COMMONWEALTH of VIRGINIA
Office of the Attorney General

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120

Mark R. Herring
Attorney General

MEMORANDUM

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

FROM: **Usha Koduru**
Assistant Attorney General
Office of the Attorney General

DATE: **July 22, 2016**

SUBJECT: **Proposed Regulations to Implement the Commonwealth Coordinated Care Program 12 VAC 30-50-600 et seq.**

I have reviewed the attached proposed regulations allowing the Department of Medical Assistance Services (DMAS) to combine certain aspects of Medicaid managed care and long-term care, and Medicare into one program. Based on that review, it is my view that the Director of DMAS, acting on behalf of the Board pursuant to Virginia Code § 32.1-325, 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 § 32.1-325 grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance, and §§ 32.1-324 and 325 grant the authority to the Director to administer the Plan according to the Board's requirements. Additionally, Section 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payment for Medicaid services. These particular regulations are authorized by Chapter 806, Item 307AAAA of the 2013 Acts of the Assembly (the 2013 Acts), Chapter 3, Item 301 HHH of the 2014 Acts of Assembly and Chapter 665, Item 301 HHH of the 2015 Acts of the Assembly; (ii) Chapter 806, Item 307 RRRR of the Acts, and; (iii) Item 307 RR of the 2013 Acts, Chapter 3, Item 301 TTT of the 2014 Acts of the Assembly, Chapter 665, Item 301 TTT of the 2015 Acts of the Assembly.

These regulations will amend the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services also will be required.

If you have any additional questions, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

Proposed Text

Action: Commonwealth Coordinated Care

Stage: Proposed 7/22/16 3:26 PM [latest]

12VAC30-50-600. Section 1932 Medicare-Medicaid eligible individuals.

A. Consistent with the Social Security Act § 1932(a)(1)(A) (the Act), the Commonwealth enrolls Medicaid enrollees on a voluntary basis into Medicare-Medicaid Plans (MMPs) in the absence of § 1115 or § 1915(b) waiver authority.

B. Consistent with § 1932(a)(1)(B) of the Act, the Commonwealth shall contract with MMPs. The payment method to the contracting entity shall be a capitation method.

C. Enrollment will be voluntary in the counties and cities designated by the following regions: (i) Central Virginia, (ii) Northern Virginia, (iii) Tidewater, (iv) Western/Charlottesville, and (v) Roanoke.

D. The Commonwealth assures that all of the applicable requirements of § 1903 (m) of the Act for MMPs and MMP contracts are met.

E. The Commonwealth assures that all the applicable requirements of § 1932 of the Act for the state's option to limit freedom of choice by requiring enrollees to receive their benefits through managed care entities will be met. MMPs shall be required to pass readiness reviews prior to enrolling individuals.

F. The Commonwealth assures that all the applicable requirements of 42 CFR § 431.51 regarding freedom of choice for family planning services and supplies as defined in § 1905(a)(4)(C) of the Act will be met.

G. The Commonwealth assures that all applicable managed care requirements of 42 CFR Part 438 for MMPs will be met. Enrollees shall be permitted to opt out at any time with or without cause from the program pursuant to 42 CFR § 438.56(c).

H. The Commonwealth assures that all applicable requirements of 42 CFR § 438.6 (c) for payments under any risk contracts will be met.

I. The Commonwealth assures that all applicable requirements of 45 CFR § 92.36 for procurement of contracts will be met.

J. Enrollment process.

1. DMAS shall use a pre-assignment algorithm, through its Medicaid Management Information System (MMIS), and a contracted enrollment broker to facilitate the continuity of care for Medicaid individuals by providers that have traditionally served this population.

2. DMAS shall not use a lock in (restricting a beneficiary's ability to move between health plans except during the designated annual open enrollment period) for managed care.

3. Individuals shall have 60 days to choose a health plan before being automatically assigned.

4. Eligible individuals will receive a notice that indicates to which MMP they have been assigned. The notice will have instructions for the individual to contact the DMAS contracted enrollment facilitator to:

a. Accept the preassigned MMP;

b. Select a different MMP that is operating in their region; or

c. Opt out of the program altogether.

5. If an individual does not select an MMP, he shall be passively enrolled into the preassigned MMP.

6. Enrollees shall be assigned to an MMP based on six months of claims prior to pre-assignment using the rules below in order of priority:

a. Individuals in a nursing facility shall be preassigned to an MMP that includes the individual's nursing facility in its provider network;

b. Individuals in the EDCD Waiver shall be assigned to an MMP that includes the individual's current adult day health care provider in its provider network;

c. If more than one MMP network includes the nursing facility or adult day healthcare provider used by an individual, the individual will be assigned to the MMP with which he has previously been assigned in the past six months. If he has no history of previous MMP assignment, he shall be randomly assigned to an MMP in which his provider participates.

d. Individuals shall be preassigned to an MMP with whom they have previously been assigned within the past six months.

K. The Commonwealth assures that it has an enrollment system that allows individuals who are already enrolled to be given priority to continue that enrollment if the MMP does not have capacity to accept all who are seeking enrollment under the program.

L. The Commonwealth assures that, pursuant to the choice requirements in 42 CFR § 438.52, Medicaid individuals who are enrolled in an MMP will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR § 438.52(b)(3).

M. The Commonwealth shall apply the automatic reenrollment provision in accordance with 42 CFR § 438.56(g) if the individual is disenrolled solely because he loses Medicaid eligibility for a period of two months or less.

N. The following services shall be excluded from coverage by the MMP in this program:

1. Induced abortions;

2. Targeted case management; and

3. Dental services (see 12VAC30-121-70 for specific coverage).

O. The Commonwealth shall intentionally limit the number of entities it contracts with under the option permitted by § 1932 of the Act. The Commonwealth assures that such limits on the number of contracting entities shall not substantially impair enrollee access to services.

P. DMAS has established an advisory committee that meets quarterly throughout the duration of the program to discuss topics such as program design, educational and outreach materials, and provider and beneficiary issues.

CHAPTER 121
MEDICARE-MEDICAID DEMONSTRATION WAIVER

THE TEXT OF THESE REGULATIONS (12 VAC 30-50-600 AND 12 VAC 30-121-10 THROUGH 12 VAC 30-121-250) ARE IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-121-10. Demonstration program authority.

A. Medicare authority. The Medicare elements of the program shall operate according to existing Medicare Parts C and D laws and regulations, as amended or modified, except to the extent these requirements are waived or modified as provided for in the memorandum of understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the department. As a term and condition of the program, participating plans will be required to comply with Medicare Advantage and Medicare Prescription Drug Program requirements in Part C and Part D of Title XVIII of the Social Security Act (the Act) and 42 CFR Parts 422 and 423, as amended from time to time, except to the extent specified in the MOU for waivers and the three-way contract.

