# COMMONWEALTH of VIRGINIA

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## MEMORANDUM

**TO:** **EMILY MCCLELLAN**
Regulatory Supervisor
Department of Medical Assistance Services

**FROM:** **ELIZABETH M. GUGGENHEIM**
Assistant Attorney General

**DATE:** **May 4, 2018**

**SUBJECT:** **Proposed regulations regarding the CCC Plus program (12 VAC 30-120-500 through 600)**

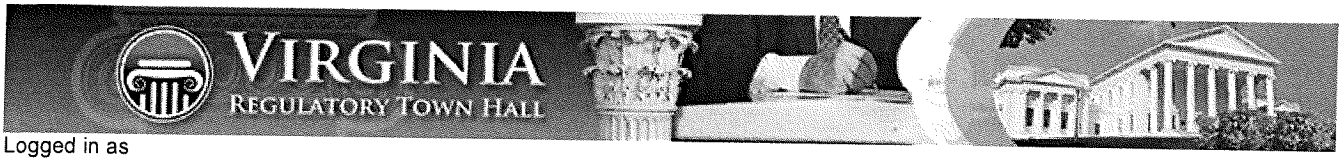
I have reviewed the proposed regulations that provide a new statewide Medicaid managed long term services and supports program to individuals with complex care needs through an integrated delivery model across the full continuum of care. Based on my review, DMAS has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Virginia Code §§ 32.1-324 and 32.1-325 grant to the Board of Medical Assistance Services the authority to administer and amend the plan for Medical Assistance and authorizes the Director of DMAS to administer and amend the plan for Medical Assistance according to the Board's requirements. The authority for these proposed regulations derives from Item 306.JJJ(3) of the 2016 *Acts of Assembly*, and Item 306.JJJ(3) of the 2017 *Acts of Assembly*.

If you have any questions or need additional information, please feel free to contact me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General

Virginia.gov Agencies | Governor

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Elizabeth Guggenheim

## Proposed Text

**Action**: CCC Plus

**Stage**: Proposed

4/23/18 12:17 PM [latest]

**12VAC30-120-600. Definitions.**

The following words and terms when used in this part shall have the following meanings unless the context clearly indicates otherwise:

"Adverse action" means the denial, suspension, or reduction in services or the denial or retraction, in whole or in part, of payment for a service that has already been rendered.

"Adverse benefit determination" means, consistent with 42 CFR 438.400, a determination by the participating plan, subcontractor, service provider, or Virginia Department of Medical Assistance Services that constitutes a (i) denial or limited authorization of a service authorization request, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) reduction, suspension, or termination of a previously authorized service; (iii) failure to act on a service request; (iv) denial in whole or in part of a payment for a service; (v) failure by the participating plan to render a decision within the required timeframes; (vi) failure to provide services in a timely manner; (vii) denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities or (viii) denial of an enrollee's request to exercise his right under 42 CFR 438.52(b)(2)(ii) to obtain services outside of the network.

"Appellant" means an applicant for or recipient of Medicaid benefits who seeks to challenge an adverse benefit determination taken by the participating plan, subcontractor, service provider, or DMAS regarding eligibility for services and payment determinations.

"Authorized representative" means the same as set forth in 12VAC30-110-1380 and 12VAC30-110-1390.

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"Carved-out services" means the subset of Medicaid covered services for which the plan shall not be fiscally responsible.

"Centers for Medicare and Medicaid Services" or "CMS" means the federal agency of the U.S. Department of Health and Human Services that is responsible for the administration of Titles XVIII, XIX, and XXI of the Social Security Act.

"Commonwealth Coordinated Care" or "CCC" means the program for the Virginia Medicare-Medicaid Financial Alignment Demonstration Model.

"Commonwealth Coordinated Care Plus Program" or "CCC Plus" means the department's mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long-term services and supports (LTSS). The CCC Plus program includes individuals who receive

services through nursing facility (NF) care or from four of the department's five home and community-based services (HCBS) § 1915(c) waivers (the Alzheimer's Assisted Living (AAL) Waiver individuals are not eligible for the CCC Plus program).

"Continuity of Care Period" or "Care Transition" means a set period of time during which the MCO shall ensure a seamless transition from Medicaid FFS, or from another MCO, for all members upon enrollment into their plan.

"Contractor" means a managed care health plan selected by DMAS and contracted to participate in the CCC Plus program.

"Covered services" means the set of required services offered by the participating plan.

"Department of Medical Assistance Services," "department," or "DMAS" means the Virginia Department of Medical Assistance Services, the single state agency for the Medicaid program in Virginia that is responsible for implementation and oversight of CCC Plus.

"Disenrollment" means the process of changing enrollment from one participating plan to another participating plan or the process of being excluded from CCC Plus by the department as described in 12VAC30-120-610.

"Division" or "Appeals Division" means the Appeals Division of the Department of Medical Assistance Services.

"Dual eligible enrollees" means a Medicare enrollee who receives Medicare Parts A, B, and D benefits and also receives full Medicaid benefits.

"Effective date" means the date on which a participating plan's coverage begins for an enrollee.

"Enrollee" means an individual that has enrolled in a participating plan to receive services under this program.

"Enrollee appeal" means an enrollee's request for review of an adverse benefit determination.

