Form: TH-03
April 2020

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Final Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 30-120-500 through 600
VAC Chapter 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	7/19/2019

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

Commonwealth Coordinated Care Plus (CCC Plus) is a statewide Medicaid managed long term services and supports program that serves 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

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

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

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary entitled "CCC Plus" and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

7/19/2019
Date

/signature/
Jennifer S. Lee, M.D., Director
Dept. of Medical Assistance Services

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The 2016 *Acts of the Assembly*, Chapter 780, Item 306.JJJ (3); the 2017 *Acts of Assembly*, Chapter 836, Item 306.JJJ (3); the 2018 *Acts of Assembly*, Chapter 2, Item 303.SS (3); and the 2019 *Acts of Assembly*, Chapter 854, Item 303.SS (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 and these final stage regulations follow the emergency regulations.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

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Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's 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. The regulation is essential to protect the health, safety, and welfare of citizens in that managed care offers better care coordination and integration of care for covered populations.

Substance

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 has transitioned 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 operated as a voluntary managed care program with three health plans and included 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 transitioned to CCC Plus on January 1, 2018.

DMAS has worked collaboratively with stakeholders over the past several 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. The final implementation phase occurred in January 2018 and included individuals transitioning from CCC as well as aged, blind, and disabled (ABD) populations from Medallion. In January, 2019, individuals enrolled through Medicaid Expansion who are determined to be medically complex were enrolled in CCC Plus.

Total enrollment figures (as of April 12, 2019) are shown in the chart below.

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.

C. **CCC Plus Enrollment by Plan by Region:**

CCC Plus Actual Enrollment							
As of Week 04/12/2019							
MCO	Tidewater	Central	Charlottesville	Roanoke Alleghany	Southwest	Northern VA/ Winchester	Total
Aetna	6,329	10,314	4,620	4,426	4,628	5,566	35,883
Anthem	15,892	17,908	5,894	5,278	4,193	17,538	66,703
Magellan	6,501	5,865	3,346	2,892	2,642	3,671	24,917
Optima	13,197	8,488	8,041	3,034	2,972	3,303	39,035
United	5,159	5,774	2,743	3,752	2,823	7,498	27,749
VA Premier	6,205	10,585	8,145	9,933	7,750	4,484	47,102
Total	53,283	58,934	32,789	29,315	25,008	42,060	241,389

Issues

Identify the issues associated with the regulatory change, 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, include a specific statement to that effect.

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

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

There are no changes to the previously-reported information: there are no requirements in this regulation that are more restrictive than applicable federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

There are no changes to the previously-reported information: no localities will be particularly affected, as these regulations will apply statewide.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Commenter	Comment	Agency response
Virginia Board for People with Disabilities	The commenter recommends: A) updating outdated references used throughout the regulations, B) using people-first language, and C) including the Medicaid expansion population.	A) The Department will update the outdated references where suggested, however references to EDCD, Tech Waiver, ID, DD, and Day Support Waivers will not be updated due to the fact that emergency regulations are not a part of the VAC; B) While we respect and value person-centered language, these regulations are not often copied or re-produced for member consumption. The definition for intermediate care facilities is reflective of the definition of intermediate care facilities in 12VAC30-120-600 and 12VAC30-120-610); C) The Department will include the Medicaid Expansion population language. However, the continuity of care period language will stay as written in the regulations. The Medicaid expansion population who transitioned to CCC Plus on January 1, 2019 did not receive continuity of care. Continuity of care only applies to individuals who are in Medicaid fee-for-service and those who transfer from one CCC Plus plan to another. The definition as written does not exclude new populations such as the Medicaid Expansion population.