B. Medicaid authority. The Medicaid elements of the program shall operate according to existing Medicaid laws and regulations, including but not limited to all requirements of the § 1915(c) of the Act waivers for individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver, as amended or modified, except to the extent waived as provided for in the MOU. As a term and condition of the program, the Commonwealth and participating plans shall comply with Medicaid managed care requirements under Title XIX of the Act and 42 CFR Part 438, other applicable regulations, as amended or modified, except to the extent specified in the MOU, and the three-way contract.

12VAC30-121-20. Definitions.

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

"Action" or "adverse decision" means, consistent with 42 CFR § 438.400, a decision by the participating plan, subcontractor, service provider, or Virginia Department of Medical Assistance Services that constitutes a denial or limited authorization of a service authorization request, including (i) type or level of service; (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 covered service; (v) failure by the participating plan to render a decision within the required timeframes; or (vi) 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 action taken by the participating plan regarding eligibility for services and payment determinations.

"CPT" means Current Procedural Terminology, Revised 2015, as published by the American Medical Association.

"Capitation payment" means a payment the department makes periodically to a participating plan on behalf of each enrollee enrolled under a contract with that participating plan for the provision of services under the state plan and waivers, regardless of whether the enrollee receives services during the period covered by the payment.

"Capitation rate" means the monthly amount payable to the plan per enrollee for the provision of contract services. The plans shall accept the established capitation rates paid each month by the department and CMS as payment in full for all Medicaid and Medicare services to be provided pursuant to the three-way contract and all associated administrative costs, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

"Care management" means the collaborative, person-centered process that assists enrollees in gaining access to needed health care services and includes (i) assessing for and planning of health care services; (ii) linking the enrollee to services and supports identified in the plan of care; (iii) working with the enrollee directly for the purpose of locating, developing, or obtaining needed health care services and resources; (iv) coordinating health care services and service planning with other agencies, providers, and family members involved with the enrollee; (v) making collateral contacts to promote the implementation of the plan of care and community integration; (vi) monitoring to assess ongoing progress and ensuring services are delivered; and (vii) education and counseling that guides the enrollee and develops a supportive relationship that promotes the plan of care.

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

"Centers for Medicare and Medicaid Services" or "CMS" means the federal agency of the United States 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," "CCC," or "the program" means the program for the Virginia Medicare-Medicaid Financial Alignment Demonstration Model.

"Cost sharing" means copayments, coinsurance, or deductibles paid by an enrollee when receiving medical services.

"Covered services" means the set of required services offered by the participating plan as set forth in the three-way contract.

"Cultural competency" means understanding those values, beliefs, and needs that are associated with an enrollee's age, gender identity, sexual orientation, or racial, ethnic, or religious background. Cultural competency (i) includes a set of competencies that are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities and (ii) is based on the premise of respect for the enrollee and his existing cultural differences and on an implementation of a trust-promoting method of inquiry and assistance.

"Demonstration" means the capitated model under the Medicare-Medicaid Financial Alignment Demonstration Model as authorized by the Centers for Medicare and Medicaid Services (CMS) and as set out in the Patient Protection and Affordable Care Act of 2010 and authorized under § 1115A of the Social Security Act.

"Department of Medical Assistance Services," "the 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 the demonstration.

"Disenrollment" means the process of changing enrollment from one participating plan to another participating plan or opting out of the demonstration altogether but shall not include ending eligibility in the Medicare or Medicaid programs.

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

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

"Elderly or Disabled with Consumer Direction Waiver" or "EDCD Waiver" means, as provided in Part IX (12VAC30-120-900 et seq.) of Waivered Services (12VAC30-120) the CMS-approved waiver that covers a limited range of community support services offered to enrollees who are elderly or who have a disability and meet Virginia nursing facility level of care criteria as set out in 12VAC30-60-300, 12VAC30-60-303, and 12VAC30-60-307.

"Employer of record" or "EOR" means the person who performs the functions of the employer in the consumer-directed model of service delivery and may be the individual enrolled in the waiver, a family member, caregiver, or other person.

"Enrollee appeal" means an enrollee's request for review of a participating plan's coverage or payment determination. In accordance with 42 CFR § 438.400, a Medicaid-based appeal is defined as a request for review of an action, as defined herein. An appeal is an enrollee's challenge to the actions regarding services, benefits, and reimbursement provided by the participating plan, its service providers, or the Department of Medical Assistance Services. Enrollees and/or providers or other individuals acting on behalf of enrollees and with the enrollee's written consent may appeal adverse decisions to the participating plan and to the Department (for Medicaid covered services) after the participating plan's internal appeals process is exhausted.

"Enrollee communications" means the materials designed to communicate to enrollees plan benefits, policies, processes, and enrollee rights, including pre-enrollment, post-enrollment, and operational materials.

"Enrollment" means the completion of approved enrollment forms by or on behalf of an eligible person and assignment of an enrollee to a participating plan by DMAS in accordance with federal law.

"Enrollment facilitator" means an independent entity contracted with DMAS that (i) enrolls beneficiaries in the plan, (ii) is responsible for the operation and documentation of a toll-free helpline, (iii) educates enrollees about the plan, (iv) assists with and tracks enrollees' grievance resolutions, and (v) may market and perform outreach to potential enrollees.

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

"Evidence of coverage" or "EOC" means a document, prepared by the MMP and provided to the enrollee that is consistent with the requirements of 42 CFR §§ 438.10, 422.11, and 423.128 and includes information about all the services covered by that plan.

"Expedited appeal" means the process by which the department 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 appeal decision, to the state fair hearing process for Medicaid-based adverse decisions or to the Medicare process for Medicare-based adverse decisions. The department's external appeal decision shall be binding upon the participating plan or plans and not subject to further appeal by the participating plan or plans.

"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.

"Fiscal/employer agent" or "F/EA" means an organization (i) operating under § 3504 of the IRS Code, IRS Revenue Procedure 70-6, and IRS Notice 2003-70 and (ii) that has a separate federal employer identification number used for the sole purpose of filing federal employment tax forms and payments on behalf of program enrollees who are receiving consumer-directed services.

"Final decision" means a written determination by a hearing officer that is binding on the department, unless modified during or after the judicial process and that may be appealed to the local circuit court.

"Good cause" means to provide sufficient cause or reason for failing to file a timely appeal or for missing a scheduled appeal hearing.

"Health risk assessment" or "HRA" means a comprehensive assessment of an enrollee's medical, psychosocial, cognitive, and functional status in order to determine his medical, behavioral health, long-term care services and supports, and social needs.

"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.

"Home and community-based waiver services" or "waiver services" means a variety of home and community-based services eligible for payment by DMAS as authorized under a § 1915(c) waiver designed to offer enrollees an alternative to institutionalization.

"ICF/IID" means an intermediate care facility for individuals with intellectual disabilities.

"Integrated appeals process" means the process that incorporates relevant Medicare and Medicaid requirements and allows enrollees to appeal actions for either Medicare-based services or Medicaid-based services to the MMP with one request.

