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

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 30-120-360 through 440; 12 VAC 30-120-600 through 690; 12 VAC 30-120-1100 through 12 VAC 30-120-1230
VAC Chapter title(s)	Waivered Services
Action title	Cardinal Care Managed Care Program
Date this document prepared	March 30, 2022

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

This action reflects the Cardinal Care Managed Care Program, the Department of Medical Assistance Services' (DMAS' or the Department's) statewide Medicaid managed care program that merges the Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 managed care programs into a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth. Members who have been served by Medallion 4.0 and the CCC Plus will be served under the Cardinal Care Managed Care Program. As a result, the Medallion 4.0 and CCC Plus regulations will no longer be in effect, so this action also repeals those regulations.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

CCC Plus = Commonwealth Coordinated Care Plus
CMS = Centers for Medicare & Medicaid Services
DMAS = Department of Medical Assistance Services
LTSS = Long-Term Services and Supports
MCO = Managed Care Organization

Mandate and Impetus (Necessity for Emergency)

Explain why this rulemaking is an emergency situation in accordance with § 2.2-4011 A and B of the Code of Virginia. In doing so, either:

a) *Indicate whether the Governor's Office has already approved the use of emergency regulatory authority for this regulatory change.*
b) *Provide specific citations to Virginia statutory law, the appropriation act, federal law, or federal regulation that require that a regulation be effective in 280 days or less from its enactment.*

As required by § 2.2-4011, also describe the nature of the emergency and of the necessity for this regulatory change. In addition, delineate any potential issues that may need to be addressed as part of this regulatory change

Section 2.2-4011 of the *Code of Virginia* states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006(A)(4).

The 2022 Special Session, Item 304.Y directs the agency to "seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to merge the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs, effective July 1, 2022, into a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth. The department shall have the authority to promulgate emergency regulations to implement these amendments within 280 days or less from the enactment of this Act. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change."

The Governor is hereby requested to approve this agency's adoption of the emergency regulations entitled Cardinal Care (12 VAC 30-120-1100 through 12 VAC 30-120-1230) and also authorize the initiation of the promulgation process provided for in § 2.2-4007.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia or Acts and Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

In addition, Section 2.2-4011 of the Code of Virginia states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of subdivision A. 4. of § 2.2-4006.

The 2022 Special Session, Item 304.Y directs the agency to "seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to merge the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs, effective July 1, 2022, into a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth."

Purpose

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

The Medallion 4.0 and CCC Plus regulations can be repealed because they are no longer needed due to the July 2022 implementation of the mandated Cardinal Care Program.

The 2022 Special Session, Item 304.Y directs DMAS to merge the Medallion 4.0 and CCC Plus programs into a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth.

These regulatory changes protect the health, safety, and welfare of Medicaid recipients by ensuring that DMAS regulations and current DMAS practices are aligned.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

The sections of the State regulations that are affected by repealing the Medallion 4.0 and the CCC Plus program are 12VAC30-120-360 through 12VAC30-120-440 and sections 12VAC30-120-610 through 12VAC30-120-690 respectively.

Virginia Medicaid serves the vast majority of its members through managed care to ensure financial stability to the Commonwealth, reduce risk in the unpredictable health care sector and provide comprehensive care coordination for members with significant health needs. Over the past 25 years, DMAS has expanded its managed care programs to cover members residing throughout the Commonwealth, while adding new eligibility populations and including additional services.

More than 96% of Virginia Medicaid's full-benefit Medicaid and Family Access to Medical Insurance Security (FAMIS) members currently receive services through managed care. DMAS currently runs two separate, mature, managed care programs. Medallion 4.0 serves approximately 1.47 million individuals, and primarily includes children, pregnant individuals, and expansion adults. The CCC Plus program serves nearly 284,000 individuals, including vulnerable populations, such as members receiving long-term services and supports (LTSS), those with severe mental illness, and dual Medicare-Medicaid eligible members. Both programs operate with the same six managed care organizations (MCOs).