"Enrollment" means assignment of an individual to a health plan by the department in accordance with the terms of the contract with the participating plan. This does not include attaining eligibility for the Medicaid program.

"Enrollment broker" means an independent contractor that enrolls individuals in the contractors plan and is responsible for the operation and documentation of a toll-free individual service helpline. The responsibilities of the enrollment broker include, but shall not be limited to, individual education and MCO enrollment, assistance with and tracking of individuals complaints and their resolutions, and may include individual marketing and outreach.

"Enrollment period" means the time that an enrollee is actually enrolled in a participating plan.

"Expedited appeal" means the process by which the participating plan must respond to an appeal by an enrollee if a denial of care decision and the subsequent internal appeal by a participating plan may jeopardize life, health, or ability to attain, maintain, or regain maximum function.

"External appeal" means an appeal, subsequent to the participating plan internal appeal or reconsideration decision, to the state fair hearing process (for a member appeal) or informal appeals process (for a provider appeal).

"Fee-for-service" or "FFS" means the traditional health care payment system in which physicians and other providers receive a payment for each service they provide.

"Final decision" means a written determination by a department hearing officer from an appeal of an informal evidentiary proceeding that is binding on the department, unless modified during or after the judicial process.

"Handbook" means a document prepared by the MCO and provided to the enrollee that is consistent with the requirements of 42 CFR 438.10 and the CCC Plus contract, and includes information about all the services covered by that plan.

"Hearing" means an informal evidentiary proceeding conducted by a department hearing officer during which an enrollee has the opportunity to present his concerns with or objections to the participating plan's internal appeal decision.

"Hearing officer" means an impartial decision maker who conducts evidentiary hearings for enrollee appeals on behalf of the department.

"Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" means a facility licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to intellectually disabled individuals who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming home, boarding home, or group home. Such facilities must comply with Title XIX standards, provide health or rehabilitative services, and provide active treatment to enrollees toward the achievement of a more independent level of functioning.

"Internal appeal" means a request to the MCO by a member, a members authorized representative, or provider, acting on behalf of the member and with the members written consent, for review of a Contractors adverse benefit determination. The internal appeal is the only level of appeal with the MCO and must be exhausted by a member or deemed exhausted according to 42 CFR 438.408(c)(3) before the member may initiate a state fair hearing.

"Long-term services and supports" or "LTSS" means a variety of services and supports that (i) help elderly enrollees and enrollees with disabilities who need assistance to perform activities of daily living and instrumental activities of daily living to improve the quality of their lives and (ii) are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

"MCO" means a health plan selected to participate in Virginia's CCC Plus program. "MCO" means the same as "participating plan."

"Medicaid" means the program of medical assistance benefits under Title XIX of the Social Security Act.

"Medically necessary" or "medical necessity" means an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12VAC30-130-600 et seq.) EPSDT criteria (for those younger than 21 years of age) in accordance with 42 CFR 441 Subpart B (§§ 50 through 62) and 42 CFR 438.210 and 42 CFR 440.230.

"Medicare" means Title XVIII of the Social Security Act, the federal health insurance program for people age 65 years or older, people younger than 65 years of age who have certain disabilities, and people with end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).

"Member" means the same as "enrollee."

"Money Follows the Person" or "MFP" means a demonstration project administered by DMAS that is designed to create a system of long-term services and supports that better enable enrollees to transition from certain long-term care institutions into the community.

"Network provider" means a doctor, hospital, or other health care provider that participates or contracts with a participating plan and, as a result, agrees to accept a mutually-agreed upon payment amount or fee schedule as payment in full for covered services that are rendered to eligible enrollees.

"Nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the Social Security Act, as amended, and § 32.1-137 of the Code of Virginia.

"Participating plan" means the same as "MCO."

"Plan of care" or "POC" means a plan, primarily directed by the enrollee and family members of the enrollee as appropriate with the assistance of the enrollee's interdisciplinary care team to meet the enrollee's medical, behavioral health, long-term care services and supports, and social needs.

"Previously authorized" means, in relation to continuation of benefits, as described in 42 CFR 438.420, a prior approved course of treatment.

"Primary care provider" or "PCP" means a practitioner who provides preventive and primary medical care and certifies service authorizations and referrals for medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, geriatricians, and specialists who perform primary care functions (such as surgeons) and clinics including local health departments, federally qualified health centers (FQHCs), and rural health clinics (RHCs).

"Program of All-Inclusive Care for the Elderly" or "PACE" means the program in which the PACE provider provides the entire spectrum of health services (preventive, primary, and acute) and long-term services and supports to its enrollees without limit as to duration or cost of services pursuant to 12VAC30-50-320 et seq.

"Provider appeal" means an appeal to the department filed by a Medicaid-enrolled or network service provider that has already provided a service to an enrollee and has received an adverse reconsideration decision regarding service authorization, payment, or audit result.

"Reconsideration" means a provider's request to the MCO for review of an adverse action related to service authorization or payment. The MCO's reconsideration decision is a prerequisite to a provider's filing of an appeal to the DMAS Appeals Division.

"Remand" means the return of a case by the department's hearing officer to the MCO for further review, evaluation, and action.