"Interdisciplinary care team" or "ICT" means a team of professionals who collaborate, either in person or through other means, with the enrollee to develop and implement (employing both medical and social models of care) a plan of care that meets the enrollee's medical, behavioral health, long-term care services and supports, and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and social workers, as may be appropriate for the enrollee's medical diagnoses and health condition, comorbidities, and community support needs.

"Intermediate sanctions" means sanctions that may be imposed on the Medicare-Medicaid Plans (MMP) such as civil money penalties, appointment of temporary management, permission for individuals to terminate enrollment in the Medicare-Medicaid Plan without cause, suspension or default of all enrollment of individuals, and suspension of payment to the Medicare-Medicaid Plan for individuals enrolled pursuant to 42 USC § 1396u-2(e)(2).

"Internal appeal" means an enrollee's initial request to the participating plan for review of the participating plan's coverage or payment determination.

"Long-stay hospitals" mean specialty Medicaid facilities that serve enrollees who require a higher intensity of nursing care than that which is normally provided in a nursing facility and who do not require the degree of care and treatment that an acute care hospital is designed to provide.

"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. Examples of these activities include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation.

"Medicaid" means the program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

"Medically necessary" or "medical necessity" means, per Medicare, services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of a patient's condition consistent with community standards of medical practice and in accordance with Medicaid policy (12VAC30-130-600). Furthermore, services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Virginia Medicaid.

"Medicare" means Title XVIII of the Social Security Act, the federal health insurance program for people age 65 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).

"Medicare independent review entity" means an independent organization contracted by CMS to review appeals for Medicare-covered services that have been denied by the enrollee's MMP

"Medicare-Medicaid enrollees" means, for the purposes of this demonstration, enrollees who are (i) entitled to Medicare Part A and enrolled in Medicare Parts B and D (ii) receive full benefits under the Virginia State Plan for Medical Assistance, and (iii) otherwise meet eligibility criteria for the demonstration.

"Medicare Part A" means hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

"Medicare Part B" means insurance that helps cover medically necessary services such as doctor's services, outpatient care, durable medical equipment, home health services, other medical services, and some preventive services.

"Medicare Part C" or "Medicare Advantage" means plans that (i) provide all of an enrollee's Medicare Part A and Medicare Part B coverage; (ii) may offer extra coverage, such as vision, hearing, dental, or health and wellness programs; and (iii) may include Medicare prescription drug coverage (Part D).

"Medicare Part D" means Medicare prescription drug coverage.

"Memorandum of understanding" or "MOU" means the Memorandum of Understanding between the Centers for Medicare and Medicaid Services (CNS) and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (5/2013), the document that sets out the mutually agreed to understanding of this program between CMS and DMAS.

"Minimum Data Set" or "MDS" means part of the federally-mandated process for assessing enrollees receiving care in certified skilled nursing facilities in order to record their overall health status, regardless of payer source.

"Model of care" means a comprehensive plan that (i) describes the plan's population; (ii) identifies measurable goals for providing high quality care and improving the health of the enrolled population; (iii) describes the plan's staff structure and care management roles; (iv) describes the interdisciplinary care team and the system for disseminating the model of care to plan staff and network providers; and (vi) contains other information designed to ensure that the plans provide services that meet the needs of enrollees.

"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" means doctors, hospitals, or other health care providers that participate or contract with a participating plan and, as a result, agree 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 United States Social Security Act, as amended, and § 32.1-137 of the Code of Virginia.

"Opt-out option" means the process by which an enrollee can choose to not participate in the demonstration.

"Participating plan," "Medicare-Medicaid Plan," or "MMP" means a health plan selected to participate in Virginia's Medicare-Medicaid Financial Alignment Demonstration Model and that is a party to the three-way contract with CMS and DMAS.

"Passive enrollment" means an enrollment process through which an eligible enrollee is enrolled by DMAS (or its vendor) into a participating plan, when not otherwise affirmatively electing one plan following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision or opt out of the demonstration prior to the enrollment effective date.

"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.

"Preadmission screening" means the process to (i) evaluate the functional, medical/nursing, and social support needs of enrollees referred for preadmission screening; (ii) assist enrollees in determining what specific services the enrollees need; (iii) evaluate whether a service or a combination of existing community services are available to meet the enrollees' needs; and (iv) refer enrollees to the appropriate entity for either Medicaid-funded nursing facility services or home and community-based care for those enrollees who meet the criteria for nursing facility level of care.

"Preadmission screening team" means the entity contracted with DMAS that is responsible for performing preadmission screening pursuant to § 32.1-330 of the Code of Virginia.

"Previously authorized" means, in relation to continuation of benefits, as described in 42 CFR § 438.420, a prior approved course of treatment and is further clarified in 12VAC30-121-150.

"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, but not limited to, local health departments, federally qualified health centers (FQHCs), rural health clinics (RHCs).

"Privacy" means the requirements established in the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 CFR §§ 431.300 through 431.307, as well as relevant Virginia privacy laws.

"Program of All-Inclusive Care for the Elderly" or "PACE" means the program in which the provider renders 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 filed by a Medicare, Medicaid or other service provider that has already provided a service and has received an action regarding payment or audit result.

"Quality withhold amounts" means percentages of the respective components, with the exception of Medicare Part D amounts, of the capitation rate due to the participating plans to be retained by CMS and DMAS until such time as the plan's performance is consistent with established quality thresholds.

"Remand" means the return of a case by the hearing officer to the participating plan for further review, evaluation, and action.

"Remote patient monitoring" means monitoring a patient remotely and is often used for patients with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases, or the need for anticoagulation treatment and must be agreed to by the enrollee. Examples of remote patient monitoring activities include, but are not limited to, transferring vital signs such as weight, blood pressure, blood sugar, and heart rate from the enrollee to the physician's office.

"Representative" means an attorney or other individual who has been authorized to represent an enrollee pursuant to these regulations.

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

"Secretary" means the Secretary of the U.S. Department of Health and Human 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.

"Spend down" means when a Medicaid applicant meets all Medicaid eligibility requirements other than income, Medicaid eligibility staff conduct a "medically needy" calculation that compares the enrollee's income to a medically needy income limit for a specific period of time referred to as the "budget period" (not to exceed six months). When a Medicaid applicant's incurred medical expenses equal the spend down amount, the applicant is eligible for full benefit Medicaid for the remainder of the spend down budget period.

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

"State Plan for Medical Assistance" or "State Plan" means the comprehensive written statement submitted to CMS by the department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures, and conditions for obtaining federal financial participation. DMAS has the authority to administer such State Plan for the Commonwealth pursuant to the authority of the § 32.1-325 of the Code of Virginia, as amended.

"Store and forward" means when prerecorded images, such as x-rays, video clips, and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include: (i) teledermatology, where digital pictures of a skin problem are transmitted and assessed by a dermatologist; (ii) teleradiology, where x-ray images are sent to and read by a radiologist; and (iii) teleretinal imaging, where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy.

"Sustain" means to uphold the participating plan's appeal decision.

