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Proposed Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-120-360 through 120-420
Regulation title(s)	Mandatory Capitated Managed Care Delivery System (Medallion 3.0)
Action title	2014 Mandatory Managed Care Changes
Date this document prepared	March 24, 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.*

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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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.

This regulatory action proposes to require qualifying individuals who are enrolled in the Elderly or Disabled with Consumer Direction Waiver, to also be enrolled in managed care for their acute care services. Prior to the currently effective emergency regulations, these individuals received their acute care services through the fee-for-service model of care. This action also proposes that expedited enrollment into DMAS' contracted managed care organizations be provided.

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.

DMAS - Department of Medical Assistance Services
CMS - Centers for Medicare and Medicaid (CMS).

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including: 1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable; and 2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person'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] (the *Act*) provides governing authority for payments for services.

DMAS operates its managed care program under the authority of section 1915(b) of the *Social Security Act* which permits the waiving of Medicaid individuals' freedom of choice of providers of health care to enable mandatory enrollment in managed care. DMAS sought federal approval of these changes to this § 1915(b) of the *Social Security Act* waiver and received CMS approval dated July 14, 2014. This action conforms the Department's regulations to the federally approved waiver changes.

DMAS operates its home and community based care waivers (such as the Elderly or Disabled with Consumer Direction waiver) under the authority of section 1915(c) of the *Act* that permits the waiving of the comparability rule (42 CFR 440. 240), which requires that services covered for any eligible individual in a covered group must be covered for all individuals in that group. These waivers enable the coverage of specific services, such as personal care, respite care, adult day health care, etc., to enable individuals to avoid institutionalization and remain in their homes and communities.

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 purpose of this regulation is to implement several mandates from various legislative actions to: (i) require qualifying individuals in the Elderly or Disabled with Consumer Direction waiver, to also be enrolled in Medicaid contracted managed care organizations; and (ii) require expedited enrollment for Medicaid individuals into Medicaid contracted managed care organizations, especially for pregnant women. These regulatory changes will improve the health and welfare of the affected Medicaid individuals by providing care coordination and well-person preventive services in addition to routine acute care.

These regulations apply to Managed Care Organizations (MCOs). Small business requirements do not apply to MCOs because managed care organizations do not meet the definition of small businesses.

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.

The regulations that are affected by this action are: Mandatory Capitated Managed Care (Medallion 3.0) (12 VAC 30-120-360; 120-370; 120-380; 120-390; 120-395, and; 120-420).

Medallion II, a mandatory Managed Care Organization (MCO) program, expanded throughout the Commonwealth the use of managed care for the delivery of health care to Medicaid recipients. Medallion II was created for the purposes of further improving access to care, promoting disease prevention, ensuring quality care, and reducing Medicaid expenditures. The program requires mandatory enrollment into a contracted MCO for certain specified groups of Medicaid individuals (12 VAC 30-120-370 A). Also, certain specified groups of individuals are excluded from managed care enrollment (12 VAC 30-120-370 B). MCOs have provided the Commonwealth with the most value per taxpayer dollar for the provision of high quality health care and provide an integrated, comprehensive delivery system to individuals enrolled in Medicaid.

In 2007, the managed care health plans began providing acute care coverage for approximately 4,600 home and community-based (HCB) waiver participants through the Acute and Long Term Care (ALTC) Phase 1 program. This included individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, the Intellectual Disability (ID) Waiver, the Individuals and Family Developmental Disabilities Support (IFDDS) Waiver, the Day Support (DS) Waiver, and the Alzheimer's Assisted Living (AAL) Waiver. Under the Phase 1 program, if a MCO enrolled Medicaid member subsequently becomes eligible for and enrolled into one of five HCB waivers, then he remains enrolled with the MCO for primary and acute care services while all long-term care waiver services, such as personal care, respite care, Personal Emergency Response Systems, and environmental modifications, are covered under the fee-for-service reimbursement system.

The 2011 *Acts of Assembly* Item 297 MMMM.1 directed the Department to:

…seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services

On December 1, 2014, the Department launched the Health and Acute Care Program (HAP). This initiative allows eligible EDCD waiver individuals to receive their acute and primary medical care through one of the managed care health plans and, concurrently, the individual's HCB care waiver services, including transportation to the waivered services, are paid for through the Medicaid fee-for-service system as a "carved out" service. These individuals participate concurrently in both § 1915(b) and § 1915(c) waivers. As part of the HAP initiative, approximately 2,700 individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver who received acute medical services in the fee-for-service program and who were eligible for managed care (i.e., do not have any managed care exclusions) were transitioned into managed care in December 2014. The ALTC program was rebranded as HAP for approximately 7,300 individuals enrolled in both the 1915(b) and 1915(c) waivers.

The 2012 *Acts of Assembly*, Chapter 3 Item 307 FFF provided: '*The department may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to develop and implement programmatic and system changes that allow expedited enrollment of Medicaid eligible recipients into Medicaid managed care, most importantly for pregnant women.*'

In an effort to ensure that newly eligible Medicaid individuals, especially pregnant women, have quicker access to the managed care delivery system, the Department shortened the period of time between an individual being identified as Medicaid eligible and that individual's enrollment into a managed care organization (MCO). This new process reduces disruptions to continuity of care by minimizing the movement of individuals between the fee-for-service and the managed care delivery systems.

