Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30 – 120-370; 12VAC 30-120-380
Regulation title	Managed Care
Action title	Acute Long-Term Care
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

This proposed change, generally referred to as Phase I of the Integration of Acute and Long-Term Care, will permit persons who become newly enrolled home and community-based care (CBC) waiver recipients (HIV-AIDS, Individual and Family Developmental Disabilities Support (IFDDS), Mental Retardation (MR), Elderly or Disabled with Consumer Direction (EDCD), Day Support, and Alzheimer's Waiver programs) to retain their enrollment in their managed care organization for purposes of obtaining needed acute medical care. Excluded from this change will be persons newly admitted to the Technology Assisted waiver, to nursing facilities, and those persons who become dual eligibles (eligible for both Medicare and Medicaid). Prior to the agency's current emergency regulation, these persons have been disenrolled from their managed care organization (once they qualify for certain CBC waivers) and have been required to seek needed acute care services in the unmanaged fee-for-service environment. The persons who will be affected by this change will have their home and community-based waiver services, including necessary transportation to waiver services, reimbursed by the Department of Medical Assistance Services (DMAS) through a fee-for-service mechanism. The Managed Care Organizations (MCO) will be financially responsible for these affected persons' acute medical care. DMAS estimates approximately 500 persons will be affected by this change annually.

Legal basis

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., the 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 legislation (*Special Session Services I, 2006 Virginia Acts of Assembly, Chapter 3*) directed the DMAS, in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated acute and long-term care system. In addition to this plan, the Department was directed to move forward with two different models for the integration of acute and long-term care services: a community model (*Chapter 847 Item 302, AAA*) and the regional model (Item 302, BBB). Item 302 M.1 and M.2 of the 2006 *Acts of Assembly* provided DMAS with the authority to seek federal approval of these changes to its MEDALLION and Medallion II waivers.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal, the environmental benefits, and the problems the proposal is intended to solve.

In order to best protect the health, safety, and welfare of the persons who qualify for home and community-based care services, DMAS is proposing that they retain their enrollment in their managed care organizations once approved for waiver services rather than being required to seek needed acute care services from the fee-for-service program. This change will sustain already established physician-patient relationships for these often fragile Medicaid recipients.

The goals of this action are (i) to better support these affected often fragile Medicaid recipients in their receipt of acute care services, once they qualify for waiver services and (ii) to begin the process of integrating acute and long-term care services as mandated to the Department.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the "Detail of changes" section.)

The regulations affected by this action are the following sections of the Medallion II (12VAC 30-120-370) and (12 VAC 30-120-380).

Managed care systems (MCOs) were introduced in the Commonwealth in 1996. Currently, 114 localities are served by MCOs, with their approved provider networks that provide services to 400,783 Medicaid recipients. DMAS expends $1.17 billion on capitation rates for the seven MCOs that operate in the Commonwealth. The recipients who live in localities of the Commonwealth that are not served by MCOs obtain their acute medical care from individual fee-for-service providers. Presently, when a recipient who has been in managed care qualifies for waiver services, this individual is disenrolled from his MCO thereby requiring that he obtain his acute care services from individual fee-for-service providers. This has disrupted long-standing physician-patient relationships and forced vulnerable Medicaid recipients to negotiate a complex, unmanaged health care system on their own.

Governor Timothy Kaine, with support from the 2006 General Assembly, set in motion a major reform of the Virginia Medicaid funded long-term care services program to focus on care coordination and integration of acute and long-term care services for our most vulnerable citizens—low-income seniors and individuals with disabilities. The legislation (*Special Session I, 2006 Virginia Acts of Assembly, Chapter 3*) directed DMAS, in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated acute and long-term care system. In addition to this plan, the Department was directed to move forward with two different models for the integration of acute and long-term care services: a community model and a regional model.

The change proposed herein will permit managed care enrolled persons to remain in their MCOs while receiving their waiver services. Excluded from this proposed program change are those persons who qualify for the Technology Assisted Waiver, nursing facility residents and persons classified as dual eligibles (Medicare-Medicaid eligibles).

The home and community-based waiver population is currently excluded from participation in the managed care program. This policy derives from years of federal policy which precluded recipients from participating in more than one waiver program at a time. In light of the ever increasing nationwide aging population, more federal policy options are available to the states than ever before.