"Targeted case management" or "TCM" means the Medicaid-funded State Plan case management service provided by private providers for enrollees with substance use disorders or developmental disabilities and by community services boards or behavioral health authorities for enrollees with behavioral health disorders or intellectual disabilities, and encompasses both referral and transition management and clinical services such as monitoring, self-management support, and medication review and adjustment. TCM is separate from "care management" as defined in the MOU.

"Telehealth" or "telemedicine" means the real time or near real time two-way transfer of data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

"Three-way contract" means the three-way agreement between CMS, DMAS, and a participating plan specifying the terms and conditions pursuant to which a participating plan shall participate in CCC.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional questionnaire that is completed by a preadmission screening team, or a hospital discharge planner for applicants residing in a hospital setting, that assesses an enrollee's psychosocial health, physical health, mental health, and functional abilities to determine if an applicant meets level of care criteria for long-term services and supports that are funded through Medicaid.

"Vulnerable subpopulation" means, at a minimum, individuals from the following groups: (i) individuals who are enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver (12VAC30-120-900 et seq.); (ii) individuals who have either intellectual or developmental disabilities, or both; (iii) individuals who have cognitive or memory problems, or both, (e.g., dementia and traumatic brain injury); (iv) individuals with physical or sensory disabilities; (v) individuals who are residing in nursing facilities; (vi) individuals who have serious and persistent mental illness or illnesses; (vii) individuals who have end stage renal disease; and (viii) individuals who have complex or multiple chronic health conditions, or both.

"Withdrawal" means a written request from the enrollee or the enrollee's representative for the department to terminate the appeal process without a final decision on the merits.

12VAC30-121-30. Selected localities.

A. The demonstration shall operate in specific regions within the Commonwealth.

B. The department and CMS will implement the demonstration in Central Virginia, Northern Virginia, Roanoke, Tidewater, and Western/Charlottesville regions.

C. Under the demonstration, DMAS will conduct a regional phase-in. Phase I will impact Central Virginia and Tidewater. Phase II will impact Western/Charlottesville, Northern Virginia, and Roanoke.

D. Participating plans must cover all eligible enrollees in all localities within the region or regions in which such plans participate.

12VAC30-121-40. Eligible enrollees.

A. Medicaid-eligible enrollees who qualify as follows may be eligible to be enrolled in the demonstration:

1. Individuals who are 21 years of age and older at the time of enrollment;

2. Individuals who are entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and who are receiving full Medicaid benefits. This includes enrollees participating in the EDCD Waiver and those residing in nursing facilities;

3. Individuals who reside in a program region; and

4. Individuals who do not meet any of the exclusions identified in 12VAC30-121-45.

B. Individuals who have been excluded from CCC, for any reason, shall be permitted to opt in to the program once the reason for their exclusion no longer exists.

12VAC30-121-45. Individuals excluded from enrollment.

Individuals who meet at least one of the following criteria shall be excluded from the program:

1. Individuals who are younger than 21 years of age.

2. Individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements.

3. Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full-benefit Medicaid beneficiaries. These Individuals may receive Medicaid coverage for the following: (i) Medicare monthly premiums for Medicare Part A, Medicare Part B, or both (carved-out payment); (ii) coinsurance, copayment, and deductible for Medicare-allowed services; and (iii) Medicaid-covered services, including those that are not covered by Medicare. These individuals may include:

a. Qualified Medicare Beneficiaries (QMBs);

b. Special Low Income Medicare Beneficiaries (SLMBs);

c. Qualified Disabled Working Individuals (QDWIs); or

d. Qualifying Individuals (QIs).

4. Individuals who are inpatients in state mental hospitals, including but not limited to Catawba Hospital, Central State Hospital, Eastern State Hospital, Hiram W. Davis Medical Center, Northern Virginia Mental Health Institute, Piedmont Geriatric Hospital, Southern Virginia Mental Health Institute, Southwestern State HM&S, Southwestern Virginia Mental Health Institute, Western State HM&S, and Western State Hospital.

5. Individuals who are residents of state hospitals, ICF/IID facilities, residential treatment facilities, or long stay hospitals.

6. Individuals who are participating in federal waiver programs for home and community-based Medicaid coverage other than the EDCD waiver (e.g., Individual and Family Developmental Disabilities Support, Intellectual Disability, Day Support, Technology Assisted, and Alzheimer's Assisted Living waivers).

7. Individuals receiving hospice services at the time of enrollment shall be excluded from the program. If an enrollee enters a hospice program while enrolled in the waiver, he shall be disenrolled from the program. If such enrollees opt out of this program, they shall not be permitted to reenter it. If enrollees do not opt out but leave this program due to program action, they shall be permitted to return to the program upon their leaving the hospice program. However, participating plans shall refer these individuals to the preadmission screening team for additional LTSS if not already in place.

8. Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the program. However, an enrollee who develops ESRD while enrolled in the waiver shall remain in the program unless he opts out. If he opts out, the enrollee shall not be permitted to opt back into the program.

9. Individuals with other comprehensive group or enrollee health insurance coverage, other than full benefit Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program.

10. Individuals who have a Medicaid eligibility period that is less than three months.

11. Individuals who have a Medicaid eligibility period that is only retroactive.

12. Individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

13. Individuals enrolled in the MFP program.

14. Individuals residing outside of the program coverage regions.

15. Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll in the CCC program if they choose to disenroll from their PACE provider.

16. Individuals participating in the CMS Independence at Home (IAH) demonstration or any other demonstration that bases some or all payment on achievement of Medicare savings.

12VAC30-121-50. Enrollment process.

Individuals who qualify as indicated in 12VAC30-121-40 and are not excluded as provided in 12VAC30-121-45 shall be enrolled as follows, except if they choose to opt out:

1. Enrollees shall be passively assigned to a participating plan based on their previous six months of Medicaid claims history prior to preassignment using the rules in this order of priority:

a. Enrollees in a nursing facility shall be preassigned to a participating plan that includes the enrollee's nursing facility in its provider network;

b. Enrollees in the EDCD Waiver shall be assigned to a participating plan that includes the enrollee's current adult day health care provider in the MMP's existing provider network;

c. If more than one participating plan network includes the nursing facility or adult day health care provider used by an enrollee, he shall be assigned to the participating plan with which he has previously been assigned in the past six months.

d. If he has no history of previous participating plan assignment, he shall be randomly assigned to a participating plan in which his provider participates.

e. In the absence of these foregoing conditions, enrollees shall be preassigned to a participating plan, first the Medicare plan and secondly the Medicaid participating plan, with whom they have previously been assigned within the past six months.

2. Utilizing passive enrollment, eligible enrollees shall be notified of their right to select among contracted participating plans no fewer than 60 days prior to the effective date of enrollment.

3. Eligible enrollees shall receive a notice that indicates the participating plan to which they have been preassigned. The notice shall have instructions for the enrollee to contact the department's contracted enrollment facilitator to either: (i) accept the preassigned participating plan; (ii) actively select a different participating plan that is operating in their region; or (iii) to opt out of the program.

