Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	Chapter 121
Regulation title	Integrated §§1932 and 1915(c) of the *Social Security Act* Waiver
Action title	Commonwealth Coordinated Care
Date this document prepared	

Preamble

The APA (Code of Virginia § 2.2-4011) states that an "emergency situation" is: (i) a situation involving an imminent threat to public health or safety; or (ii) a situation in which Virginia statutory law, the Virginia appropriation act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment, or in which federal regulation requires a regulation to take effect no later than 280 days from its effective date.

1) Please explain why this is an "emergency situation" as described above.
2) Summarize the key provisions of the new regulation or substantive changes to an existing regulation.

The Administrative Process Act (Section 2.2-4011) states that an "emergency situation" is: (i) a situation involving an imminent threat to public health or safety; or (ii) a situation in which Virginia statutory law, the Virginia appropriation act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment, or in which federal regulation requires a regulation to take effect no later than 280 days from its effective date. This suggested emergency regulation meets the standard at *COV* 2.2-4011(ii) as discussed below.

In order for the state regulations to conform to the Virginia Appropriation Act, Chapter 806, Item 307 RR, and to implement the provisions of this Act, the Department of Medical Assistance Services (DMAS) shall promulgate emergency regulations to become effective within 280 days or less from the enactment of this act. DMAS shall implement these necessary regulatory changes to be consistent with federal approval of a Medicare-Medicaid Financial Alignment

Demonstration (FAD) for persons who are dually eligible. This new program is to be called Commonwealth Coordinated Care.

The Governor is hereby requested to approve this agency's adoption of the emergency regulations entitled Commonwealth Coordinated Care and also authorize the initiation of the permanent regulatory promulgation process as provided for in §2.2-4007 or §2.2-4012.1, as appropriate.

Legal basis

Other than the emergency authority described above, please identify the state and/or federal legal authority to promulgate this proposed regulation, including: 1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and 2) promulgating entity, i.e., agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

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) [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 recipients 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.

In this regulatory action, DMAS is responding to multiple 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*.

Item 307 AAAA (1) directed DMAS to implement a process for administrative appeals of Medicaid/Medicare dual eligible recipients 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, will be called Commonwealth Coordinated Care.

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

Purpose

Please describe the subject matter and intent of the planned regulatory action. Also include a brief explanation of the need for and the goals of the new or amended regulation.

The Commonwealth of Virginia is implementing the Commonwealth Coordinated Care to allow the DMAS to combine certain aspects of Medicaid managed care and long-term care, and Medicare 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 FAD will be established under authority granted by *Social Security Act* § 1932(a) state plan amendment and concurrent authority to the relevant existing § 1915(c) home and community based care programs.

HISTORY

In 2011, CMS announced an opportunity for states to align incentives between Medicare and Medicaid. 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 will began on January 1, 2014 and 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 home- and community-based waiver (HCBS) programs operated 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 services, and long-term care services through a single managed delivery system, thereby increasing the coordination of services across the spectrum of care.

Need

Please detail 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, delineate any potential issues that may need to be addressed as the regulation is developed.

The dual eligible population is of particular interest for a managed care program because they represent some of the most vulnerable citizens, typically having extensive medical, behavioral

health, social, and long-term care needs. In the Commonwealth, dual eligibles are currently excluded from managed care and receive care in Medicaid's fee-for-service system. Dual eligible persons were originally excluded from managed care because Medicare, being their first payer of services, covered their acute care services and also because the original managed care organizations did not cover long term care services (nursing facilities nor home and community based care services).

As a result of being in the fee-for-service system, no single person or entity is responsible for coordinating all of the individuals' care resulting in an inefficient system that is cumbersome for the participant 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 services into one delivery system will streamline delivery of services 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.

Substance

Please detail any changes that will be proposed. Please outline new substantive provisions, all substantive changes to existing sections, or both where appropriate.

This action expands a chapter in the Virginia Administrative Code, Chapter 121, to include the Commonwealth Coordinated Care program.

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 twelve PACE sites and six more will be implemented in the next twelve months.

The regional model, referred to as Acute and Long-Term Care (ALTC) (effective September 1, 2007) focuses on care coordination and integrating acute and long-term 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 fully integrate 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 will be phased in later in the 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*. Consumer direction allows 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 altogether of the new program 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 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 the agency is seeking comments on the intended regulatory action, to include 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 meeting is to be held to receive comments on this notice.

The agency is seeking comments on the regulation that will permanently replace this emergency regulation, including but not limited to 1) ideas to be considered in the development of the permanent replacement regulation, 2) the costs and benefits of the alternatives stated in this background document or other alternatives and 3) 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 1) projected reporting, recordkeeping and other administrative costs, 2) the probable effect of the regulation on affected small businesses, and 3) 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 Kristen Burhop, Program Manager, DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219, ((804) 371-2637; (804) 786-1680 fax); Kristen.Burhop@dmas.virginia.gov 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.

DMAS has and will continue to engage stakeholders in the development and implementation of the Commonwealth Coordinated Care. Specifically:

- **Stakeholder meetings:** DMAS held extensive stakeholder meetings during the development of the CCC to ensure that the Demonstration was developed with stakeholder concerns in mind. In March 2012, DMAS conducted a series of stakeholder meetings with providers, health plans, nursing facilities, hospitals, state agencies, advocacy groups, associations, and individuals, among others. All of these meetings were open to the public, but some of the meetings focused on specific aspects of the Demonstration that were most relevant to targeted groups. Approximately 200 individuals attended these meetings. DMAS held another stakeholder meeting in July 2012 to discuss care coordination. Meeting materials, including presentations for all the stakeholder meetings can be accessed on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx. DMAS continues to meet with specific provider and advocacy groups on an ongoing basis.

- **Website and dedicated e-mail box:** DMAS created a website dedicated to the CCC which provides public access to stakeholder meeting announcements and agendas,

meeting presentations, materials and summary notes, comments received, and other related information http://dmasva.dmas.virginia.gov/Content_pgs/altc-enrl.aspx. The web site and all written meeting materials direct interested parties to a dedicated e-mail address (Commonwealthcoordinatedcare@dmas.virginia.gov) to submit questions, comments or concerns about the Demonstration. The e-mail box is monitored daily and all e-mails are reviewed and directed to the appropriate DMAS staff member.

- **Public comment period on DMAS' CCC proposal:** DMAS complied with CMS' requirements regarding seeking public comments on Virginia's Demonstration proposal. The proposal was posted on for two distinct thirty day comment periods. DMAS reviewed all comments and incorporated them, as appropriate, into the Demonstration proposal.

- **Stakeholder advisory committee:** DMAS formed a stakeholder advisory committee to support the implementation of care coordination systems for dual eligible individuals. To date, two advisory committee meetings have been held (one in November 2012, and one in April 2013). The advisory committee meets quarterly and is comprised of a wide range of stakeholders.

- **Outreach and Education Workgroup:** DMAS also formed an Outreach and Education workgroup to help educate providers, stakeholders, recipients (and their families) about the CCC. This workgroup will play an active role leading up to the CCC's implementation and thereafter.

Family impact

Assess the potential 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; or 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 increase or decrease disposable family income.