Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC30-120-370 12VAC30-120-380
Regulation title	Waiver Services 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

Please provide a brief summary (no more than 2 short 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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

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, which focused 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 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.

Key provisions of the regulation allows for newly enrolled recipients in the AIDS, Individual and Family Developmental Disabilities Supports (IFDDS), Mental Retardation (MR), Elderly or Disabled with Consumer Direction (EDCD), Day Support, or Alzheimers Waiver programs to continue enrollment in the Medicaid Managed Care Organizations (MCOs) for their acute care medical needs. The Department promulgated emergency and proposed regulations to implement these changes. This regulation is the final step in creating permanent regulations for this new program.

Statement of final agency action

Please 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 for Acute Long-Term Care 12VAC30-120-370 and 12VAC30-120-380) 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. I hereby certify that these regulations are full, true and correctly dated.

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

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 numbers, 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 legislation (Special Session Services 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 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*, provides DMAS with the authority to seek federal approval of these changes to its MEDALLION waiver and its Medallion II waiver.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons it 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.

Virginia is one state that moved forward with moving the elderly and disabled into managed care years ago. At the present time, more than 49,000 elderly and disabled have their health care needs successfully managed by one of seven managed care organizations across Virginia. However, once these clients 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 the legislation from the special Session I, 2006 Virginia Acts of Assembly, Chapter 3, DMAS implemented a program change that expanded its current managed care population by retaining those enrollees in managed care once they require long term care services.

Currently, once an enrollee is identified from the community they are assigned to a Pre-Admission Screening Team (PAS) to determine if the patient requires long term care services. Long-term care services are defined by the Commonwealth as nursing facility care, Intermediate Care Facility for the Mentally Retarded (ICF/MR), PACE Site placement, or home and community based waiver services. Once the enrollee is approved for any of these services they are removed from the MCO. Removal from the MCO due to enrollment into a waiver service impacts approximately 700 enrollees per year (this excludes those who require Technology Assisted Waiver services).

Effective September 1, 2007, once the enrollee is approved for home and community-based services (excluding Technology Assisted Waiver services) they remain in the MCO for their acute medical care services. Their waiver services, including transportation to the waivered services, are paid through the Medicaid fee for service program. This program change does not address the dual eligibles; all services for these enrollees will still be moved out of managed care when they become Medicare eligible.

This program change prevents the enrollee from having to change their current managed care organization for their acute medical care, therefore eliminating any disruption in care. This program change begins the process to expanding managed care for the elderly and disabled for their primary and acute care needs, in efforts to expand managed care coverage for more Virginia Medicaid enrollees.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The regulations affected by this action are the following sections of the Waiver Services Managed Care (12VAC30-120-370 and 12VAC30-120-380).

Currently, persons who are enrolled in managed care organizations who subsequently become enrolled for long-term care services (either nursing facility ICF/MR, care or waiver services), are being canceled from their MCOs to receive their acute and long-term care services through the fee-for-service payment mechanism in conjunction with their nursing facility or waiver services. This change will permit waiver enrolled persons to remain in their MCOs while receiving their waiver services. This change will not affect those persons who qualify for the Technology Assisted Waiver, nursing facility, ICF/MR nor for 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 regulatory change will 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 certain persons with disabilities. This program change will prevent enrollees from having to change their current managed care organization for their acute medical care, therefore eliminating any disruptions in care. Key provisions allow for MCO enrollees who are newly enrolled into the 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 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 Alzheimers 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 Waivers will continue to be excluded from managed care participation
12VAC30-120-380		Identifies the services that are provided outside (carved out) of	Adds services provided under the AIDS, IFDDS, MR, EDCD,

		the MCO network to recipients enrolled in the MCO.	Day Support, and Alzheimers 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 there are no disadvantages to the public or the Commonwealth, please indicate.

There are no disadvantages to the public for the approval of these proposed regulations. The advantages to the public and the Commonwealth are that reductions in Medicaid expenditures may be realized for coordination of services previously unmanaged. 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. 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 how to curb 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 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 no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with no 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.

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.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

Changes to the regulation from publication of the proposed regulation to the final regulation adds language to further clarify the existing regulations or conform the existing regulations to the newly approved federal 1915(b) waiver from CMS. These changes include clarification of recipients excluded from managed care, the pre-assignment to managed care enrollment process, defining the newborn enrollment period, and adding midwife as an obstetrical provider.