4. If an enrollee does not select a participating plan, he shall be passively enrolled into the preassigned participating plan.

5. Prior to the effective date of their plan enrollment, enrollees who would be passively enrolled shall have the opportunity to opt out and shall receive sufficient notice and information with which to do so.

6. All enrollment effective dates shall be prospective. Enrollment shall be effective the first day of the month following an enrollee's request to enroll, so long as the request is received on or before five days before the end of the month. Active enrollment requests, including requests to change among participating plans, received later than five days before the end of the month shall become effective the first of the second month following the request. Passive enrollment shall be effective not sooner than 60 days after enrollee notification.

7. Disenrollment from participating plans and transfers between participating plans shall be allowed on a month-to-month basis any time during the year; however, coverage for these enrollees shall continue through the end of the month. All disenrollment requests shall be effective the first day of the month following an enrollee's request to disenroll from the CCC Program.

8. CMS and DMAS monitors enrollments and disenrollments for both evaluation purposes and for compliance with applicable marketing and enrollment laws, regulations, and CMS policies, for the purpose of identifying any inappropriate or illegal marketing practices. As part of this analysis, CMS and DMAS monitors any unusual shifts in enrollment by enrollees identified for passive enrollment into a particular participating plan to a Medicare Advantage plan operated by the same parent organization. If those shifts appear to be due to inappropriate or illegal marketing practices, CMS or DMAS, or both, may require corrective action. Any illegal marketing practices shall be referred to appropriate agencies for investigation.

9. As mutually agreed upon in the three-way contract, CMS and DMAS shall utilize an independent third party entity to facilitate all enrollments into the participating plans.

10. Participating plan enrollments, transfers, and opt-outs shall become effective on the same day for both Medicare and Medicaid. For enrollees who lose Medicaid eligibility during a month, coverage and federal financial participation will continue through the end of the month in which Medicaid eligibility is ended.

12VAC30-121-70. Covered services.

A. CMS and DMAS shall contract with participating plans that demonstrate the capacity to provide directly, or by subcontracting with other qualified entities, the full continuum of medically necessary Medicare and Medicaid covered services to enrollees, in accordance with (i) the MOU; (ii) CMS guidance; (iii) the three-way contract; (iv) 42 CFR Part 422, 42 CFR Part 423, and 42 CFR Part 438; (v) the requirements in the State Plan for Medical Assistance, including any applicable State Plan amendments and § 1915(c) of the Act; (vi) the EDCD Waiver (12VAC30-120-900 et seq.); (vii) 42 USC § 1395y; (viii) 12VAC30-130-600; (ix) the ADA; and (x) the Olmstead decision (Olmstead v. L.C. (98-536) 527 U.S. 581 (1999)). Furthermore, as set out in 42 CFR § 440.230, services shall be sufficient in amount, duration, and scope to reasonably achieve their purpose. Participating plans shall be required to provide services in a way that preserves all protections to enrollees and provides enrollees with coverage to at least the same extent provided by Medicare and Medicaid. Where there is overlap between Medicare and Medicaid benefits, coverage and rules shall be delineated in the three-way contract. Participating plans shall be required to abide by the more generous of the applicable Medicare, Medicaid, or the combined Medicare-Medicaid standard.

B. With the exception of those services that are specifically carved out of this program as set out in 12VAC30-121-83, the required covered services shall include, but not be limited to:

1. Medicare Parts A, B, and D services.

2. Medically necessary procedures. Participating plans will be responsible for medically necessary procedures, including but not limited to, the following:

a. CPT codes billed for dental services performed as a result of a dental accident (i.e., an accident that damages the mouth);

b. Preparation of the mouth for radiation therapy, maxillary or mandibular frenectomy when not related to a dental procedure, orthognathic surgery to attain functional capacity, and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.

c. Anesthesia and hospitalization for medically necessary services.

d. At the option of the MMP, additional flexible dental services for program enrollees.

e. For participants of auxiliary grants, case management services. Although not widely used, this service is included as part of the annual reassessment screening process for assisted living recipients and will be provided under fee-for-service.

3. Acute care services provided under the State Plan for Medical Assistance as found in 12VAC30-50, and further defined by DMAS' written regulations, policies, and instructions, except as otherwise modified or excluded in the three-way contract;

4. Covered LTSS provided under the EDCD Waiver, including adult day health care, personal care (agency and consumer-directed options), personal emergency response services with or without medication monitoring, respite care (agency and consumer-directed options), transition coordination, and transition services.

5. The integrated formulary for prescription drugs, including Medicaid-covered drugs that are excluded by Medicare Part D. Participating plans shall also cover drugs covered by Medicare Parts A and B. In all respects, unless stated otherwise in the MOU or the three-way contract, Medicare Part D requirements continue to apply.

6. Nursing facility services as defined in 42 CFR § 440.40. Skilled nursing level care may be provided in a long-term care facility without a preceding acute care inpatient stay for enrollees enrolled in the program when the provision of this level of care can avert the need for an inpatient hospital stay.

7. Participating plans shall be permitted to use and reimburse telehealth for Medicare and Medicaid services as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access, and increase timely interventions. Participating plans shall also encourage the use of telehealth to promote community living and improve access to behavioral health services. Participating plans shall be permitted to use telehealth in rural and urban settings and reimburse for store-and-forward applications. Participating plans shall also have the ability to cover remote patient monitoring. All telehealth and remote patient monitoring activities shall be compliant with HIPAA requirements and as further set out in the three-way contract.

8. Health risk assessments.

a. Each enrollee shall receive and be an active participant in a timely, comprehensive, assessment completed by the participating plan's care management team. All health risk assessment tools are subject to approval by DMAS. Assessment domains shall include, but not be limited to, the following: medical, psychosocial, functional, cognitive, and behavioral health. Relevant and comprehensive data sources, including the enrollee, providers, family, caregivers, and additional significant others as may be designated by the enrollee, shall be used by the participating plans in order to thoroughly complete the assessment.

b. During the first year of the program, all enrollees meeting any of the following criteria shall receive a health risk assessment to be completed no later than 60 days from the onset of these enrollees' enrollment:

(1) Individuals enrolled in the EDCD Waiver;

(2) Individuals with intellectual or developmental disabilities;

(3) Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);

(4) Individuals with physical or sensory disabilities;

(5) Individuals residing in nursing facilities;

(6) Individuals with serious and persistent mental illnesses;

(7) Individuals with end stage renal disease; and

(8) Individuals with complex or multiple chronic health conditions.

c. During the first year of the program and for all other enrollees, health risk assessments shall be conducted within 90 days of enrollment.

d. Health risk assessments for individuals enrolled in the EDCD Waiver and for individuals residing in nursing facilities shall be conducted face to face. The health risk assessments for individuals residing in nursing facilities shall also incorporate the MDS.

e. During subsequent years of the program, individuals enrolled in the EDCD Waiver shall receive a health risk assessment within 30 days of enrollment and all other enrollees shall receive a health risk assessment within 60 days of enrollment.