Moms in Motion	A) The commenter 1) asks a question about whether HIPP is moving to CCC+ program; 2) states that the payment criteria should be the DMAS criteria; 3) notes text that may contradict provider choice for the consumer; 4) notes text where their experience is that the MCOs are more restrictive; 5) notes text where their experience is that the MCOs are not in compliance; 6) notes text where their experience is that the MCOs are not currently providing services in equal amount, duration, and scope. B) The commenter also includes a general comment that the appeal process through the MCO's is painfully long and that MCOs should be held accountable for keeping services going while the appeal is being processed. The commenter feels that someone from DMAS needs to be involved in the MCO appeal process.	A) 1) HIPP is excluded from CCC Plus. The Department will update the regulations to reflect this; 2) As reflected in the regulations, the MCOs must follow claims payment procedures established in 42 CFR 447.45 and 42 CFR 447.46 and § 1902(a)(37) of the Social Security Act. The payment criteria are established by the MCO and monitored by the Department. Revisions to the regulations as requested are unnecessary; 3) It is a CCC Plus Contract requirement and a federal requirement (see 42 CFR § 455.436) that the MCO conduct monthly checks for all of the MCO's owners and managing employees against the Federal listing of excluded individuals and entities (LEIE database). If a provider is excluded, this does not mean that the member cannot choose that provider, but that the provider cannot be reimbursed. Revisions to the regulations as requested are unnecessary; 4), 5) and 6) Thank you for your concerns. If you have specific concerns, please bring those to the Department's attention by emailing cccplus@dmas.virginia.gov. This comment did not bring about any revisions to the CCC Plus Regulations. B) Thank you for your concerns. It is a CCC Plus Contract requirement that the MCO ensure member services are continued as the appeal is being processed. If you have specific concerns, please bring those to the Department's attention by emailing cccplus@dmas.virginia.gov. This comment did not bring about any revisions to the CCC Plus Regulations.
Virginia Poverty Law Center	A) The commenter suggested changes to the definitions of the following terms: expedited appeal, final decision, hearing, and internal appeal. B) The commenter suggests adding text to the definition of "medical necessity" to add specificity, based on the federal regulation. C) The commenter notes that section 610 should be amended to: 1) include the expansion population; 2) clarify how	A) The definition of "expedited appeal" will be removed from the regulations; the definition of "final decision" will be revised (the definition of "final decision only applies to member appeals. Please see DMAS Appeals regulations); the definition of "hearing" will be removed from the regulations (see "state fair hearing"). The Department will revise the definition for internal appeal in Section 600 to include that the internal appeal can be filed orally or in writing.

	individuals with end stage renal disease are notified of their option to opt-out or request an extension of the 90-day rule; 3) define "incarcerated." D) The commenter notes that section 625 should clarify the 90/30 day continuity of care rule. E) The commenter notes that section 640 should 1) clarify the timeframes for requesting continuation of benefits; 2) clarify that appeal time limits run from the date of notice of receipt (rather than the date of the notice); and 3) require DMAS to notify the MCO when a request for fair hearing has been filed so that services are continued. F) 1) The commenter notes that the term "delay" should be changed to "prehearing delay" (vs. posthearing delay in the next section). 2) The commenter notes that section 650 should be eliminated or revised – the formula for extending the hearing is overly complex and the extensions are too long. G) The commenter notes that section 660 should require prehearing decisions to be sent to both the appellant and the appellants authorized representative. H) 1) In section 670, the commenter notes that the cross reference to 650H is incorrect, and 2) requests that the following phrase be deleted: "but the hearing officer must determine whether or not it will be used in making the decision" I) The commenter also noted that regulations related to CCC, the Alzheimer's Assisted Living Waiver, Medallion 3.0, HAP, the EDCD waiver, Technology Assisted Waiver, ID Waiver, Day	B) The definition of "medical necessity" is appropriate as written. The definition in Section 610 includes the CFR citation requested, which is 42 CFR 438.210. C) 1) The Medicaid expansion population will be included under Section 610; 2) The Department does not have a way to identify individuals with end stage renal disease, so we are not notifying them. It is the member's responsibility to opt out or request an extension of the 90-day rule. Typically, members are made aware by the dialysis centers they are attending and the social workers then notify DMAS; 3) Thank you for your comment. The Department does not find it necessary to add clarification to this definition. D) The continuity of care period for all members from the beginning of the CCC Plus Program to April 1, 2018 was 90 days. On April 1, 2018, the continuity of care period for all members changed to 30 days. This will be reflected in the regulations. E) 1) Section 640 J (2 and 3) clarifies the timeframes for requesting continuation of benefits for both an internal appeal and for a state fair hearing. The member or authorized representative has 10 calendar days from the mail date of the MCO's notice. No revision to the regulations is necessary. 2) Yes, appeal time limits run from the date of notice of receipt. 3) Section 640 J denotes that the member has the right to have his benefits continued during the MCO's appeal or the state fair hearing. Revisions to the regulations are unnecessary. F) 1) The regulations in Section 650 are correct as written and are aligned with DMAS Appeals Division Regulations and 42 CFR § 438.408 (c)(2). The term "prehearing delay" is not used in the CFR. 2) Thank you for your concerns, however Section 650 will not be eliminated or revised. The language as written in Section 650 is reflective of DMAS Appeals regulations.