At the direction of the 2020 General Assembly, DMAS developed a plan to merge the CCC Plus and Medallion 4.0 programs. Agency leaders shared the Department's plan for Cardinal Care with the Governor and members of the General Assembly in November 2020. In 2021, also at the direction of the General Assembly, DMAS performed and shared a review of its current contracts and staffing to determine the operational savings that would result from merging the CCC Plus and Medallion 4.0 programs. The 2022 Special Session, Item 304.Y directs the agency to merge the CCC Plus and Medallion 4.0 managed care programs, effective July 1, 2022, into a single, streamlined managed care program.

The goal of the Cardinal Care Managed Care Program is to promote an efficient, well-coordinated system of care for members; to streamline the administrative processes for DMAS, providers, and the MCOs; and to build a strong and equitable program foundation on which to build future program innovations and improvements.

In the first major step of a multi-phase initiative, DMAS will consolidate the programs into a single contract, effective July 1, 2022. Aligning the programs will include the following five components: (1) streamlining and aligning managed care contract requirements and MCO administrative tasks, such as reporting requirements; (2) aligning the model of care to promote timely, high-quality care based on member need and risk, including as the member's needs evolve; (3) ensuring sufficient levers for compliance monitoring and oversight, including around network adequacy; (4) rebranding the fee-for-service and managed care programs under a single name, Cardinal Care, for a clearer identity; simplifying program messaging to avoid added complexity; and, (5) modifying system enrollment processes to eliminate interruption to a member's managed care coverage for improved continuity of care.

Consolidating the two programs into one will enable DMAS to ensure better continuity of care for members, eliminate redundancies, and strengthen the focus on the diverse and evolving needs of

the populations served. The Cardinal Care Managed Care Program will require some upfront investment for systems, operational development and communications costs. Over time, agency leaders anticipate that Cardinal Care will provide DMAS with enhanced capacity to focus on strengthening and refining its monitoring and oversight policies, processes, and systems, and to continue numerous initiatives to improve the Medicaid health system.

Merging to one managed care program will improve the member experience by streamlining processes for members, removing the need for disruptive transitions between two managed care systems, eliminating the use of multiple program names, keeping program messaging simple and straightforward, and avoiding confusion, especially for families with members in both programs. The Cardinal Care managed care delivery system will provide coverage for the full scope of Medicaid managed care covered services, including LTSS within the established screening and coverage criteria. The Cardinal Care Managed Care Program will continue to provide comprehensive care management for members with significant health needs.

One unified managed care program will also reduce confusion and administrative burden for providers, and potentially improve provider participation in Medicaid. One managed care program will simplify the contracting and billing processes for providers, and, in general, streamline the provider experience in working with the MCOs.

The Cardinal Care Managed Care Program will add value for DMAS, its MCOs, providers, members and the Commonwealth. Specifically, the program unifies the two managed care contracts and two managed care waivers, streamlines the rate development and the Centers for Medicare & Medicaid Services (CMS) approval processes, enables DMAS to operate more effectively and provides enhanced opportunity for value-based payment activities to promote better health outcomes, and will align DMAS's internal processes, which will enable and promote enhanced transparency and oversight, and will empower DMAS to derive greater value from our managed care program.

Financially, a single managed care program and contract will result in combining medical loss ratio requirements and maximum allowable underwriting gains. The merged Cardinal Care program will allow health plans to have a larger risk pool in which to manage the year-to-year uncertainty. Additional guardrails, including quality measures and value-based programs, will be added to ensure plans are spending appropriate amounts for a given population and not subsidizing losses or gains at the detriment of member care.

DMAS' plans to streamline and combine the CCC Plus and Medallion 4.0 managed care programs will ultimately reduce the administrative burden for all parties and allow for more effective and efficient program administration, a critical component of DMAS' role as a key steward of taxpayer dollars. Furthermore, aligning programs provides many opportunities to improve care equity, continuity of care, and quality of care for one in five Virginians.