12VAC30-121-73. Level of Care (LOC) determinations.

A. Initial LOC determinations shall be conducted by hospitals and local preadmission screening teams as defined in § 32.1-330 of the Code of Virginia.

B. Participating plans shall ensure that LOC annual reassessments are conducted timely for EDCD waiver participants (minimum within 365 days of the last annual reassessment or as the participants' needs change). Participating plans shall conduct annual face-to-face assessments for continued nursing facility LOC eligibility requirements for the EDCD Waiver.

C. The plans shall establish criteria including health status changes (i.e., the triggering events that precipitate a need for reassessment, including a change in the ability to perform activities of daily living and instrumental activities of daily living) for reassessments to be performed prior to the reassessment.

D. The LOC annual reassessment shall include all the elements required by the three-way contract for enrollees who are in the EDCD Waiver.

E. LOC annual reassessments for EDCD waiver enrollees shall be performed by providers with the following qualifications: (i) a registered nurse (RN) licensed in Virginia with at least one year of experience as an RN; (ii) a social worker licensed in Virginia; or (iii) an individual who holds at least a bachelor's degree in a health or human services field and has at least two years of experience working with individuals who are elderly or have disabilities, or both.

F. Participating plans shall ensure that quarterly and annual assessments are conducted timely for nursing facility residents based on the MDS process and shall work cooperatively with nursing facilities to provide information regarding the completion of the assessments for continued nursing facility placement.

G. Participating plans shall communicate annual LOC reassessment data for EDCD Waiver enrollees and nursing facility residents to DMAS according to requirements in the three-way contract.

12VAC30-121-75. Plans of Care (POCs).

A. Participating plans shall develop a person-centered POC for each enrollee. The POC shall be tailored to the individual enrollee's needs and be agreed to and signed by the enrollee or the enrollee's employer of record.

B. Participating plans shall implement a person-centered and culturally competent POC development process. Participating plans shall also develop a process that will incorporate but not duplicate targeted case management for applicable enrollees.

C. During the first year of the CCC, participating plans shall ensure that plans of care for all enrollees are completed within 90 days of the enrollees' enrollment. Participating plans shall honor all existing plans of care and service authorizations until the authorization ends or 180 days from enrollees' enrollment, whichever is sooner. For EDCD Waiver individuals, the plan of care shall be developed and implemented by the participating plan no later than the end date of any existing service authorization.

D. During subsequent years of the program, participating plans shall ensure that plans of care are developed within the following timeframes:

1. Within 30 days of enrollment for EDCD Waiver participants;

2. Within 60 days of enrollment for vulnerable subpopulations (excluding EDCD Waiver participants); and

3. Within 90 days of enrollment for all other enrollees.

E. Participating plans shall incorporate information from the UAI and the LOC determinations into the POCs for individuals in the EDCD Waiver.

F. Participating plans shall develop a process for obtaining nursing facility MDS data and incorporating that information into the POC. Participating plans shall ensure that nursing facilities' residents who wish to move to the community will be referred to the preadmission screening teams or the MFP program. If the individual enrolls in the MFP program, he will be disenrolled from this program.

G. Participating plans shall develop a process for addressing health, safety (including minimizing risk), and welfare of the enrollee in the POC.

H. The POC shall contain the following:

1. Prioritized list of enrollee's concerns, needs, and strengths;

2. Attainable goals, outcome measures, and target dates selected by the enrollee or caregiver, or both;

3. Strategies and actions, including interventions and services to be implemented, the providers responsible for specific interventions and services, and the frequency of the interventions and strategies;

4. Progress noting success, barriers, or obstacles;

5. Enrollee's informal support network and services;

6. Back up plans as appropriate for EDCD Waiver enrollees using personal care and respite services in the event that the scheduled provider or providers are unable to provide services;

7. Determined need and plan to access community resources and noncovered services;

8. Enrollee choice of services (including consumer-direction) and service providers; and

9. Elements included in the DMAS-97AB form, (which can be downloaded from https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) for individuals enrolled in the EDCD Waiver.

I. Participating plans shall ensure that reassessments and POC reviews are conducted:

1. By the POC anniversary for vulnerable subpopulations (excluding EDCD Waiver participants and nursing facility residents) and all other enrollees;

2. By the POC anniversary, not to exceed 365 days for EDCD Waiver enrollees (must be face to face); and

3. Following MDS guidelines and timeframes for quarterly and annual POC development for nursing facility residents.

J. Participating plans shall ensure that POCs are revised based on triggering events, such as hospitalizations or significant changes in health or functional status.

12VAC30-121-78. Interdisciplinary care team (ICT).

A. For each enrollee, participating plans shall support an ICT to ensure the integration of the enrollee's medical, behavioral health, substance abuse/use, LTSS, and social needs. The team's focus shall be person-centered, built on the enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competency, and dignity.

B. Participating plans ICTs shall employ both medical and social models of care, as appropriate for their enrollees' documented needs.

C. Participating plan members of the team shall agree to participate in approved training on the person-centered planning processes, cultural competency, accessibility and accommodations, independent living and recovery, ADA/Olmstead requirements, and wellness principles, along with other required training as specified by the Commonwealth. Participating plans shall offer training to additional members of the team such as primary care providers and specialists, as appropriate.

D. If an enrollee is receiving targeted case management services, the participating plans shall develop a mechanism to include the targeted case manager as a member of the ICT.

E. If an enrollee is identified to be eligible to transition into the community through the Department of Justice Settlement Agreement (Case: 3:12-CV-00059-JAG, available at http://www.dbhds.virginia.gov/settlement/FullAgreement.pdf), the participating plan's ICT shall collaborate with the locality's community services board (CSB) or behavioral health authority, as appropriate, and the Department of Behavioral Health and Developmental Services to successfully transition the enrollee into the community. The enrollee's CSB case manager shall participate as a part of the participating plan's ICT to monitor the enrollee's service needs. If the enrollee transitions into either the Individuals with Intellectual Disabilities Waiver or Developmental Disability Waiver, the enrollee shall be disenrolled from this program. If the enrollee transitions to the EDCD Waiver, the enrollee may remain in the program.

12VAC30-121-80. Requirements for care coordination.

A. The participating plan shall provide person-centered care management functions for all enrollees.

B. All enrollees shall have access to the following supports depending on their needs and preferences; however, care management for vulnerable subpopulations shall include the items described below in subdivisions (6) through (12):

1. A single, toll-free point of contact for all questions;

2. Ability to develop, maintain and monitor the POC;

3. Assurance that referrals result in timely appointments;

4. Communication and education regarding available services and community resources;

5. Assistance developing self-management skills to effectively access and use services;

6. Assistance in receiving needed medical and behavioral health services, preventive services, medications, LTSS, social services, and enhanced benefits; this includes (i) setting up appointments, (ii) in-person contacts as appropriate, (iii) strong working relationships between care managers and physicians; (iv) evidence-based enrollee education programs, and (v) arranging transportation as needed;

7. Monitoring of functional and health status;

8. Seamless transitions of care across specialties and care settings;

9. Assurance that enrollees with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options;

10. Connecting enrollees to services that promote community living and help avoid premature or unnecessary nursing facility placements;

11. Coordination with social service agencies (e.g., local departments of health, local departments of social services, and community services boards) and referrals for enrollees to state, local, and other community resources; and

12. Collaboration with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalizations and to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the nursing facility benefit.