"Reverse" means to overturn the MCO's internal appeal decision and to direct that the MCO fully approve the amount, duration, and scope of requested services.

"Social Security Act" means the federal act, codified through Chapter 7 of Title 42 of the United States Code that established social insurance programs including Medicare and Medicaid.

"State fair hearing" means the DMAS evidentiary hearing process as administered by the Appeals Division of DMAS.

"Subcontractor" means an entity that has contracted with the Contractor to perform part of the responsibilities within the CCC Plus program. All subcontractors shall be approved by DMAS.

"Sustain" means to uphold the MCO's appeal decision.

"Withdraw" means a written request from the enrollee or the enrollee's authorized representative for the department to terminate the enrollee appeal.

**12VAC30-120-610. CCC Plus mandatory managed care enrollees; enrollment process.**

A. The following individuals shall be enrolled in CCC Plus per the CCC Plus § 1915(b) waiver:

1. Dual eligible individuals with Medicare A or B coverage and full Medicaid coverage.

2. Individuals enrolled in the Commonwealth Coordinated Care (CCC) program will transition to CCC Plus in January 2018, which is after the CCC program ends.

3. Non-dual eligible individuals who receive long-term services and supports through an institution, the CCC Plus waiver (formerly known as the EDCD and Technology Assisted waivers), Building Independence waiver, Community Living waiver, and Family and Individual Supports waiver.

Those enrolled in the Building Independence, Community Living, and Family and Individual Supports waivers will continue to receive their LTSS including LTSS related transportation services through Medicaid fee-for-service.

4. Individuals enrolled in the Department's Medallion Health and Acute Care Program (HAP), except individuals in the Alzheimer's Assisted Living (AAL) Waiver; AAL is excluded from CCC Plus.

5. All individuals classified as aged, blind, or disabled (ABD) without Medicare and not receiving LTSS. The majority of these individuals are currently enrolled in Medallion and will transition to CCC Plus effective January 1, 2018.

6. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program, as defined in 12VAC30-20-205 and 12VAC30-20-210.

B. The following individuals shall be excluded from enrollment in CCC Plus:

1. Individuals enrolled in the Alzheimer's Assisted Living (AAL) Waiver. However, individuals with Alzheimers disease and persons with dementia will be included if they meet other eligibility requirements and are not enrolled in the Alzheimers Assisted Living Waiver. (The AAL waiver will discontinue on June 30, 2018. At that time, individuals who were enrolled in the AAL waiver may become enrolled in the CCC Plus program if they meet the other eligibility requirements of the program.)

2. Individuals enrolled in another DMAS managed care program (e.g., Medallion, FAMIS, and FAMIS MOMS).

3. Individuals enrolled in a PACE program.

4. Newborns whose mothers are CCC Plus enrollees on their date of birth.

5. Individuals who are in limited coverage groups, such as:

a. Dual eligible individuals without full Medicaid benefits, such as:

(1) Qualified Medicare beneficiaries (QMBs);

(2) Special low-income Medicare beneficiaries (SLMBs);

(3) Qualified disabled working individuals (QDWIs); or

(4) Qualifying individuals (QIs) for whom Medicaid pays the Part B premium.

b. Individuals enrolled in Plan First.

c. Individuals enrolled in the Governor's Access Plan.

6. Individuals enrolled in a Medicaid-approved hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in CCC Plus, the member will remain enrolled in CCC Plus.

7. Individuals who live on Tangier Island.

8. Individuals younger than 21 years of age who are approved for DMAS psychiatric residential treatment center (RTC) Level C programs as defined in 12VAC30-130-860. Any individual admitted to an RTC Level C program for behavioral health services will be temporarily excluded from CCC Plus until after they are discharged. RTC Level C services may be transitioned to the CCC Plus program in the future.

9. Individuals with end stage renal disease (ESRD) and in fee-for-service at the time of enrollment will be auto-enrolled into CCC Plus but may request to be disenrolled and remain in fee-for-service. The department will exclude these individuals if requested by the member within the first ninety days of CCC Plus enrollment. However, an individual who does not request an extension within the first ninety days of CCC Plus enrollment or who develops ESRD while enrolled in CCC Plus will remain in CCC Plus.

10. Individuals who are institutionalized in certain state and private ICF/IID and mental health facilities as specified in the CCC Plus contract.

11. Individuals who are patients at nursing facilities operated by the Veterans Administration.

12. Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH individuals may enroll in CCC Plus if they choose to disenroll from IAH.

13. Certain individuals in out-of-state placements as specified in the CCC Plus contract.

14. Individuals placed on spenddown. However, spenddown individuals are included if they are residing in a nursing home.

15. Individuals enrolled in the department's Money Follows the Person (MFP) Demonstration project.

16. Incarcerated individuals. Individuals on house arrest are not considered incarcerated.

17. All children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program, established pursuant to Chapter 50 of Title 38.2 (§38.2-5000, et seq.) of the Code of Virginia, who shall maintain enrollment in Medicaid fee-for-service.

C. Enrollment in CCC Plus will be mandatory for eligible individuals. The department shall have sole authority and responsibility for the enrollment of individuals into the CCC Plus program and for excluding enrollees from CCC Plus.