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.

The primary advantage of this regulatory action is that the expedited enrollment component of this regulation will ensure that Medicaid individuals who are eligible for managed care get placed into an MCO sooner than the previous "pre-assignment" methodology allowed, resulting in less time waiting to enroll in an MCO. Both expedited enrollment and the additional population becoming eligible for managed care ensure access to care coordination and additional services offered by the MCOs that are not available under Medicaid fee-for-service.

Another advantage is that this regulation is projected to create savings for the Department and the Commonwealth.

The Department does not anticipate any disadvantages to the public 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 that exceed the applicable federal requirements, and the actions have been approved by the federal Center for Medicare and Medicaid (CMS).

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.

These changes have no particular effect on any locality; they apply equally across the state.

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.

DMAS conducted several training sessions for stakeholders and affected groups. The trainings provided each stakeholder group listed below an opportunity to learn about the proposed program, how it would work, and how it would affect them. There was an opportunity for the stakeholders to ask questions and provide additional feedback. (These trainings occurred on 9/16/14, 9/30/14, 10/14/14, and 2/24/15.)

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 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, email or fax to Kayla Anderson, DMAS, 600 E. Broad Street, Richmond, VA 23219; Kayla

Anderson, DMAS, Health Care Services Division; 600 E. Broad Street, Richmond, VA 23219; phone (804) 371-2645; email: Kayla.Anderson@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**	FY 2015 ($1,589,635) FY 2016 ($3,180,949)
Projected cost of the new regulations or changes to existing regulations on localities.	$0
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	The Department of Medical Assistance Services currently contracts with the following Managed Care Organizations (MCOs) for mandatory managed care services: Anthem Healthkeepers Coventry Cares InTotal Health Kaiser Permanente Optima Family Care Virginia Premier
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 has gross annual sales of less than $6 million.	The Department of Medical Assistance Services currently contracts six (6) Managed Care Organizations (MCOs) for mandatory managed care services, none of which appear to meet the small business criteria. As of March 2015, a total of 681,456 Medicaid members were enrolled in Medicaid Managed Care. No small businesses are expected to be

	affected.
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.**	Reporting changes pursuant to this regulation are minimal. Existing reporting mechanisms will be used for the initiatives contained herein. Systems changes for expedited enrollment have already been employed by the MCOs as a result of federal 1915(b) waiver approval. This authority requires submission of an independently certified cost effectiveness estimate upon renewal. CMS will not approve a 1915(b) waiver if the program is not cost effective. The addition of a new population group to managed care will incur additional costs to the MCOs of providing health care to these members. The MCOs, however, receive compensation under a "per member, per month" capitation rate methodology that offsets the additional costs for these additional members. The Program is projected to incur savings to the Department and the Commonwealth.

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.

Due to the nature of the legislative mandates, policy alternatives were not permitted to DMAS.

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.

The regulatory changes proposed in this action have no impact on small businesses as managed care organizations do not meet the definition of small businesses.

Public comment

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

DMAS Notice of Intended Regulatory Action was published in the Virginia Register of January 26, 2015, (VR 31:11). The comment period ended on February 25, 2015. There were no comments received during the comment period.

Family impact

Please assess the impact of this 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, nor increase or decrease disposable family income.

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 following changes were made in the emergency stage regulation, and remain in the proposed stage:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12VAC 30-120-		Definitions. Updated with current terminology and	Updating of terminology and program name.

360		removed unused terms.	
12VAC 30-120-370		Mandatory enrollees. Program name updated; exception provided for certain EDCD participants to enroll in managed care.	Allows enrollees to access services via managed care in an expedited manner. Requires certain EDCD individuals who currently receive acute and primary medical services through fee-for-service to receive those services via the managed care delivery system. MCO enrollment for newborn infants is provided for.
12VAC 30-120-380		MCO responsibilities.	Updating terminology.
12VAC 30-120-390		Payment rate.	Updating terminology.
12 VAC 30-120-395		Payment rate for out-of-network providers.	Updating terminology.
12VAC 30-120-410		Sanctions.	Updating terminology. DMAS is required to appoint a temporary manager before providing a sanctioned MCO with a pretermination hearing.
12VAC 30-120-420		Enrollee grievances and appeals.	Updating terminology.

The following changes were made between the emergency regulation and the proposed regulation:

- In all sections, the terms "recipient," "individual," and "enrollee" were changed to "member."
- In the definitions section 12 VAC 30-120-360, definitions that were not used in the regulations were removed.
- In the definitions section, the term "Exclusion from Medallion II" was changed to be a definition for the word "exclude."
- In 12 VAC 30-120-370 (A)(2) and (B)(4) language was added to clarify the enrollment requirements for qualifying individuals enrolled in the Elderly or Disabled with Consumer Direction waiver.
- In 12 VAC 30-120-370, the term "preassigned" was changed to "assigned" to match current DMAS terminology.
- Section 12 VAC 30-120-400 was added to the regulatory package so that the term "enrollee" could be changed to "member" for consistency throughout the applicable sections.