This regulatory change will expand managed care operations over previously "un-managed" populations and also integrate acute and long-term care by increasing care coordination for the elderly and certain persons with disabilities. This program change will prevent enrollees, when they are approved for CBC waiver services, from having to change their current managed care organization for their acute medical care, therefore eliminating any disruptions in care (loss of

established provider relationships). Key provisions allow for MCO enrollees who are newly enrolled into the HIV-AIDS, IFDDS, MR, EDCD, Day Support, and Alzheimer's Waiver programs to continue enrollment in one of the contracted MCOs for their acute care medical needs.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-120-370		Excludes recipients enrolled in one of the home and community-based waivers from participation in the managed care program (Medallion II)	This regulation will allow newly enrolled recipients in the AIDS, IFDDS, MR, EDCD, Day Support, or Alzheimer's Waiver programs to continue enrollment in one of the contracted Medicaid managed care organizations (MCOs) for their acute care medical needs. Recipients enrolled in the Technology Assisted Waiver will continue to be excluded from managed care participation
12VAC30-120-380		Identifies the services that are provided outside (carved out) of the MCO network to recipients enrolled in the MCO.	Adds services provided under the AIDS, IFDDS, MR, EDCD, Day Support, and Alzheimer's Waiver programs to the list of services provided outside of the MCO network to those recipients enrolled in the MCO.

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 the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

There are no disadvantages to the public for these proposed regulations. The advantages to the public and the Commonwealth are that reductions in Medicaid expenditures may be realized for the coordination of services previously provided in an unmanaged care environment. Medicaid recipients will still have ready access to medical and long-term care providers and services.

The degree of chronic illness and disability among seniors and individuals with disabilities is a key policy and budget issue for the Commonwealth as well as nationwide with the graying of the general population. Seniors and individuals with disabilities make up 30 percent of the Medicaid population in the state, but 70 percent of the costs of a budget that now exceeds $5 billion annually. The Commonwealth's challenge is curbing Medicaid growth in the long run without compromising access to services for vulnerable populations. While Virginia has been successful in implementing managed care for low-income children and families, it has not yet applied the same successful principles to programs specifically designed for the long-term care populations. Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care for these often fragile individuals is provided in a fee-for-service environment with little chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with little overall care coordination or case management. In addition, many Medicaid seniors and individuals with disabilities qualify for both Medicare and Medicaid which further complicates the access, quality, and funding of an integrated system.

This regulatory change responds to the need to expand managed care operations over "un-managed" populations and also integrate acute and long-term care by improving the current system and increasing care coordination for the elderly and disabled population.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which are 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 provisions that exceed applicable federal requirements or are more restrictive.

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.

This regulatory change impacts the 114 localities that currently operate under the managed care organizations for Virginia's Medicaid recipients.

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 board/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.

Legislation (*Special Session I, 2006 Virginia Acts of Assembly, Chapter 3*) directed the Department of Medical Assistance Services (DMAS), in consultation with the appropriate stakeholders, to develop a long range blueprint for the development and implementation of an integrated acute and long-term care system.

In response to the legislation, DMAS held three meetings from September through October 2006 to involve the community, state, and local stakeholders in the development of the Blueprint. The meetings provided an overview of other states' integration models and the opportunity for the public to comment and provide input into the design of the program.

DMAS' stakeholders' comments about the design and implementation of the integrated acute and long-term care models ensures that consumer protections, consumer choice, consumer direction, quality of care, and access to needed services are maintained. DMAS supports the vision of *One Community; the Olmstead Initiative* to allow individuals to live as independently as possible and in the most integrated setting. Seven additional meetings with stakeholders were held in September 2007. This also was the topic of discussion at the five semi-annual MCO case manager's waiver meetings in October, 2007. All meeting materials (including presentations and summaries) may be found on the DMAS website at http://www.dmas.virginia.gov/altc-home.htm.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to ALTC, DMAS 600 East Broad Street Richmond, VA 23219 or **altc@dmas.virginia.gov**. Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last day of the public comment period.

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

Projected cost to the state to implement and enforce the proposed regulation, including	There are no new funds required for the implementation of this change as the medical

(a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	expenses for the enrollees are currently covered by the MCOs and the long-term care services are covered by the DMAS fee-for-service program.
Projected cost of the regulation on localities	There is no cost to localities to implement this regulation.
Description of the individuals, businesses or other entities likely to be affected by the regulation	Medicaid recipients, managed care organizations
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 (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Approximately 500 Medicaid recipients per year under 7 managed care organizations will be affected by this regulation.
All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.	There is no cost to Medicaid recipients or managed care organizations to implement this regulation.