D. There shall be no retroactive enrollment for CCC Plus.

E. The MCO shall notify the enrollee of his enrollment in the MCO's plan through a letter submitted simultaneously with the handbook. Upon disenrollment from the plan, the MCO shall notify the enrollee through a disenrollment notice that coverage in the MCO's plan will no longer be effective.

F. The department reserves the right to revise the CCC Plus intelligent default assignment methodology (as described in subsection I of this section) as needed based upon DMAS sole discretion.

G. Eligible individuals as defined in subsection A of this section shall be enrolled in a CCC Plus contracted health plan through a CCC Plus intelligent assignment methodology as defined by DMAS in the CCC Plus contract.

1. The enrollee will be, at a minimum, notified of his assigned MCO, right to select another CCC Plus MCO operating in his locality, CCC Plus service begin date, and instructions for the individual, or his designee, to contact DMAS or its enrollment broker to either:

a. Accept the assigned MCO; or

b. Select a different CCC Plus MCO that is operating in his locality.

2. If an individual does not contact DMAS or its enrollment broker to accept the assigned MCO or select a different CCC Plus MCO operating in his locality, the individual shall be enrolled into the assigned MCO.

3. For the initial 90 calendar days following the effective date of CCC Plus enrollment, the enrollee will be permitted to disenroll from one MCO and enroll in another without cause. This 90-day timeframe applies only to the enrollee's initial start date of enrollment in CCC Plus; it does not reset or apply to any subsequent enrollment periods. After the initial 90-day period following the initial enrollment date, the enrollee may not disenroll without cause until the next annual open enrollment period.

4. Open enrollment is a period of time when individuals are able to change from one MCO to another without cause.

a. Open enrollment will occur at least once every 12 months per 42 CFR 438.56(c)(2) and (f)(1). The open enrollment will occur during October through December with any changes to taking effect the following January 1.

b. Within 60 days prior to the open enrollment effective date, the department will inform enrollees of the opportunity to remain with the current plan or change to another plan without cause. Those individuals who do not choose a new MCO during the open enrollment period shall remain in their current MCO until their next open enrollment effective date.

H. Individuals transferring from CCC and Medallion 3 (other than HAP as described in subdivision A 4 of this section) will transition with a CCC Plus service begin date of January 1, 2018. However, DMAS retains the authority to change this date if deemed necessary by DMAS or CMS. Individuals impacted by a delay will be notified of their new CCC Plus service begin date.

I. DMAS shall utilize an intelligent default assignment process to assign eligible individuals, other than the ABD populations described in subdivision A 5 of this section, to a CCC Plus MCO contracted to operate in their locality. If none of the criteria used in the intelligent default assignment process applies to an individual, he will be randomly assigned to a CCC Plus MCO operating in his locality. The intelligent default assignment process will, at a minimum, take into account:

1. The individuals previous Medicare and Medicaid MCO enrollment within the past two months if known at the time of assignment; and

2. Which MCO their current providers are contracted with. This may include the nursing facility an individual is residing in at the time of assignment, adult day health care for CCC Plus Waiver enrolled members, and an individual's private duty nursing provider.

J. Consistent with 42 CFR 438.56(d), DMAS must permit an enrollee to disenroll at any time for cause.

1. An enrollee may disenroll from his current plan for the following reasons:

a. The enrollee moves out of the MCO's service area;

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

c. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the individual to unnecessary risk;

d. The enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO and, as a result, would experience a disruption in his residence or employment; and

e. Other reasons as determined by DMAS, including poor quality of care, lack of access to services covered under this MCO, or lack of access to providers experienced in dealing with the enrollee's care needs.

2. The enrollee's request to change from one plan to another outside of open enrollment, or for cause request, may be submitted orally or in writing to the department as provided for in 42 CFR 438.56(d)(1) and cite the reasons why he wishes to disenroll from one plan and enroll in another. The department will review the request in accordance with cause for disenrollment criteria defined in 42 CFR 438.56(d)(2). The department will respond to "for cause" requests, in writing, within 15 business days of the department's receipt of the request. In accordance with 42 CFR 438.56(e)(2), if the department fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the disenrollment request shall be considered approved and effective on the date of approval. Enrollees who are dissatisfied with the department's determination of the enrollee's request to disenroll from one plan and enroll in another for cause shall have the right to appeal through the state fair hearing process at 12VAC30-110-10 et seq.

K. CCC Plus eligible individuals who have been previously enrolled with a CCC Plus MCO and who regain eligibility for the CCC Plus program within 60 calendar days of the effective date of exclusion or disenrollment will be reassigned to the same MCO whenever possible and without going through the selection or assignment process.

**12VAC30-120-620. MCO responsibilities; sanctions.**

A. The MCO and any of its subcontractors shall abide by all CCC Plus Contract requirements, including:

1. The MCO shall provide medically necessary covered services in accordance with the CCC Plus contract.

a. 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 member'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 shall consult with the requesting provider when appropriate.

b. In accordance with § 1932(f) of the Social Security Act (42 USC § 1396a-2), the contractor shall pay all in-network and out-of-network providers (including Native American health care providers) on a timely basis, consistent with the claims payment procedure described in 42 CFR 447.45 and 42 CFR 447.46 and § 1902 (a)(37) of the Social Security Act, upon receipt of all clean claims, for covered services rendered to covered members who are enrolled with the contractor at the time the service was delivered. The MCO may deny claims in whole or in part for not meeting payment criteria established by the MCO.

c. Utilization review and audit: MCOs may perform utilization reviews and audits on their network providers. As a result of such a review or audit, an overpayment may be determined.

