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Notice of Intended Regulatory Action (NOIRA)
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	_12_ VAC_30_-_121__
Regulation title(s)	Medicare-Medicaid Demonstration Waivers
Action title	Commonwealth Coordinated Care
Date this document prepared	February 2, 2015

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

Subject matter and intent

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

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

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

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

Legal basis

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

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

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

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

In this regulatory action, DMAS is responding to multiple General Assembly mandates: (i) Chapter 806, Item 307 AAAA of the *2013 Acts of the Assembly (*the *Acts)*; (ii) Chapter 806, Item 307 RRRR of the *Acts*, and; (iii) Item 307 RR of the *Acts*.

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

Item 307 RR directed DMAS to implement a care coordination program for Medicare- Medicaid Enrollees (dual eligibles). This action included the joint Memorandum of Understanding between DMAS and the Centers for Medicare and Medicaid Services (CMS) as well as three way contracts between CMS, DMAS, and participating health care plans. This program, to be established in Chapter 121 of the Virginia Administrative Code, is being called Commonwealth Coordinated Care.

Item 307 RR of the *Acts* provides for achieving cost savings and standardization of administrative and other processes for providers and also authorized DMAS to promulgate emergency regulations.

Emergency regulations for the CCC were approved by the Governor on December 10, 2014, adopted by the agency and submitted to the Registrar to become effective December 10, 2014. This NOIRA stage is required to initiate the permanent rule making action.

Purpose

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

The Commonwealth of Virginia is implementing the Commonwealth Coordinated Care (CCC) to allow DMAS to combine certain aspects of Medicaid managed care and long-term care and Medicare-covered services into one program. To accomplish its goal, DMAS is including certain populations and services previously excluded from managed care into a new managed care program. The CCC will be established under authority granted by a *Social Security Act* § 1932(a) state plan amendment and concurrent authority to the relevant existing § 1915(c) home and community based services programs. This proposed regulatory action is essential to protect the health, safety, and welfare of the affected dual eligible individuals because their care will be coordinated across all disciplines (medical, social, long term care) thereby reducing unnecessary, duplicative and inappropriate services.

HISTORY:

In 2011, CMS announced an opportunity for states to align incentives between Medicare and Medicaid. Pursuant to § 1932(a) of the *SSA*, CMS created a capitated model of care through which full-benefit dual eligible individuals will receive all Medicare and Medicaid covered benefits from one managed care plan and the health plans will receive a blended capitated rate. In May 2013, DMAS was accepted into the demonstration. Six other states have also been accepted. The demonstration began in Virginia on January 1, 2014, and will operate through December 2017.

The populations include adults (21 years of age and older) who are eligible for both Medicare and Medicaid (full-benefit duals only), including individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver (one of six waivers for home- and community-based

services (HCBS) administered by DMAS) and individuals residing in nursing facilities. Approximately, 78,600 dual eligible individuals will be eligible for this program.

The goal of this action is to provide integrated care to dual eligible individuals who are currently excluded from participating in managed care programs. This change will enable these participants to access their primary, acute, behavioral health, and long-term care services through a single managed delivery system, thereby increasing the coordination of services across the spectrum of care.

Substance

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

This action adds a chapter in the Virginia Administrative Code, Chapter 121, to include the Commonwealth Coordinated Care program (12 VAC 30-121-10 et seq.).

Program Description and History

In 1996, Medallion II, DMAS' managed care program, was created to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. Since that time, DMAS' managed care program has met these objectives and has undergone numerous expansions. In July 2012, the managed care program became operational statewide.

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

As the managed care program exists today, the majority of individuals who are in the elderly or disabled populations are excluded from managed care. Specifically, DMAS' managed care program does not include dual eligibles or individuals who receive long-term care services – either through home and community-based waiver programs or an admission to a nursing facility (except in limited circumstances through ALTC, as described below).

The 2008 Acts of Assembly, Chapter 847 directed DMAS to implement two different models for the integration of acute and long-term care services: a community model and a regional model. The community model entailed developing Programs of All-Inclusive Care for the Elderly (PACE) across the Commonwealth. PACE serves individuals 55 years and older who meet nursing facility criteria in the community, provides all health and long term care services

centered around an adult day health care model, and combines Medicaid and Medicare funding. DMAS currently operates fourteen PACE sites and three more are in the process of becoming operational.

The regional model, referred to as Acute and Long-Term Care (ALTC) (effective September 1, 2007) focuses on care coordination and managing acute care services for seniors and certain individuals with disabilities. ALTC allows individuals currently enrolled in an MCO to remain in their MCO if they subsequently become eligible for a Medicaid home- and community-based waiver (except for the Technology Assisted Waiver). These individuals receive their primary and acute medical services through their MCO and receive long-term care services through the DMAS' FFS system. However, ALTC neither addressed dual eligible individuals nor individuals residing in nursing facilities. It also did not integrate the management of acute and long term care services.

Program Enrollees and Care Plans

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

This regulatory action will allow DMAS to combine certain aspects of managed care, long-term care, and Medicare into one program. The program is expected to offer participants care coordination, which will, it is anticipated, improve their quality of care. To accomplish this, DMAS is including certain populations and certain services previously excluded from managed care into a new managed care program. This new managed care program will be offered on a voluntary basis in five (5) regions of the Commonwealth: Central Virginia, Tidewater, Northern Virginia, Charlottesville/Western and the Roanoke region. The program will be phased in on a regional basis over the first twelve months of the new program, starting with the Central Virginia and Tidewater regions. Eligible individuals were notified of the opportunity to enroll during March 2014 and the first opportunity for enrollment was effective on April 1, 2014. The remaining three regions were phased in later in 2014.

Covered Services

Covered services will include the following:

1. All Medicare Parts A, B, and D services (including inpatient, outpatient, durable medical equipment (DME), skilled NFs, home health, and pharmacy);
2. The majority of Medicaid State Plan services that are not covered by Medicare, including behavioral health and transportation services;
3. Medicaid-covered EDCD Waiver services: adult day health care, personal care (consumer-and agency-directed), respite services (consumer-and agency-directed),

personal emergency response system (PERS), transition coordination, and transition services;
4. Personal care services for persons enrolled in the Medicaid Works program;
5. Nursing facility services; and,
6. Flexible benefits that will be at the option of participating plans.

The new program will offer dual eligible individuals care coordination, health risk assessments, interdisciplinary care teams, and plans of care, which are currently unavailable for this population. Care coordination is essential to providing appropriate and timely services to often-vulnerable participants.

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

Enrollment in CCC will be voluntary for qualified individuals—an opt-in period will be followed by passive enrollment. Individuals can switch among participating plans in their regions or opt-out of the new program altogether at any time at each month's end.

Alternatives

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

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

The health plans that are participating in Commonwealth Coordinated Care are not considered small businesses because they each have more than 500 employees and annual budgets of more than $5 million.

Public participation

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

The agency is seeking comments on this regulatory action, including but not limited to: ideas to be considered in the development of this proposal, the costs and benefits of the alternatives stated in this background document or other alternatives, and the potential impacts of the regulation.

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

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

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