Section number	Requirement at proposed stage	What has changed	Rationale for change
12VAC30-120-370.B.6	Indicates individuals under age 21 in residential treatment or treatment foster care are excluded from managed care.	Clarification of the levels of recipients in residential treatment who are excluded from managed care.	Clarifies that there are Level A, B and C residential services for children. Level A and B services are generally provided in group homes. The children receiving Level A & B services are not excluded from managed care, however Level C is excluded. This is not a policy change but merely an explicit statement of existing policy.
12VAC30-120-370.B.7	Indicates exclusion reason for recipient in third trimester of pregnancy and classifies obstetrical provider.	Clarifies that midwives are classified as an obstetrical provider.	Adds "midwife" to the list of obstetrical providers from whom Medicaid recipients can receive care and not be required to join an MCO if she is in the third trimester of her pregnancy. This is an expansion of provider types that pregnant women can be using and still qualify for this MCO exclusion reason.
12VAC30-120-370.B.11	Indicates exclusion reason for a recipient hospitalized at the time of MCO enrollment.	Adds language per newly approved federal waiver.	Clarifies per 1915(b) waiver approved July 2008 that exclusion does not apply to those who are hospitalized at the time of MCO enrollment.
12VAC30-120-370.E.3	Outlines pre-assignment process to MCO.	Adds language per newly approved federal waiver.	Clarifies per 1915(b) waiver approved July 2008 that recipients who are immediately determined eligible for another MCO program are excluded from the pre-assignment process in order to maintain consistent enrollment.

12VAC30-120-370.E.4	Outlines that newborn born to recipient enrolled in an MCO shall be considered an enrollee of the MCO.	Defines newborn enrollment period.	Adds language to clarify the newborn time period for which the MCO is responsible for the newborn's care. This is not a policy change merely a clarification of an existing policy.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.

DMAS' proposed regulations were published in the September 15, 2008, *Virginia Register* for their public comment period from September 15, 2008, through November 14, 2008. A summary of the comments received and the agency's response follows.

Commenter	Comment	Agency response
Citizen	Comments address the tremendous shortage of providers	The comments have no impact on this regulatory package. They have been referred to the appropriate division within the Department for review and attention.
Virginia Poverty Law Center	Comment recommended two language changes changing the word "that" to "who" to clarify that the reference is to the person and not the MCO. in 12VAC30-120-370.C and 12VAC30-120-370.I.6.	The Agency will incorporate this recommendation into the final regulations.

All changes made in this regulatory action

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

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-		Outlines reasons for exclusions from	Adds link to state regulation that

120-370.B.		MCO participation	defines "exclusion" as it relates to managed care participation
12VAC30-120-370.B.4		Indicates recipients in home and community based waivers are excluded from managed care participation	Indicates recipients in home and community based waivers are excluded from managed care participation if it occurs prior to managed care enrollment – this allows those who are enrolled in an 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.B.6		Indicates individuals under age 21 in residential treatment or treatment foster care are excluded from managed care.	Clarifies that there are Level A, B and C residential services for children. Level A and B services are generally provided in group homes. The children receiving Level A & B services are not excluded from managed care, however Level C is excluded. This is a clarification of existing policy.
12VAC30-120-370.B.7		Indicates exclusion reason for recipient in third trimester of pregnancy and classifies obstetrical provider.	Adds "midwife" to the list of obstetrical providers who pregnant recipients can be getting care from and be excluded from MCO participation if she is in her trimester of pregnancy.
12VAC30-120-370.B.11		Indicates exclusion reason for a recipient hospitalized at the time of MCO enrollment.	Clarifies per 1915(b) waiver federally approved July 2008 that exclusion does not apply to those who are already enrolled in an MCO program.
12VAC30-120-370.D.3	12VAC30-120-370.E.3	Outlines pre-assignment process to MCO.	Clarifies per 1915(b) waiver federally approved July 2008 that recipients who are immediately determined eligible for another MCO program are excluded from the pre-assignment process in order to maintain consistent enrollment.
12VAC30-120-370.D.4	12VAC30-120-370.E.4	Outlines that newborn born to recipient enrolled in an MCO shall be considered an enrollee of the MCO.	Adds language to clarify the newborn time period for which the MCO is responsible for the newborn's care.
12VAC30-	12VAC30-	Outlines requirements for	Adds link to state regulation that

120-370.F	120-370.G	disenrollment while participating in MCO	defines "disenrollment" as it relates to managed care participation
12VAC30-120-370.E	12VAC30-120-370.F.5	No previous language.	Adds language to clarify the Department has discretion to utilize alternative enrollment strategy.
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

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 was not considered in the development of this regulatory package.

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.

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, but may decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.