2. The MCO shall report data to DMAS per CCC Plus contract requirements, which includes data, claims reports, and quality studies performed by the MCO.

3. The MCO shall maintain records, including written policies and procedures, as required by the CCC Plus contract.

4. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representative, or the State Medicaid Fraud Control Unit upon request and in the form requested.

5. The MCO shall meet standards specified in the CCC Plus contract for sufficiency of provider networks. In accordance with 1915(b)(4) of the Social Security Act, 42 CFR 431.51, and 42 CFR 438.12b(1), the MCO does not have to contract with any willing provider.

6. The MCO shall conduct monthly checks to screen providers for exclusion.

7. The MCO shall require its providers and subcontractors to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and CHIP programs, as described in 42 CFR 455 Subpart B.

8. In accordance with 42 CFR 447.50 through 42 CFR 447.60, the MCO shall not impose any cost sharing obligations on members except as set forth in 12VAC30-20-150 and 12VAC30-20-160 and as described in the CCC Plus contract.

B. Sanctions shall be the same as those set forth in the CCC Plus contract.

C. As provided in 42 CFR 438.210(a)(5(i), the MCO's medical necessity criteria shall not be more restrictive than the department's criteria.

D. The MCO's coverage rules for contract covered services shall also ensure compliance with federal EPSDT coverage requirements for enrollees younger than 21 years of age.

E. The MCO shall provide services at least in equal amount, duration, and scope as available under the Medicaid fee-for-service program and as described in Attachment 5 of the CCC Plus contract.

**12VAC30-120-625. Continuity of Care.**

A. The MCO shall ensure continuity of care for all members upon enrollment into their plan. During the time period set forth in this section, the MCO shall maintain the members current providers at the Medicaid FFS rate and honor service authorizations (SAs) issued prior to enrollment for the specified time period. The continuity of care period is as follows:

1. Within the first ninety calendar days of a members enrollment, the MCO shall allow a member to maintain their current providers (including out-of-network providers). For members enrolling effective on or after April 1, 2018, the continuity of care time period will change to a minimum of thirty calendar days. The MCO shall extend this time frame as necessary to ensure continuity of care pending the providers contracting with the MCO or the members safe and effective transition to a contracted provider. (DMAS has sole discretion to extend the continuity of care period time frame.)

2. The MCO shall reimburse nursing facilities and specialized care services (specialized care services as described in 12VAC30-60-40, 12 VAC30-60-320, and 12VAC30-60-340) no less than the Medicaid established per diem rate for Medicaid covered days, using the DMAS methodologies, unless the MCO and the provider mutually agree to an alternative payment methodology or value-based payment arrangement; however, the rate paid shall not be less than the current Medicaid fee-for-service rate.

**12VAC30-120-630. Covered services.**

A. The MCO shall, at a minimum, provide all medically necessary Medicaid covered services required under the state plan (12VAC30-50-10 through 12VAC30-50-310, 12VAC30-50-410 through 12VAC30-50-430, and 12VAC30-50-470 through 12VAC30-50-580) and Elderly and Disabled with Consumer Direction waiver regulations (12VAC30-120-924 and 12VAC30-120-927) and the Technology Assisted waiver regulations (12VAC30-120-1720) and, effective January 1, 2018, community mental health services (12VAC30-50-130 and 12VAC30-50-226).

B. The following services are not covered by the MCO and shall be provided through fee-for-service outside the CCC Plus MCO contract:

1. Dental services (12VAC30-50-190);

2. School health services (12VAC30-50-130);

3. Preadmission screening (12VAC30-60-303);

4. Individual and Developmental Disability Support waiver services (12VAC 30-120-700 et seq.);

5. Intellectual Disability Waiver (12VAC30-120-1000 et seq.);

6. Day Support Waiver (12VAC30-120-1500 et seq.)

C. The Program of All-Inclusive Care for the Elderly, or PACE, is not available to CCC Plus members.

**12VAC30-120-635. Payment rates for MCOs.**

A. The payment rate to MCOs shall be set by negotiated contracts and in accordance with 42 CFR 438.6 Subpart A 42 CFR 438.8 and other pertinent federal regulations.

B. In accordance with section 1932(b)(2)(D) of the Social Security Act and State Medicaid Director Letter 06-010, the Contractor shall pay non-contracted providers

for emergency services no more than the amount that would have been paid if the service had been provided under the states fee-for-service (FFS) Medicaid program. The Contractor shall reimburse out-of-network, and providers of emergent or urgent care, as defined by 42 CFR § 424.101 and 42 CFR § 405.400 respectively, at the Medicaid FFS payment level for that service.

**12VAC30-120-640. State fair hearing process.**

A. Notwithstanding the provisions of 12VAC30-110-10 through 12VAC30-110-370, the following regulations govern state fair hearings for individuals enrolled in CCC Plus.

