12VAC30-120-370. Medallion II enrollees.

A. DMAS shall determine enrollment in Medallion II. Enrollment in Medallion II is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program.

B. The following individuals shall be excluded from participating in Medallion II. Individuals not meeting the exclusion criteria must participate in the Medallion II program.

1. Individuals who are inpatients in state mental hospitals;

2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded;

3. Individuals who are placed on spend-down;

4. Individuals who are participating in federal waiver programs for home-based and community-based Medicaid coverage;

5. Individuals who are participating in foster care or subsidized adoption programs;

6. Individuals who are enrolled in DMAS authorized residential treatment or treatment foster care programs;

7. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state MCOs. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;

8. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;

9. Individuals who receive hospice services in accordance with DMAS criteria;

10. Individuals with Medicare coverage.

11. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge;

12. Individuals who have been preassigned to an MCO but have not yet been enrolled, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less, if they request exclusion. The client's physician must certify the life expectancy; and

13. Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC §1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment.

14. DMAS reserves the right to restrict from participation in the Medallion II managed care program any recipient who has been consistently non-compliant with the policies, procedures, and philosophies of managed care, or is threatening to providers, MCO(s), or DMAS. There must be sufficient documentation from various providers, the MCO(s), and DMAS of these non-compliance issues and any attempts at resolution. Recipients excluded from Medallion II through this provision may appeal the decision to DMAS.

C. Medallion II managed care plans shall be offered to recipients, and recipients shall be enrolled in those plans, exclusively through an independent enrollment broker under contract to DMAS.

D. Clients shall be enrolled as follows:

1. All eligible persons, except those meeting one of the exclusions of subsection B of this section, shall be enrolled in Medallion II.

2. Clients shall receive a Medicaid card from DMAS during the interim period, and shall be provided authorized medical care in accordance with DMAS' procedures, after eligibility has been determined to exist.

3. Once individuals are enrolled in Medicaid, they will receive a letter indicating that they may select one of the contracted MCOs. These letters shall indicate a preassigned MCO, determined

as provided in subsection E of this section, in which the client will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days.

4. A child born to a woman enrolled with an MCO will be enrolled with the MCO from birth until the last day of the third month including the month of birth, unless otherwise specified by the Enrollment Broker. For instance, a child born during the month of February will be automatically enrolled until April 30. By the end of that third month, the child will be disenrolled unless the Enrollment Broker specifies continued enrollment. If the child remains an inpatient in a hospital at the end of that third month, the child shall automatically remain enrolled until the last day of the month of discharge, unless this child's parent requests disenrollment.

5. Individuals who lose then regain eligibility for Medallion II within 60 days will be reenrolled into their previous MCO without going through preassignment and selection.

E. Clients who do not select an MCO as described in subdivision D 3 of this section shall be assigned to an MCO as follows:

1. Clients are assigned through system algorithm based upon the client's history with a contracted MCO.

2. Clients not assigned pursuant to subdivision 1 of this subsection shall be assigned to the MCO of another family member, if applicable.

3. All other clients shall be assigned to an MCO on a basis of approximately equal number by MCO in each locality.

4. In areas where there is only one contracted MCO, recipients have a choice of enrolling with the contracted MCO or the PCCM program. All eligible recipients in areas where one contracted MCO exists, however, are automatically assigned to the contracted MCO. Individuals are allowed 90 days after the effective date of new or initial enrollment to change from either the contracted MCO to the PCCM program or vice versa.

F. Following their initial enrollment into an MCO or PCCM program, recipients shall be restricted to the MCO or PCCM program until the next open enrollment period, unless appropriately disenrolled or excluded by the department.

1. During the first 90 calendar days of enrollment in a new or initial MCO, a client may disenroll from that MCO to enroll into another MCO or into PCCM, if applicable, for any reason. Such disenrollment shall be effective no later than the first day of the second month after the month in which the client requests disenrollment.

2. During the remainder of the enrollment period, the client may only disenroll from one MCO into another MCO or PCCM, if applicable, upon determination by DMAS that good cause exists as determined under subsection H of this section.

