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Final Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-120-360 through 120-420
Regulation title(s)	Mandatory Capitated Managed Care Delivery System (Medallion 3.0)
Action title	2014 Mandatory Managed Care Changes
Date this document prepared	March 10, 2016

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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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

This regulatory action proposes to require qualifying individuals who are enrolled in the Elderly or Disabled with Consumer Direction Waiver to also be enrolled in managed care for their acute care services. Prior to the currently effective emergency regulations that implemented this change, these individuals received their acute care services through the fee-for-service model of care. The emergency action also provided expedited enrollment into DMAS' contracted managed care organizations. The current regulatory action seeks to make these changes permanent.

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.

DMAS - Department of Medical Assistance Services
CMS - Centers for Medicare and Medicaid (CMS).

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 amended Virginia Administrative Code sections 12 VAC 30-120-360 through 120-420and 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.

3/10/2016
Date

/Signature/
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] (the *Act*) provides governing authority for payments for services.

DMAS operates its mandatory managed care program under the authority of section 1915(b) of the *Social Security Act* which permits the waiving of Medicaid individuals' freedom of choice of providers of health care to enable mandatory enrollment in managed care. DMAS sought federal

approval of these changes to this § 1915(b) of the *Social Security Act* waiver and received CMS approval dated July 14, 2014. This action conforms the Department's regulations to the federally approved waiver changes.

DMAS operates its home and community based care waivers (such as the Elderly or Disabled with Consumer Direction waiver) under the authority of section 1915(c) of the *Act* that permits the waiving of the comparability rule (42 CFR 440. 240), which requires that services covered for any eligible individual in a covered group must be covered for all individuals in that group. These waivers enable the coverage of specific services, such as personal care, respite care, adult day health care, etc., to enable individuals to avoid institutionalization and remain in their homes and communities.

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 purpose of this regulation is to implement several mandates from various legislative actions to: (i) require qualifying individuals in the Elderly or Disabled with Consumer Direction waiver, to also be enrolled in Medicaid contracted managed care organizations; and (ii) require expedited enrollment for Medicaid individuals into Medicaid contracted managed care organizations, especially pregnant women. These regulatory changes will improve the health and welfare of the affected Medicaid individuals by providing care coordination and well-person preventive services in addition to routine acute care. These regulatory changes do not apply to individuals enrolled in the voluntary managed care program for dual eligibles known as Commonwealth Coordinated Care (CCC).

These regulations apply to Managed Care Organizations (MCOs). Small business requirements do not apply to MCOs because managed care organizations do not meet the definition of small businesses.

Substance

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

The regulations that are affected by this action are: Mandatory Capitated Managed Care (Medallion 3.0) (12 VAC 30-120-360; 120-370; 120-380; 120-390; 120-395, and; 120-420).

Medallion II, a mandatory Managed Care Organization (MCO) program, expanded throughout the Commonwealth the use of managed care for the delivery of health care to Medicaid recipients. Medallion II was created for the purposes of further improving access to care,

promoting disease prevention, ensuring quality care, and reducing Medicaid expenditures. The program requires mandatory enrollment into a contracted MCO for certain specified groups of Medicaid individuals (12 VAC 30-120-370 A). Also, certain specified groups of individuals are excluded from managed care enrollment (12 VAC 30-120-370 B). MCOs have provided the Commonwealth with the most value per taxpayer dollar for the provision of high quality health care and provide an integrated, comprehensive delivery system to individuals enrolled in Medicaid.

In 2007, the managed care health plans began providing acute care coverage for approximately 4,600 home and community-based (HCB) waiver participants through the Acute and Long Term Care (ALTC) Phase 1 program. This included individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, the Intellectual Disability (ID) Waiver, the Individuals and Family Developmental Disabilities Support (IFDDS) Waiver, the Day Support (DS) Waiver, and the Alzheimer's Assisted Living (AAL) Waiver. Under the Phase 1 program, if a MCO enrolled Medicaid member subsequently becomes eligible for and enrolled into one of five HCB waivers, then he remains enrolled with the MCO for primary and acute care services while all long-term care waiver services, such as personal care, respite care, Personal Emergency Response Systems, and environmental modifications, are covered under the fee-for-service reimbursement system.