B. The Appeals Division maintains an appeals and fair hearings system for enrollees (also referred to as appellants) to challenge appeal decisions rendered by the MCO in response to enrollee appeals of adverse benefit determinations related to Medicaid services. Exhaustion of the MCO's appeals process is a prerequisite to requesting a state fair hearing with the department. Appellants who meet the criteria for a state fair hearing shall be entitled to a hearing before a department hearing officer.

C. The MCO shall conduct an internal appeal hearing, pursuant to 42 CFR Part 431 Subpart E and 42 CFR Part 438 Subpart F, and issue a written decision that includes its findings and information regarding the appellant's right to file an appeal with DMAS for a state fair hearing for Medicaid appeals.

D. Enrollees must be notified in writing of the MCO's internal appeals process in accordance with 42 CFR 438.400 et seq.:

1. With the handbook; and

2. Upon receipt of a notice of adverse benefit determination from the MCO.

E. Enrollees must be notified in writing of their right to an external appeal to DMAS upon receipt of the MCO's final internal appeal decision.

F. An appellant shall have the right to representation by an attorney or an authorized representative at the internal appeal and external appeal before DMAS.

1. An authorized representative may be designated to represent the appellant, pursuant to 12 VAC 30-110-60, 30-110-1380, and 30-110-1390, at the internal appeal and external appeal before DMAS. The appellant shall designate the authorized representative in a written statement that is signed by the appellant whose Medicaid benefits were adversely affected. If the appellant is physically unable to sign a written statement and proof is submitted to that effect, the department or MCO shall allow a family member or other person acting on the appellant's behalf to be the authorized representative. If the appellant is mentally unable to sign a written statement, the department or MCO shall require written documentation that a family member or other person has been appointed or designated as his authorized representative.

2. If the authorized representative is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant prepared on the attorney's letterhead shall be accepted as a designation of representation.

3. An individual of the same law firm as a designated authorized representative shall have the same rights as the designated authorized representative.

4. An appellant may revoke representation by another person at any time. The revocation is effective when the department receives written notice from the appellant.

G. Any communication from an enrollee or his authorized representative that expresses that he wants to present his case to a reviewing authority shall constitute an appeal request.

1. This communication should explain the basis for the appeal of the MCO's internal appeal decision.

2. The appellant or his authorized representative may examine witnesses or documents, or both, provide testimony, submit evidence, and advance relevant arguments during the hearing.

H. After the MCO's internal appeal process has been exhausted, an appellant may request a state fair hearing by filing an appeal with the DMAS Appeals Division via U.S. mail, fax transmission, telephone, email, in person, or through other commonly available electronic means.

I. Expedited appeals referenced in subsection K of this section may be filed by telephone or any of the methods set forth in subsection H of this section.

J. The enrollee has the right to have his benefits continued during the MCO's appeal or the state fair hearing.

1. All of the following requirements must be met in order for benefits to be continued during the MCO and state fair hearing appeals:

a. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

b. The services were ordered by an authorized provider;

c. The original period covered by the initial authorization has not expired; and

d. The enrollee requests that the benefits be continued.

2. For continuation of benefits for an internal appeal with the MCO, the enrollee or authorized representative must file the appeal before the effective date of the adverse benefit determination or within 10 calendar days of the mail date of the MCO's notice of the adverse benefit determination.

3. For continuation of benefits for a state fair hearing, the enrollee, or authorized representative must file the appeal within 10 calendar days of the mail date of the MCO's final appeal decision.

4. The MCO shall also continue benefits for enrollees who initiate a state fair hearing directly because of deemed exhaustion of appeals processes due to failure of the MCO to adhere to the notice and timing requirements in 42 CFR 438.408.

5. If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's adverse benefit determination, the MCO may recover the costs of services furnished to the enrollee while the appeal and the state fair hearing was pending, to the extent they were furnished solely because of the pending appeal.

K. The MCO and the department shall maintain an expedited process for appeals when an appellant's treating provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

1. Resolution of an expedited appeal shall be no longer than 72 hours after the MCO receives the appeal.

2. Enrollees must exhaust the MCO's internal appeals processes prior to filing an expedited appeal request with the department with the exception of those enrollees with direct access to state fair hearings because of deemed exhaustion of appeals processes with the MCO.

3. The MCO and the department may extend the timeframes for resolution of an expedited appeal by up to 14 calendar days if the enrollee or the enrollee's authorized representative requests the extension, or if the MCO or the department:

a. Shows that there is a need for additional information and how the delay is in the enrollee's best interest;

b. Requirements following extension. If the MCO extends the timeframes not at the request of the enrollee, it shall complete the following:

(1) Promptly notify the enrollee of the reason for an extension, and provides the date the extension expires; and

(2) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

**12VAC30-120-650. Appeal timeframes.**

A. Appeals to the Medicaid state fair hearing process must be filed with the DMAS Appeals Division within 120 days of the date of the MCO's final internal appeal decision.

B. It is presumed that appellants will receive the MCO's final internal appeal decision five days after the MCO mails it unless the appellant shows that he did not receive the notice within the five-day period.

C. A request for a state fair hearing on the grounds that the MCO has not acted with reasonable promptness in response to an internal appeal request may be filed at any time until the MCO has acted.