C. Participating plans shall develop innovative arrangements to provide care management such as:

1. Partnering or contracting, or both, with entities, such as community services boards, adult day care centers, and nursing facilities, that currently perform care management and offer support services to individuals eligible for the program;

2. Medical homes;

3. Sub-capitation, such as payment arrangement where the MMP pays its contracted providers on a capitated basis rather than a fee-for-service basis;

4. Shared savings; and

5. Performance incentives.

D. Participating plans and DMAS shall collaborate to avoid duplication of care management services provided under the program.

E. Participating plans shall be required to use one statewide F/EA to manage the F/EA services for individuals using consumer direction.

12VAC30-121-83. Carved out services.

The following services shall be carved out of the program and provided under the fee-for-service system:

1. Abortions, induced (this service shall be provided under limited circumstances, e.g., when the life of the mother is endangered);

2. Targeted case management services and;

3. Dental services (in limited cases).

12VAC30-121-85. Flexible benefits.

A. Flexible benefits are those that MMPs may elect to offer to their enrollees.

B. Examples of such benefits are (i) annual physical examinations, (ii) meal benefits, (iii) preventive and comprehensive dental services for adults, (iv) eye examinations, (v) prescription eyeglasses, (vi) hearing examinations, (vii) hearing aids, and (viii) reduced or eliminated drug co-pays.

12VAC30-121-90. Capitation payment rates.

A. Capitation rates and payment rules shall be established in the MOU and three-way contract and may be adjusted by state or federal regulatory changes.

B. If other state or federal statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DMAS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.

C. Any and all costs incurred by the participating plan in excess of the capitation payment shall be borne in full by the plan.

D. Additional costs shall not be balance billed to the plan's enrollees.

E. Out-of-network reimbursement rules.

1. In an urgent or emergency situation, participating plans shall reimburse an out-of-network provider of emergency or urgent care at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. For example, where this service would traditionally be covered under Medicare FFS, the participating plan shall pay out-of-network providers the lesser of providers' charges or the Medicare FFS.

2. During the 180-day transition period as outlined in the MOU, the participating plan shall honor existing service authorization timeframes and continue to provide access to the same services and providers at the same levels and rates of Medicare or Medicaid FFS payment (not to exceed 180 days) as enrollees were receiving prior to entering the participating plan.

3. Beyond this 180-day period, the participating plan will be required to offer single-case out-of-network agreements to providers that are currently serving enrollees and are willing to continue serving them at the participating plan's in-network payment rate, but are not willing to accept new patients or enroll in the participating plan's network.

12VAC30-121-110. Cost sharing requirements.

A. Participating plans shall not charge a Medicare Part C or D premium nor assess any cost sharing for Medicare Parts A and B services.

B. For drugs and pharmacy products (including those covered by both Medicare Part D and Medicaid), participating plans shall be permitted to charge co-pays to enrollees currently eligible to make such payments consistent with co-pays applicable for Medicare and Medicaid drugs, respectively. Co-pays charged by participating plans for Part D drugs shall not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

C. Patient pay requirements, which are applicable to long term-care services, shall be detailed in the contract between CMS, DMAS, and the participating plans.

D. Participating plans shall not assess any cost sharing for DMAS services, beyond the pharmacy cost sharing amounts allowed under Medicaid coverage rules.

E. No enrollee may be balance billed by any provider for any reason for covered services or flexible benefits (see 12VAC30-121-90).

12VAC30-121-130. Access standards.

A. Participating plans shall have the capacity to provide, directly or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services to enrollees, in accordance with the MOU, CMS guidance, and the three-way contract.

B. Network adequacy. State Medicaid standards shall be utilized for long-term services and supports or for other services for which Medicaid is exclusively responsible for payment, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is primary, unless applicable Medicaid standards for such services are more stringent. Home health and durable medical equipment requirements, as well as any other services for which Medicaid and Medicare may overlap, shall be subject to the more stringent of the applicable Medicare and Medicaid standards.

C. Participating plans shall ensure that they maintain a network of providers that is sufficient in number, mix of primary care and specialty providers, and geographic distribution to meet the complex and diverse needs of the anticipated number of enrollees in the service area as defined by CMS for Medicare and defined by DMAS for Medicaid.

D. For services for which Medicaid is the traditional primary payer (including, but not limited to, LTSS and community mental health and substance abuse services), each enrollee shall have a choice of at least two providers of each covered service type located within no more than 30 minutes travel time from any enrollee in urban areas unless the participating plan has a DMAS-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours).

E. The participating plan shall ensure that each enrollee shall have a choice of at least two providers of each covered service type located within no more than 60 minutes travel time from any enrollee in rural areas unless the participating plan has a DMAS-approved alternative time standard.

F. DMAS shall require contractual agreements between nursing facilities and participating plans. Participating plans shall be required to contract with any nursing facility that is eligible to participate in Medicare and Medicaid and is willing to accept the participating plan payment rates and contract requirements for the time duration of the demonstration period. Participating plans shall make payments for services directly to NFs.

G. For any covered services for which Medicare requires a more rigorous network adequacy standard than Medicaid (including time, distance, or minimum number of providers or facilities), the participating plan shall meet the Medicare requirements.

12VAC30-121-140. MMPs having low performance.

A. As long as that the MMP is determined by DMAS to meet all plan selection requirements in the three-way contract, an interested organization that (i) is an outlier in the CMS past performance analysis for the upcoming contract year, (ii)

has a low performance indicator (LPI) on the Medicare Plan Finder website for the upcoming year, or (iii) both may still qualify to offer CCC services.

B. Such MMPs shall not be eligible to receive new enrollees (via passive enrollment) until the MMP is either (i) no longer considered by CMS to be a past performance outlier or (ii) no longer has an LPI on the Medicare Plan Finder.

C. CMS or DMAS, or both, shall determine if an MMP is eligible to accept passive enrollment prior to the scheduled date of execution of the three-way contract.

D. An MMP that is ineligible to receive passive enrollment shall only be able to enroll (i) individuals who are currently enrolled in another Medicare or Medicaid managed care plan sponsored by the same organization and (ii) individuals who opt in to the organization's MMP.

12VAC30-121-145. Sanctions for noncompliance.