G. The department shall conduct an annual open enrollment for all Medallion II participants, including in areas where there is only one contracted MCO. The open enrollment period shall be the 60 calendar days before the end of the enrollment period. Prior to the open enrollment period, DMAS will inform the recipient of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. In areas with only one contracted MCO, recipients will be given the opportunity to select either the MCO or the PCCM program. Enrollment selections will be effective on the first of the next month following the open enrollment period. Recipients who do not make a choice during the open enrollment period will remain with their current MCO selection.

H. Disenrollment for good cause may be requested at any time.

1. After the first 90 days of enrollment in an MCO, clients must request disenrollment from DMAS based on good cause. The request may be made orally or in writing to DMAS and cite the reasons why the client wishes to disenroll. Good cause for disenrollment shall include the following:

a. A recipient's desire to seek services from a federally qualified health center which is not under contract with the recipient's current MCO, and the recipient (i) requests a change to another MCO that subcontracts with the desired federally qualified health center or (ii) requests a change to the PCCM, if the federally qualified health center is contracting directly with DMAS as a PCCM;

b. Performance or nonperformance of service to the recipient by an MCO or one or more of its providers which is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care;

c. Lack of access to necessary specialty services covered under the State Plan; or lack of access to providers experienced in dealing with the enrollee’s health care needs.

d. A client has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted MCO or PCCM program, if applicable, or provider; ~~or~~

e. The enrollee moves out of the MCO’s service area;

f. The MCO does not, because of moral or religious objections, cover the service the enrollee seeks;

g. The enrollee needs related services to be performed at the same time; not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or

h. Other reasons as determined by DMAS through written policy directives.

2. DMAS shall determine whether good cause exists for disenrollment. Written responses are provided within a timeframe set by Department policy and in compliance with 42 CFR 438.56.

3. Good cause for disenrollment shall be deemed to exist and the disenrollment shall be granted if DMAS fails to take final action on a valid request prior to the first day of the second month after the request.

4. The DMAS determination concerning good cause for disenrollment may be appealed by the client in accordance with the department's client appeals process at 12VAC30-110-10 through 12VAC30-110-380.

5. The current MCO shall provide, within two working days of a request from DMAS, information necessary to determine good cause.

12VAC30-120-380. Medallion II MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part. Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the emergency departments.

B. Services that shall be provided outside the MCO network, and reimbursed by DMAS shall include, but are not limited to, those services defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include school-based services and community mental health services (rehabilitative, targeted case management and substance abuse services). The

MCOs shall pay for emergency services and family planning services and supplies whether they are provided inside or outside the MCO network.

C. The MCOs shall report data to DMAS under the contract requirements, which may include data reports, report cards for clients, and ad hoc quality studies performed by the MCO or third parties.

D. Documentation requirements

1. The MCO shall maintain such records as may be required by federal and state law and regulation and by DMAS policy. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

2. Each MCO shall have written policies regarding enrollee rights and must comply with any applicable Federal and State laws that pertain to enrollee and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees in accordance with 42 CFR § 438.100.

E. The MCO shall ensure that the health care provided to its clients meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

F. The MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the state and the contractor. Medical evaluations shall be available within 48 hours for urgent care and within 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

G. The MCOs must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor.

H. Each MCO and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate.

I. In accordance with 42 CFR §§ 447.50 - 447.60, ~~The~~ MCOs shall not ~~charge copayments to any categorically needy~~ impose any cost sharing obligations on enrollees except as set forth in 12 VAC 30-20-150 and 12 VAC 30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his patient in accordance with 42 CFR § 438.102.
K. An MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR § 438.102.

12VAC30-120-420. Client grievances and appeals.

A. The MCOs shall, whenever a client's request for covered services is reduced, denied or terminated, or payment for services is denied, provide a written notice in accordance with the notice provisions specified in 42 § CFR 438.404, and 42 § CFR 438.210(c), as defined by the contract between DMAS and the MCO, and any other statutory or regulatory requirements.

B. The MCOs shall, at the initiation of either new client enrollment or new provider/subcontractor contracts, or at the request of the enrollee, provide to every enrollee the information described in 42 § CFR 438.10(g) concerning grievance/appeals rights and procedures.

