out-of-network provider at no cost to them. This type of arrangement needs to be discussed with the member's health plan prior to seeing the out-of-network provider. The mandated change is not person-centered, limits vulnerable populations, provides more stringent guidelines on in-network healthcare and takes advantage of marginalized populations by forcing them to seek out-of-network care using their own funds. As described earlier all CCC Plus health plans are required to maintain robust provider networks that will accommodate all the enrollees service needs. Also, if a health plan's network is unable to meet a member's needs that member can see an out-of-network provider at no cost to themselves. Therefore, DMAS does not agree that CCC Plus will force members to seek out-of-network using their own funds. Additionally, one of the key benefits of the CCC Plus program is that every enrollee will be assigned a Care Coordinator from the health plan.

		This provides the enrollee with one point of contact who can assist the enrollee in navigating the health care system, identifying and obtaining needed services, addressing not only health needs, but behavioral, social and emotional aspects of care, assisting in finding network providers, etc. DMAS believes this establishes the foundation of "person centered" care.

Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please list separately: (1) all differences between the **pre**-emergency regulation and this proposed regulation; and 2) only changes made since the publication of the emergency regulation.*

The changes made at the emergency stage include the following:

Section number	Proposed requirements	Other regulations and law that apply	Intent and likely impact of proposed requirements
12 VAC 30-120-500	Definitions		Sets forth definitions for terms used in the CCC Plus regulations.
12 VAC 30-120-510	CCC Plus mandatory managed care enrollees; enrollment process	42 CFR §§ 438.54 – 438.56	Establishes who will be enrolled in CCC Plus and the enrollment process.
12 VAC 30-120-520	MCO contractor responsibilities; sanctions	42 CFR § 438 et seq. 42 CFR 438 Subpart I	Establishes what services will be covered.
12 VAC 30-120-530	Covered services	42 CFR § 438.210	Establishes payment rates for CCC Plus contractors and for out of network providers who offer emergency care.
12 VAC 30-120-540	Payment rate for CCC plus contractors	42 CFR §§ 438.4 – 438.8 42 CFR § 438.48	Establishes sanctions for CCC Plus contractors.
12 VAC 30-120-550	State fair hearing process	12 VAC 30-110-10 et seq. 42 CFR § 438.408	Establishes the hearing process for the CCC Plus program.
12 VAC 30-120-560	Appeal timeframes	42 CFR § 438.408	Establishes appeal timeframes.
12 VAC 30-120-570	Prehearing decisions		Establishes what decisions shall be made before a hearing.
12 VAC 30-120-580	Hearing process and final decision	42 CFR §§ 438.408 - 410	Establishes the hearing process.
12 VAC 30-120-	Division appeal records	42 CFR § 438.416	Establishes the rules regarding records kept by the Appeals

590			Division.
12 VAC 30-120-600	Provider appeals	12 VAC 30-20-500 et seq.	Establishes the rules for provider appeals.

The changes made at the proposed stage include the following:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12 VAC 30-120-610 B 17		Individuals who have insurance through the HIPP program are excluded from CCC Plus.	A sentence was added to clarify that these individuals may be transitioned into CCC Plus in the future.
12 VAC 30-120-630 B		The sentence said that services shall be provided outside the MCO network.	The sentence was clarified to say that services shall be provided through fee-for-service outside the CCC Plus MCO contract.