The Cardinal Care Managed Care Program regulations include the following sections:

Section number	Proposed requirement	Other regulations and laws that apply	Intent and likely impact of new requirements

12 VAC 30-120-1100	Definitions		Sets forth definitions for terms used in the Cardinal Care regulations.
12 VAC 30-120-1110	Mandatory managed care members; enrollment process	42 CFR §§ 438.54 – 438.56	Establishes who will be enrolled in Cardinal Care and the enrollment process.
12 VAC 30-120-1120	Providers; Medicaid enrollment process	42 CFR §§ 438.602, 42 CFR § 438.608(b), 42 CFR § 455.100-106, 42 CFR § 455.400-470, Section 5005(b)(2) of the 21st Century Cures Act	Establishes Cardinal Care MCO provider enrollment expectations
12 VAC 30-120-1130	MCO responsibilities and sanctions	42 CFR § 438 et seq. 42 CFR 438 Subpart I	Establishes sanctions for Cardinal Care contractors.
12 VAC 30-120-1140	Continuity of Care		Establishes continuity of care expectations.
12 VAC 30-120-1150	Covered services	42 CFR § 438.210	Establishes what services will be covered.
12 VAC 30-120-1160	Payment rate for MCOs	42 CFR §§ 438.4 – 438.8 42 CFR § 438.48	Establishes payment rates for Cardinal Care MCOs and for out-of-network providers who offer emergency care.
12 VAC 30-120-1170	Quality control and utilization review	42 CFR 438 Subpart E 42 CFR 438 Subpart D 42 CFR § 438.210	Establishes quality control and utilization review requirements.
12 VAC 30-120-1180	Member appeals: State fair hearing process	12 VAC 30-110-10 et seq. 42 CFR § 438.408	Establishes the State fair hearing process for the Cardinal Care program.
12 VAC 30-120-1190	Member appeals: Appeal timeframes	42 CFR § 438.408	Establishes appeal timeframes.
12 VAC 30-120-1200	Member appeals: Pre-hearing decisions		Establishes what decisions shall be made before a hearing.
12 VAC 30-120-1210	Member appeals: Final decision	42 CFR §§ 438.408 - 410	Establishes the final decision process.
12 VAC 30-120-1220	Provider appeals	12 VAC 30-20-500 et seq.	Establishes the rules for provider appeals.

12 VAC 30-120-1230	Appeals Division records	42 CFR § 438.416	Establishes the rules regarding records kept by the Appeals Division.

Issues

Identify the issues associated with the regulatory change, 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, include a specific statement to that effect.

The primary advantages of these regulatory changes are they repeal regulations from the Virginia Administrative Code that are no longer needed and they effectuate a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth. There are no disadvantages to the agency, the Commonwealth, or the public.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. 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 regulatory change.

No alternatives will comply with the legislative mandate.

Periodic Review and Small Business Impact Review Announcement

This Emergency/NOIRA is not being used to announce a periodic review or a small business impact review.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.

DMAS is providing an opportunity for comments on this Emergency/NOIRA, including but not limited to (i) the costs and benefits of the Emergency regulations, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Meredith Lee, DMAS, 600 E. Broad Street, Richmond, VA 23219, 804-371-0552, or Meredith.Lee@dmas.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12 VAC 30-120-360 through 440		Medallion Mandatory Managed Care	All Medallion regulations, forms, and references are repealed.
12 VAC 30-120-600 through 690		CCC Plus Program	All CCC Plus regulations, forms, and references are repealed.
	12 VAC 30-120-1100 through 1230	No regulations currently exist for the Cardinal Care Managed Care Program	New regulations are added, including: definitions, mandatory managed care enrollees; enrollment process, providers; Medicaid enrollment process, MCO responsibilities and sanctions, continuity of care, covered services, payment rates for MCOs, quality control and utilization review, member appeals: state fair hearing process, member appeals; appeal timeframes, member appeals: pre-hearing decisions, member appeals: final decisions: provider appeals, and Appeals Division records.