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Final Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation(s)	12 VAC 50-60; 12 VAC 30-121-10 through 12 VAC 30-121-250
Regulation title(s)	Commonwealth Coordinated Care Program
Action title	Commonwealth Coordinated Care
Date this document prepared	March 13, 2017

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 of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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

The Commonwealth of Virginia implemented the Commonwealth Coordinated Care (CCC) program to allow DMAS to combine certain aspects of Medicaid managed care and long-term care, and Medicare into one program. To accomplish its goal, DMAS included certain populations and services previously excluded from managed care into a new managed care program. The program was implemented through emergency regulations, and these proposed regulations will allow the program to continue past the expiration of the emergency regulations.

This program is established under authority granted by *Social Security Act* § 1932(a) state plan amendment and concurrent authority from the relevant existing § 1915(c) home and community based care Elderly or Disabled with Consumer Direction (EDCD) program. This action provides integrated care to 'dual eligible' individuals who are eligible for both Medicare and Medicaid and who were excluded from participating in Virginia's managed care programs. This change enables

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.

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.

CCC = Commonwealth Coordinated Care Program
CMS = Centers for Medicare and Medicaid Services
DMAS = Department of Medical Assistance Services
DME = Durable Medical Equipment
EDCD = Elderly or Disabled with Consumer Direction program
FAD = Financial Alignment Demonstration
FFS = Fee-For-Service
HAP = Health and Acute Care Program
HCBS = Home and Community-Based Services
MCO = Managed Care Organization
PACE = Program of All-Inclusive Care for the Elderly
PERS = Personal Emergency Response System
QDWI = Qualified Disabled Working Individuals
QI = Qualified Individuals
QMB = Qualified Medicare Beneficiaries
SLMB = Special Low Income Medicare Beneficiaries

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 with the attached regulations entitled "Commonwealth Coordinated Care Program" (12 VAC 30-50-600; 12 VAC 30-121-10 through 12 VAC 30-121-250) 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.

_March 13, 2017__
Date

/s/ Cynthia B. Jones_____
Cynthia B. Jones, Director
Dept. of Medical Assistance Services

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.

In this regulatory action, DMAS is responding to multiple mandates:

(i) Chapter 806, Item 307.AAAA of the 2013 Acts of the Assembly (followed by Chapter 3, Item 301 HHH of the 2014 Acts of Assembly; Chapter 665, Item 301 HHH of the 2015 Acts of the Assembly; and Chapter 780, Item 301.ZZ of the 2016 Acts of the Assembly);
(ii) Chapter 806, Item 307 RRRR of the 2013 Acts of the Assembly, and;
(iii) Item 307 RR of the 2013 Acts of the Assembly (followed by Chapter 3, Item 301 TTT of the 2014 Acts of the Assembly, and Chapter 665, Item 301 TTT of the 2015 Acts of the Assembly).

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 DMAS and the Centers for Medicare and Medicaid Services (CMS) for the Financial Alignment Demonstration (FAD). 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 CMS as well as three way contracts between CMS, DMAS, and participating health care plans. This program, established in Chapter 121 of the Virginia Administrative Code, is called the Commonwealth Coordinated Care program.

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 Commonwealth of Virginia is implementing Commonwealth Coordinated Care to allow DMAS to continue to combine certain aspects of Medicaid managed care and long-term care, and Medicare into one program. To accomplish its goal, DMAS includes certain populations and services previously excluded from managed care into a new managed care program. The program was established under authority granted by a *Social Security Act* § 1932(a) state plan amendment and concurrent authority from the relevant existing § 1915(c) home and community based care EDCD program.

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 would receive all Medicare and Medicaid covered benefits from one managed care plan and the health plans would receive a blended capitated rate. In May 2013, DMAS was accepted into the demonstration. The demonstration began on January 1, 2014, and is expected to 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. As of September 5, 2015, approximately 29,176 dual eligible individuals were enrolled in this program.