	Support Waiver, and GAP may no longer be necessary.	G) The regulations in Section 660 sufficiently indicate that the appellant and the appellant's authorized representative are sent the prehearing decision. Revisions to the regulations are unnecessary. H) 1) The Department will update the regulations with the correct citation in Section 670; 2) The regulations in Section 650 are correct as written and are aligned with DMAS Appeals Division Regulations. The phrase "but the hearing officer must determine whether or not it will be used in making the decision" cannot be deleted. I) The Department will update the regulations to remove any outdated references.

Detail of Changes Made Since the Previous Stage

List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. _ Put an asterisk next to any substantive changes_.*

Changes since proposed stage:

Current chapter-section number	New chapter-section number, if applicable	New requirement from previous stage	Updated new requirement since previous stage	Change, intent, rationale, and likely impact of updated requirements
30-120-600				Throughout the definition section, the word "enrollee" is changed to "member" to ensure consistency in these regulations. (The defined term "member" was removed.) The definition of "adverse benefit determination" is changed to be identical to the federal definition. In the definition of "Commonwealth Coordinated Care Plus program" an outdated reference to the Alzheimer's

				Assisted Living waiver was removed. (This waiver no longer exists.) The term "expedited appeal" was removed in response to a public comment. In the definition of "final decision," the term "informal evidentiary proceeding" was changed to "internal appeal decision" in response to a public comment. The term "hearing" was removed in response to a public comment. The term "internal appeal" was clarified to refer to oral or written requests in response to a public comment. **The term "medically complex" is added to reflect Medicaid expansion. A public commenter asked that DMAS include the Medicaid expansion population in this regulatory package. The term "open enrollment" is added to reflect Medicaid expansion. A public commenter asked that DMAS include the Medicaid expansion population in this regulatory package. In the definition for the term "state fair hearing," the word "process" was removed for clarity. A second sentence was added to the definition for clarity.
12VAC30-120-610				Outdated text in A2 is removed and the sections are re-numbered. Outdated text related to the Alzheimer's waiver is removed from paragraph A3.

				(This waiver no longer exists.) Outdated text in A4 is removed. **Text is added to A5 to describe the Medicaid Expansion population. A public commenter asked that DMAS include the Medicaid expansion population in this regulatory package. Outdated text in A6 is removed in response to public comment. Outdated text in B1 is removed and the sections are re-numbered. Text is added to B 4 (b) to clarify which Plan First members are excluded from CCC Plus. Text is added to B 4 (c) to clarify which individuals in GAP are excluded from CCC Plus. Paragraph B 5 (c) is removed because the GAP program no longer exists. Paragraph B 15, relating to Money Follows the Person is removed because MFP, a former demonstration project, ceased to be effective December 1, 2017. Paragraph B 16, related to the Health Insurance Premium Program is added to clarify that these individuals are excluded from CCC Plus. A public commenter asked that DMAS include this clarification.

				** Paragraph B 17, related to individuals who are not medically complex, is added to clarify which Medicaid Expansion members will be covered by CCC Plus. A public commenter asked that DMAS include the Medicaid expansion population in this regulatory package. Text is added to G 4 (a) to clarify when open enrollment occurs for individuals who participate through Medicaid expansion, as well as for non-expansion populations. Paragraph H, which contained outdated language, is removed. Text is added to paragraph H 1 to indicate that for expansion members, the child's MCPO enrollment will be taken into account when assigning them to an MCO.
	12 VAC 30-120-615			A new section 615 was added to include language that complies with the 21st Century Cures Act.
12 VAC 30-120-620				A8 – reference to the contract was removed because the contract just duplicates the text that is included here. **New paragraphs F through M were added to ensure compliance with the Mental Health Parity and Addiction Equity Act.
12 VAC 30-120-625				The continuity of care period was changed to 30 days in response to a public comment. Outdated language related to an April 1, 2018 date was removed.
12VAC30-120-640				F1, 2, 3, and 4 language amended to reflect OAG guidance. K2 – edits made for clarity.

Detail of All Changes Proposed in this Regulatory Action

*List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

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 30-120-590	Division appeal records	42 CFR § 438.416	Establishes the rules regarding records kept by the Appeals 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	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements

	number, if applicable		
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.