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.

This regulatory action is based on a specific mandate provided in the *2006 Acts of Assembly* and is intended to conform the agency's current policies to the integration of acute and long-term care services system. Failure to implement these recommended changes will result in the continuation of the current policy that negatively impacts these affected aging Medicaid recipients.

It will be less burdensome for these affected recipients to remain in the care of their MCOs (with their established physician and pharmacy relationships, as two examples) than to be removed from the MCO and be forced to find new physicians and pharmacies for their general acute care needs.

Regulatory flexibility analysis

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 package impacts Medicaid recipients and managed care organizations (MCOs). The contracted MCOs do not meet the statutory definition of small business therefore the adverse impact on small business did not apply in the development of this regulatory package.

Public comment

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

DMAS' Emergency regulation/Notice of Intended Regulatory Action was published in the August 6, 2007, *Virginia Register* (VR 23: 24) for its public comment period from August 6, 2007, to September 5, 2007.

No comments were received during the Notice of Intended Regulatory Action (NOIRA) comment period.

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.

Only to the extent that this regulatory change provides improved quality of care will this regulatory action have any impact on the institution of the family and family stability including strengthening or eroding the authority and rights of parents in the education, nurturing, and supervision of their children; encouraging or discouraging economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents, strengthening or eroding the marital commitment; and increasing or decreasing disposable family income.

The degree of chronic illness and disability among seniors and individuals with disabilities is a significant policy and budget issue for the Commonwealth. Seniors and individuals with disabilities make up 30 percent of the Medicaid population in the state, but 70 percent of the costs of a budget that now exceeds $5 billion annually. The challenge is to curb Medicaid growth in the long run while maintaining access to services for vulnerable populations. While Virginia

has been successful in implementing managed care for low-income children and families, it has not applied the same successful principles to programs specifically designed for the long-term care populations. Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee-for-service environment with little chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with little overall care coordination or case management. In addition, most Medicaid seniors and individuals with disabilities qualify for both Medicare and Medicaid, which further complicates the access, quality, and funding of an integrated system.

Virginia is one state that proceeded with moving the elderly and persons with disabilities into managed care years ago. At the present time, more than 49,000 elderly and persons with disabilities have their health care needs successfully managed by one of seven managed care organizations (MCOs) across Virginia. However, once these recipients need long-term care services and/or become both Medicaid and Medicare eligible (known as dual eligibles), they are moved out of a managed care environment into a fragmented fee for service environment with little coordination of their health care and long-term care needs. This disruption in care is not good for the enrollee and is costly for the Commonwealth. In response to legislation, DMAS implemented a program change that expands its current managed care population by retaining those enrollees in managed care once they require long-term care services.

This regulatory change responds to the need to expand managed care operations over "un-managed" populations and also integrate acute and long-term care by improving the current system and increasing care coordination for the elderly and persons with disabilities population.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

All changes from the Emergency regulation are in bold text.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-120-370.B.		Outlines reasons for exclusions from MCO participation	**Adds link to state regulation that defines "exclusion" as it relates to managed care participation**
12VAC30-120-370.B.4		Indicates recipients in home and community-based waivers are	Indicates recipients in home and community-based waivers are

		excluded from managed care participation	excluded from managed care participation if it occurs prior to managed care enrollment – this allows those who are enrolled in a MCO and then enrolled into a waiver to remain in the MCO – those who are enrolled into a waiver prior to managed care enrollment shall be excluded from MCO participation
	12VAC30-120-370.C	No previous requirement	Adds section to clarify that individuals who are enrolled in MCOs and then meet an exclusion requirement will be removed from MCO participation except for recipients in six home and community-based waivers – those in waivers will receive medical care via the MCO and waiver services via DMAS fee-for-service
12VAC30-120-370.F	12VAC30-120-370.G	Outlines requirements for disenrollment while participating in MCO	**Adds link to state regulation that defines "disenrollment" as it relates to managed care participation**
12VAC30-120-380.A.2		Outlines services "carved out" for MCO enrollees – these services are paid by DMAS fee-for-service	Adds services under the six home and community-based waivers as "carved out" services that will be paid for by DMAS fee-for-service