The goal of this action is to continue to provide integrated care to dual eligible individuals who are currently excluded from participating in managed care programs. This program enables 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.

Substance

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

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.

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 on the adult day health care model, and combines Medicaid and Medicare funding. With eight providers, DMAS currently operates twelve PACE sites and two more will be implemented in the next twelve months.

The regional model, referred to as Health and Acute Care Program (HAP-- which became effective September 1, 2007), focuses on care coordination and integrating acute and long-term care services for seniors and certain individuals with disabilities. HAP 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' fee-for-service (FFS) system. However, HAP 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) enrollees 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 are not eligible. CCC also does 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 allows DMAS to continue to combine certain aspects of managed care, long-term care, and Medicare into one program. The program offers participants care coordination, which will, it is anticipated, improve their quality of care. To accomplish this, DMAS includes certain populations and certain services previously excluded from managed care into a managed care program. This managed care program will continue to be offered on a voluntary basis in five regions of the Commonwealth: Central Virginia, Tidewater, Northern Virginia, Charlottesville/Western and the Roanoke region.

Covered Services

Covered services 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 program offers dual eligible individuals care coordination, health risk assessments, interdisciplinary care teams, and plans of care, which are otherwise unavailable for this population. Care coordination is essential to providing appropriate and timely services to often vulnerable participants.

Under the program, EDCD Waiver participants who receive personal and respite care 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 is 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.

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 to those individuals enrolled in the Commonwealth Coordinated Care program is receiving coordinated and integrated health care through a managed care program. This change enables 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.

The primary advantage to the Commonwealth is 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. Alternatively, the Department would continue to experience rising expenditures for primary, acute and long-term care costs for these populations.

There are no 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 are more restrictive than the relevant federal requirements.

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.

There are no localities that are disproportionately affected by this program; however, it does not operate statewide per CMS limits for this pilot program.

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

Changes made since the proposed stage

*Please list all changes that made to the text of the proposed regulation and the rationale for the changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. *Please put an asterisk next to any substantive changes.*

Section number	Requirement at proposed stage	What has changed	Rationale for change
12 VAC 30-121-10	Establishes authority for regulations.	New paragraph (C) includes sunset clause – authority for program will end when Memorandum of Agreement expires.	This program cannot operate without federal authority, which will expire when the Memorandum of Agreement with the federal government expires.
12 VAC 30-121-190(G)	Appeals must be requested in writing.	Remove the word "written."	Change in 42 CFR 341.221, as published in Federal Register on 11/30/2016 (81 FR 86448), and which became effective on January 20, 2017.
12 VAC 30-121-190(H)	Appeals must be requested in writing.	Appeals may be requested by mail, fax, telephone, email, in person, or through other commonly available electronic means.	Change in 42 CFR 341.221, as published in Federal Register on 11/30/2016 (81 FR 86448), and which became effective on January 20, 2017.
12 VAC 30-121-200(A)(3)(c)	Appeals may only be withdrawn by the appellant or his representative in writing.	Appeals may be withdrawn orally or in writing. Oral requests must be recorded with the individual's statement and telephonic signature, and the individual must be sent written confirmation.	Change in 42 CFR 431.223, as published in Federal Register on 11/30/2016 (81 FR 86448), and which became effective on January 20, 2017.

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. Please distinguish between comments received on Town Hall versus those made in a public hearing or submitted directly to the agency or board.

No public comments were submitted during the proposed stage comment period.