The 2011 *Acts of Assembly* Item 297 MMMM.1 directed the Department to:

…seek federal authority through amendments to the State Plan under Title XIX of the Social Security Act, and any necessary waivers, to allow individuals enrolled in Home and Community Based Care (HCBC) waivers to also be enrolled in contracted Medallion II managed care organizations for the purposes of receiving acute and medical care services

On December 1, 2014, the Department launched the Health and Acute Care Program (HAP). This initiative allows eligible EDCD waiver individuals to receive their acute and primary medical care through one of the managed care health plans and, concurrently, the individual's HCB care waiver services, including transportation to the waivered services, are paid for through the Medicaid fee-for-service system as a "carved out" service. These individuals participate concurrently in both § 1915(b) and § 1915(c) waivers. As part of the HAP initiative, approximately 2,700 individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver who received acute medical services in the fee-for-service program and who were eligible for managed care (i.e., do not have any managed care exclusions) were transitioned into managed care in December 2014. The ALTC program was rebranded as HAP for approximately 7,300 individuals enrolled in both the 1915(b) and 1915(c) waivers.

The 2012 *Acts of Assembly*, Chapter 3 Item 307 FFF provided: '*The department may seek federal authority through amendments to the State Plans under Title XIX and XXI of the Social Security Act, and appropriate waivers to such, to develop and implement programmatic and system changes that allow expedited enrollment of Medicaid eligible recipients into Medicaid managed care, most importantly for pregnant women.*'

In an effort to ensure that newly eligible Medicaid individuals, especially pregnant women, have quicker access to the managed care delivery system, the Department shortened the period of time between an individual being identified as Medicaid eligible and that individual's enrollment into a managed care organization (MCO). This new process reduces disruptions to continuity of care by minimizing the movement of individuals between the fee-for-service and the managed care delivery systems.

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 of this regulatory action is that the expedited enrollment component of this regulation will ensure that Medicaid individuals who are eligible for managed care get placed into an MCO sooner than the previous "pre-assignment" methodology allowed, resulting in less time waiting to enroll in an MCO. Both expedited enrollment and the additional population becoming eligible for managed care ensure access to care coordination and additional services offered by the MCOs that are not available under Medicaid fee-for-service.

Another advantage is that this regulation is projected to create savings through earlier MCO enrollment. This may allow the MCO to manage care sooner, resulting in fewer premature and NICU births.

The Department does not anticipate any 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 exceed the applicable federal requirements, and the actions have been approved by the federal Center for Medicare and Medicaid (CMS).

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.

These changes have no particular effect on any locality; they apply equally across the state.

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, nor increase or decrease disposable family income.

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.*

One change was made between the proposed and final stages. In 12VAC30-120-370(J)(6), the strike-through of the word "EDCD" is removed, and the word is maintained in the final text. It was an error to strike this word in the proposed stage, and therefore, it is being maintained in the final stage.

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 received.

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

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
12VAC 30-120-360		Definitions. Updated with current terminology and removed unused terms.	Updating of terminology and program name.
12VAC 30-120-370		Mandatory enrollees. Program name updated; exception provided for certain EDCD participants to enroll in managed care.	Allows enrollees to access services via managed care in an expedited manner. Requires certain EDCD individuals who currently receive acute and primary medical services through fee-for-service to receive those services via the managed care delivery system. MCO enrollment for newborn infants is provided for.
12VAC 30-120-380		MCO responsibilities.	Updating terminology.
12VAC 30-120-390		Payment rate.	Updating terminology.
12 VAC 30-120-395		Payment rate for out-of-network providers.	Updating terminology.
12VAC 30-120-410		Sanctions.	Updating terminology. DMAS is required to appoint a temporary manager before providing a sanctioned MCO with a pretermination hearing.
12VAC 30-120-420		Enrollee grievances and appeals.	Updating terminology.

The following changes were made between the emergency regulation and the proposed regulation:

- In all sections, the terms "recipient," "individual," and "enrollee" were changed to "member."
- In the definitions section 12 VAC 30-120-360, definitions that were not used in the regulations were removed.
- In the definitions section, the term "Exclusion from Medallion II" was changed to be a definition for the word "exclude."
- In 12 VAC 30-120-370 (A)(2) and (B)(4) language was added to clarify the enrollment requirements for qualifying individuals enrolled in the Elderly or Disabled with Consumer Direction waiver.
- In 12 VAC 30-120-370, the term "preassigned" was changed to "assigned" to match current DMAS terminology.

- Section 12 VAC 30-120-400 was added to the regulatory package so that the term "enrollee" could be changed to "member" for consistency throughout the applicable sections.

The following changes were made between the proposed regulation and the final regulation:

- In 12VAC30-120-370(J)(6), the strike-through of the word “EDCD” is removed, and the word is maintained in the final text.