D. The date of filing shall be the date the internal appeal request is received by the MCO or the date the state fair hearing request is received by the DMAS Appeals Division, or the postmark date if the state fair hearing request is sent by USPS mail.

E. In computing any time period under these regulations, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.

F. DMAS shall take final administrative action within 90 days from the date the enrollee filed an MCO appeal, not including the number of days the enrollee took to subsequently file for a state fair hearing.

G. Exceptions to standard appeal resolution timeframes. Decisions may be issued beyond the standard appeal resolution timeframes when the appellant or his authorized representative requests or causes a delay. Decisions may also be issued beyond the standard appeal resolution timeframe when any of the following circumstances exist:

1. The appellant or authorized representative requests to reschedule or continue the hearing;

2. The appellant or authorized representative provides good cause for failing to keep a scheduled hearing appointment, and the Appeals Division reschedules the hearing;

3. Inclement weather, unanticipated system outage, or the department's closure that prevents the hearing officer's ability to work;

4. Following a hearing, the hearing officer orders an independent medical assessment as described in 12VAC30-120-670 H 1;

5. The hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant;

6. The hearing officer receives additional evidence from a person other than the appellant or his authorized representative, and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence; or

7. The Appeals Division determines that there is a need for additional information and documents how the delay is in the appellant's best interest.

H. For delays requested or caused by an appellant or his authorized representative the delay date for the decision will be calculated as follows:

1. If an appellant or authorized representative requests or causes a delay within 30 days of the request for a hearing, the 90-day time limit will be extended by the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

2. If an appellant or authorized representative requests or causes a delay within 31 to 60 days of the request for a hearing, the 90-day time limit will be extended by 1.5 times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

3. If an appellant or authorized representative requests or causes a delay within 61 to 90 days of the request for a hearing, the 90-day time limit will be extended by two times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.

I. Post hearing delays requested or caused by an appellant or authorized representative (e.g., requests for the record to be left open) will result in a day-for-day delay for the decision date. The department shall provide the appellant and authorized representative with written notice of the reason for the decision delay and the delayed decision date, if applicable.

**12VAC30-120-660. Prehearing decisions.**

A. If the Appeals Division determines that any of the conditions as described in this subsection exist, a hearing will not be held and the appeal process shall be terminated.

1. A request for appeal may be invalidated if:

a. It was not filed within the time limit imposed by 12VAC30-120-650; or

b. The individual who filed the appeal ("filer") is not the appellant or parent of a minor appellant, and the DMAS Appeals Division sends a letter to the filer requesting proof of his authority to appeal on behalf of the appellant; and

(1) The filer did not reply to the request for authorization to represent the appellant within 10 calendar days; or

(2) The filer replied within 10 calendar days of the request, and the DMAS Appeals Division determined that the authorization submitted was insufficient to allow the filer to represent the appellant under the provisions of 12VAC30-120-640.

2. A request for appeal may be administratively dismissed if:

a. The MCO's internal appeals process was not exhausted prior to the enrollee's request for a state fair hearing;

b. The issue of the appeal is not related to the MCO's final internal appeal decision;

c. The adverse benefit determination being appealed was not taken by the MCO; or

d. The sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.

3. An appeal case may be closed if:

a. The Appeals Division schedules a hearing and sends a written schedule letter notifying the appellant or his authorized representative of the date, time, and location of the hearing; the appellant or his authorized representative failed to appear at the scheduled hearing; and the DMAS Appeals Division sends a letter to the appellant for an explanation as to why he failed to appear; and

(1) The appellant did not reply to the request within 10 calendar days for an explanation that met good cause criteria; or

(2) The appellant replied within 10 calendar days of the request, and the DMAS Appeals Division determined that the reply did not meet good cause criteria.

b. The Appeals Division sends a written schedule letter requesting that the appellant or his authorized representative provide a telephone number at which he can be reached for a telephonic hearing, and the appellant or his authorized representative failed to respond within 10 calendar days to the request for a telephone number at which he could be reached for a telephonic hearing.

c. The appellant or his authorized representative withdraws the appeal request. If the appeal request is withdrawn orally, the Appeals Division shall (i) record the individual's statement and telephonic signature and (ii) send the affected individual written confirmation, via regular mail or electronic notification, in accordance with the individual's election.

d. The MCO approves the full amount, duration, and scope of services requested.

e. The evidence in the record shows that the MCO's decision was clearly in error and that the case should be fully resolved in the appellant's favor.

B. Remand to the MCO. If the hearing officer determines from the record, without conducting a hearing, that the case might be resolved in the appellant's favor if the MCO obtains and develops additional information, documentation, or verification, the hearing officer may remand the case to the MCO for action consistent with the hearing officer's written instructions pursuant to 12VAC30-110-210 D.

C. A letter shall be sent to the appellant or his authorized representative that explains the determination made on his appeal.

**12VAC30-120-670. Hearing process and final decision.**

A. All hearings must be scheduled at a reasonable time, date, and place, and the appellant and his authorized representative shall be notified in writing prior to the hearing.

1. The hearing location will be determined by the Appeals Division.

2. A hearing shall be rescheduled at the appellant's request no more than twice unless compelling reasons exist.

3. Rescheduling the hearing at the appellant's request will result in automatic waiver of the 90-day deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-120-650 J.