All changes made in this regulatory action

Please list all changes that are being proposed and the consequences of the proposed changes. Describe new provisions and/or all changes to existing sections. Explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation

Changes made in the proposed stage:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
	12 VAC 30-50-600		Proposed change is required due to changes in the general (non CCC specific) Medicaid enrollment and service provision. There is no impact on CCC stakeholders.
	12 VAC 30-120-10		Section sets out foundation authorities for this waiver program.
	12 VAC 30-120-20		Section defines the terms used throughout these regulations.
	12 VAC 30-120-30		Establishes the regions of the state; establishes a phase-in schedule for specified areas of the state.
	12 VAC 30-120-40		Establishes the criteria that individuals must meet in order to enroll in CCC.
	12 VAC 30-120-45		Establishes the criteria for groups of individuals who are excluded from CCC.
	12 VAC 30-120-50		Enrollees are to be assigned to CCC on the basis of their prior provider history (as shown on paid claims). Eligible enrollees will be given the opportunity to exercise choice in the MMP that they will use. Enrollment is voluntary in CCC.
	12 VAC 30-120-70		Sets out required services for the MMPs; establishes health risk assessments as a required services provided by the MMPs.
	12 VAC 30-120-73		Establishes LOC requirements for the MMPs and the level of professional staff that must conduct them.
	12 VAC 30-120-75		MMPs are required to develop POCs for all enrollees; time-frames established for MMPs to develop POCs as well as what POCs must contain.
	12 VAC 30-120-78		MMPs are required to use ICTs to ensure the integration of enrollees' medical, behavioral health, substance abuse use, long term services and supports and social needs.
	12 VAC 30-120-80		Requirements applicable to the MMPs for how care for enrollees must be coordinated.
	12 VAC 30-		Lists the services that are not to be provided

	120-83		in CCC.
	12 VAC 30-120-85		Lists examples of additional services that MMPs are permitted to provide to their enrollees.
	12 VAC 30-120-90		Establishes capitation rates, as set out in the MOU and the three-way contract as the method of reimbursement for CCC services. Sets out out-of-network reimbursement rules for MMPs.
	12 VAC 30-120-110		Establishes limits on cost sharing requirements that MMPs may impose on their enrollees.
	12 VAC 30-120-130		Establishes requirements for MMPs to meet in their networks; sets the Medicare standard as superseding Medicaid's in instances when the Medicare standard is more rigorous.
	12 VAC 30-120-140		Sets out standards to be applied to MMPs when they meet low performance standards.
	12 VAC 30-120-145		Establishes sanctions that DMAS may impose on any MMP that fails to meet performance standards.
	12 VAC 30-120-150		Establishes requirements for the MMPs to cover existing services for enrollees during a specified time period in order to maintain continuity of care.
	12 VAC 30-120-170		Participating MMPs are required to use an evidence-based model of care.
	12 VAC 30-120-190		Establishes the process that enrollees and MMPs will be required to use if they choose to appeal a Medicaid-based adverse decision subsequent to the MMP's internal appeal decision.
	12 VAC 30-120-195		Establishes the timeframes that must be met in order to file an appeal to the Medicaid state fair hearing process. Establishes exceptions to the standard appeal resolution timeframes.
	12 VAC 30-120-200		Establishes conditions that may occur which would permit the DMAS Appeals Division to terminate the appeal process.
	12 VAC 30-120-210		Sets out time standards for the scheduling of hearings; permits enrollee witnesses/representation; the hearing officer is the established individual in charge of conducting the hearing, deciding questions of evidence, procedure, law and questioning witnesses; conduct of hearings to be informal; hearing record; written final decision to be issued by hearing officer; appellants disagreeing with the hearing officer's decision are permitted to seek judicial review.
	12 VAC 30-120-220		Established conditions for the retention and release of the division's appeal records.
	12 VAC 30-120-230		Providers are permitted to appeal to the DMAS Appeals Division on issues of

			reimbursement after an unfavorable decision by the MMP.
	12 VAC 30-120-250		MMPs are limited by federal law and regulations in the type and degree of marketing that is permitted. MMPs must obtain prior approval of all marketing and enrollee communications consistent with specified federal rules.

Changes made between proposed and final stage:

Section number	Requirement at proposed stage	What has changed	Rationale for change
12 VAC 30-121-10	Establishes authority for regulations.	New paragraph (C) includes sunset clause – authority for program will end when Memorandum of Agreement expires.	This program cannot operate without federal authority, which will expire when the Memorandum of Agreement with the federal government expires.
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