C. Disputes between the MCO and the client concerning any aspect of service delivery, including medical necessity and specialist referral, shall be resolved through a verbal or written grievance/appeals process operated by the MCO or through the DMAS appeals process. A provider who has the enrollee's written consent may act on behalf of an enrollee in the MCO grievance/appeals process or the DMAS appeals process.

1. The enrollee, provider, or representative acting on behalf of the enrollee with the enrollee's written consent, may file an oral or written grievance or appeal with the MCO. The MCO shall accept appeals submitted within 30 days from the date of the notice of adverse action. Oral

requests for appeals must be followed up in writing within ten (10) business days by the enrollee, provider, or ~~his~~ representative acting on behalf of the enrollee with the enrollee's consent, unless the request is for an expedited appeal. The enrollee may also file a written request for a standard or expedited appeal with the DMAS Appeals Division within 30 days of the client's receipt of the notice of adverse action, in accordance with 42 CFR § 431, Subpart E and 12 VAC30-110, *et. seq.*

2. In compliance with 14VAC5-210-70 H 4, pending resolution of a grievance or appeal filed by a client or his representative (including a provider acting on behalf of the client), coverage shall not be terminated for the client for any reason which is the subject of the complaint. In addition, the MCO shall not terminate or reduce services as specified in 12VAC30-110-100.

3. The MCO shall ensure that the individuals who make decisions on MCO grievances and appeals were not involved in any previous level of review or decision making, and where the reason for the grievance involves clinical issues, relates to a denial or a request for an expedited appeal, or where the appeal is based on a lack of medical necessity, shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.

D. The MCO shall develop written materials describing the grievance/appeals system and its procedures and operation.

E. The MCO shall maintain a recordkeeping and tracking system for complaints, grievances, and appeals that includes a copy of the original complaint, grievance, or appeal; the decision; and the nature of the decision. This system shall distinguish Medicaid from commercial enrollees, if the MCO does not have a separate system for Medicaid enrollees.

F. At the time of enrollment and at the time of any adverse actions, the MCO shall notify the client, in writing, that:

1. Medical necessity, specialist referral or other service delivery issues may be resolved through a system of grievances and appeals, within the MCO or through the DMAS client appeals process;

2. Clients have the right to appeal directly to DMAS; and

3. The MCO shall promptly provide grievance or appeals forms, reasonable assistance and written procedures to clients who wish to register written grievances or appeals.

G. The MCO shall, within two days of receipt of any written request for a grievance or appeal, provide DMAS with a copy of the request.

H. The MCO shall issue grievance/appeal decisions as defined by the contract between DMAS and the MCO. Oral grievance decisions are not required to be in writing.

I. The MCO shall issue standard appeal decisions within ~~14~~ 30 days from the date of initial receipt of the appeal in accordance with 42 CFR § 438.408 and as defined by the contract between DMAS and the MCO. The appeal decision shall be required to be in writing and shall include but is not limited to:

1. The decision reached, the results and the date of the decision reached by the MCO;

2. The reasons for the decision;

3. The policies or procedures which provide the basis for the decision;

A clear explanation of further appeal rights and a timeframe for filing an appeal, and

5. For appeals that involve the termination, suspension, or reduction of a previously authorized course of treatment, the right to continue to receive benefits in accordance with 42 CFR § 438.420 pending a hearing, and how to request continuation of benefits.

J. The MCO shall provide DMAS with a copy of its formal grievance decision concurrently with the provision of the decision to the client.

K. An expedited appeal decision shall be issued as expeditiously as the enrollee's condition requires and within three business days in cases of medical emergencies, in which delay could result in death or serious injury to a client. Extensions to these timeframes shall be allowed in accordance with 42 CFR § 438.408 and as defined by the contract between DMAS and the MCO. Written confirmation of the decision shall promptly follow the verbal notice of the expedited decision.

L. Any appeal decision issued by the MCO may be appealed by the client to DMAS in accordance with the department's Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-380. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-380 and shall not base any appealed decision on the record established by any appeal decision of the MCO. The MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the MCO.

M. The MCO shall provide information necessary for any DMAS appeal within timeframes established by DMAS.

CERTIFIED:

_____ _____

Date

Patrick W. Finnerty, Director
Dept. of Medical Assistance Services