B. The hearing shall be conducted by a department hearing officer. The hearing officer shall review the complete record for all MCO decisions that are properly appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; research the issues; and render a written final decision.

C. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeal record shall be made accessible to the appellant and authorized representative at a convenient place and time before the date of the hearing, as well as during the hearing. The appellant and his authorized representative may examine the content of the appellant's case file and all documents and records the department will rely on at the hearing except those records excluded by law.

D. Appellants who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request in writing the issuance of a subpoena. The request must be received by the department at least 10 working days before the scheduled hearing. Such request shall (i) include the witness's or respondent's name, home and work addresses, county or city of work and residence, and (ii) identify the sheriff's office that will serve the subpoena.

E. The hearing officer shall conduct the hearing; decide on questions of evidence, procedure, and law; question witnesses; and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in or observe the hearing.

F. Hearings shall be conducted in an informal, nonadversarial manner. The appellant or his authorized representative shall have the right to bring witnesses, establish all pertinent facts and circumstances; present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine agency representatives.

G. The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

H. The hearing officer may leave the hearing record open for a specified period of time after the hearing in order to receive additional evidence or argument from the appellant or his authorized representative.

1. At the appellants option, the hearing officer may order an independent medical assessment when the appeal involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision, and the hearing officer determines that it is necessary to have an assessment by someone other than the person or team who made the original decision (e.g., to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence). A medical assessment ordered pursuant to this regulation shall be at the departments expense, shall not extend any of the timeframes specified in these regulations, shall not disrupt the continuation of benefits, and shall become part of the record.

2. The hearing officer may receive evidence that was not presented by either party if the record indicates that such evidence exists, and the appellant or his authorized representative requests to submit it or requests that the hearing officer secure it.

3. If the hearing officer receives additional evidence from an entity other than the appellant or his authorized representative, the hearing officer shall send a copy of such evidence to the appellant and his authorized representative and give the appellant or his authorized representative the opportunity to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence.

4. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether or not it will be used in making the decision.

I. After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision that sustains or reverses, in whole or in part, the MCO's adverse benefit determination or remands the case to the MCO for further evaluation consistent with his written instructions. Some decisions may be a combination of these dispositions. The hearing officer's final decision shall be considered as the department's final administrative action pursuant to 42 CFR 431.244(f). The final decision shall include:

1. Identification of the issue or issues;

2. Relevant facts, to include a description of the procedural development of the case;

3. Conclusions of law, regulations, and policy that relate to the issue or issues;

4. Discussions, analysis of the accuracy of the MCO's appeal decision, conclusions, and hearing officer's decision;

5. Further action, if any, to be taken by the MCOs to implement the hearing officer's decision;

6. The deadline date by which further action must be taken; and

7. A cover letter informing the appellant and his authorized representative of the hearing officer's decision. The letter must indicate that the hearing officer's decision is final, and that the final decision may be appealed directly to circuit court.

J. A copy of the hearing record shall be forwarded to the appellant and his authorized representative with the final decision.

K. An appellant who disagrees with the hearing officer's final decision described in this section may seek judicial review pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and Rules of the Supreme Court of Virginia, Part Two A. Written instructions for requesting judicial review must be provided to the appellant or his authorized representative with the hearing officer's decision, and upon request by the appellant or authorized representative.

**12VAC30-120-680. Appeals Division records.**

A. No person shall take from the department's custody any original record, paper, document, or exhibit that has been certified to the department's Appeals Division except as the Appeals Division Director or his designee authorizes, or as may be necessary to furnish or transmit copies for other official purposes.

B. Information in the appellant's record can be released only to the appellant, his authorized representative, the MCO, other entities for official purposes, and other persons named in a release of information authorization signed by an appellant or his authorized representative.

C. The fees to be charged and collected for any copy of Appeals Division records will be in accordance with Virginia's Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia) or other controlling law.

D. When copies are requested from records in the Appeals Division's custody, the required fee shall be waived if the copies are requested in connection with an enrollee's own appeal.

**12VAC30-120-690. Provider appeals.**

A. The Appeals Division maintains an appeal process for network and Medicaid-enrolled providers of Medicaid services that have rendered services to enrollees and are requesting to challenge a MCO's reconsideration decision regarding an adverse action affecting service authorization or payment. The MCO's internal reconsideration process is a prerequisite to filing for an external appeal to the department's provider appeal process. The appeal process is available to network and Medicaid-enrolled providers that (i) have rendered services and have been denied payment in whole or part for Medicaid covered services; (ii) have rendered services and have been denied authorization for the services; and (iii) have received a notice of program reimbursement or overpayment demand from the department or its contractors. Providers that have had their enrollment in the MCO's network denied or terminated by the MCO do not have the right to an external appeal with the Appeals Division.

B. Department provider appeals shall be conducted in accordance with the department's provider appeal regulations (12VAC30-20-500 et seq.), § 32.1-325 et seq. of the Code of Virginia, and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

C. The department's external appeal decision shall be binding upon the MCO and not subject to further appeal by the MCO.

D. If the provider is successful in its appeal of a reimbursement issue, then the MCO shall reimburse the provider for the appealed issue.