A. DMAS may impose intermediate sanctions, which may include any of the types described in subsection C of this section, or terminate the MMP's contract if the MMP:

1. Fails substantially to provide medically necessary items and services that are required under law or under the MMP's contract with DMAS to be provided under the contract;

2. Imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this chapter;

3. Acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this chapter, or engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services;

4. Misrepresents or falsifies information that is furnished to either:

a. The Secretary or DMAS under this chapter; or

b. To an enrollee, potential enrollee, or a health care provider under this chapter; or

5. Fails to comply with the applicable requirements of 42 USC § 1396b(m)(2)(A)(x).

B. DMAS may also impose such intermediate sanction against an MMP if DMAS determines that the MMP distributed directly or through any agent or independent contractor marketing materials in violation of 12VAC30-121-250.

C. The sanctions shall be as follows:

1. Civil money penalties.

a. Except as provided in subdivision 1 b, 1 c, or 1 d of this subsection, not more than $25,000 for each determination under subsection A of this section.

b. With respect to a determination under subdivision A 3 or A 4 a of this section, not more than $100,000 for each such determination.

c. With respect to a determination under subdivision A 2 of this section, double the excess amount charged in violation, and the excess amount charged shall be deducted from the penalty and returned to the individual concerned.

d. Subject to subsection 1 b of this subsection, with respect to a determination under subdivision A 3 of this section, $15,000 for each individual not enrolled as a result of a practice described in subdivision A 3.

2. The appointment of temporary management.

a. To oversee the operation of the MMP upon a finding by DMAS that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees;

b. To assure the health of the organization's enrollees if there is a need for temporary management while there is an orderly termination or reorganization of the organization; or

c. To make improvements to remedy the violations found under subsection A of this section except that temporary management under this subdivision 2 may not be terminated until DMAS has determined that the MMP has the capability to ensure that the violations shall not recur.

3. Requiring the MMP (i) to permit individuals enrolled with the MMP to terminate enrollment without cause and (ii) to notify such individuals of such right to terminate enrollment.

4. Suspension or default of all enrollment of individuals under this chapter after the date the Secretary or DMAS notifies the MMP of a determination of a violation of any requirement of 42 USC § 1396b(m) or this section.

5. Suspension of payment to the entity under this chapter for individuals enrolled after the date the Secretary or DMAS notifies the MMP of such a determination and until the Secretary or DMAS is satisfied that the basis for such determination has been corrected and is not likely to recur.

12VAC30-121-150. Continuity of care.

A. As provided by the MOU and the three-way contract, participating plans shall be required to provide or arrange for all medically necessary services, whether by subcontract or by single-case agreement, in order to meet the health care and support needs of their enrollees.

B. Participating plans shall allow enrollees to maintain their current Medicaid providers (including out-of-network providers) for up to 180 days from enrollment. Participating plans shall also allow enrollees to maintain their previously authorized Medicaid services, including frequency and payment rate, for the duration of the prior authorization or for 180 days from enrollment, whichever is less. This shall not apply to enrollees residing in a nursing facility on the date of each region's program implementation.

C. Enrollees in nursing facilities at the time of program implementation may remain in the facility, or move to another nursing facility, as long as they continue to meet DMAS criteria for nursing facility care. In order to move to another nursing facility, the enrollee or his family, or both as may be appropriate, has to agree to the move.

D. During the 180-day period specified in subsection B of this section, change from an existing Medicaid provider can only occur in the following circumstances:

1. The enrollee requests a change;

2. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid;

3. The participating plan, CMS, or DMAS identify provider performance issues that affect the enrollee's health and welfare; or

4. The provider is excluded from participation in Medicare and Medicaid under state or federal exclusion requirements pursuant to the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website. Immediately report in writing to DMAS any exclusion information discovered to (i) DMAS, ATTN: Program Integrity/Exclusions, 600 East Broad Street, Suite 1300, Richmond, VA 23219 or (ii) providerexclusion@dmas.virginia.gov;

E. Out-of-network reimbursement rules. See 12VAC30-121-90 for requirements for out-of-network reimbursement.

12VAC30-121-170. Model of care.

A. All participating plans (in partnership with contracted providers) shall implement an evidence-based model of care (MOC). Participating plans ~~must~~ shall meet all CMS MOC standards for Special Needs Plans as well as additional requirements established in the contract by the Commonwealth. The Virginia-specific MOC elements are in addition to CMS elements; likewise, the CMS and DMAS reviews and approvals are separate processes. Participating plans shall obtain approvals from both CMS and DMAS before a MOC is considered final and approved.

B. Participating plans shall be permitted to cure problems with their MOC submissions after their initial submissions. Participating plans with MOCs scoring below 85% shall have the opportunity to improve their scores based on CMS and DMAS feedback on the elements and factors that require improvement. At the end of the review process, MOCs that do not meet CMS standards for approval will not be eligible for selection as participating plans. CMS standards for approval are issued to the states and made available on the DMAS website at http://www.dmas.virginia.gov/Content_atchs/altc/altc-fp1.pdf.

12VAC30-121-190. 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 the demonstration.

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

C. The participating plan shall conduct an internal appeal hearing, pursuant to 42 CFR Part 431 Subpart E, 42 CFR Part 438, and 12VAC30-110-10 through 12VAC30-110-370, 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 participating plan's internal appeals process:

1. At the time of the request for services;

2. With the evidence of coverage; and

3. Upon receipt of a notice of action from the participating plan.

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

F. An appellant shall have the right to representation by an attorney or other individual of his choice at all stages of an appeal.

1. For those appellants who wish to have a representative, a representative shall be designated 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, the division shall allow a family member or other person acting on the appellant's behalf to be the representative. If the appellant is mentally unable to sign a written statement, the division shall require written documentation that a family member or other person has been appointed or designated as his legal representative.

2. If the 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. A member of the same law firm as a designated representative shall have the same rights as the designated 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 written communication from an enrollee or his representative that clearly 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 participating plan's internal appeal decision.

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

H. Appeals to the state fair hearing process shall be made to the DMAS Appeals Division in writing, with the exception of expedited appeals, and may be made via U.S. mail, fax transmission, hand delivery, or electronic transmission.

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

J. Participating plans shall continue benefits while the participating plan's appeal or the state fair hearing is pending when all of the following criteria are met:

1. The enrollee or representative files the appeal within 10 calendar days of the mail date of the participating plan's internal appeal decision;

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

3. The services were ordered by an authorized provider;

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

5. The enrollee requests continuation of benefits.

K. After the final resolution and if the final resolution of the appeal is adverse to the enrollee (e.g., participating plan's internal appeal is upheld), the participating plan

may recover the costs of services furnished to the enrollee while the appeal was pending, to the extent they were furnished solely because of the pending appeal.

L. The department shall maintain an expedited process for appeals when an appellant's treating provider certifies that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. Expedited appeal decisions shall be issued as expeditiously as the enrollee's health condition requires, but no later than three business days after the agency receives a fair hearing request on an appeal decision to uphold denial of a service that it determines meets the criteria for expedited resolution.

12VAC30-121-195. Appeal timeframes.

A. Appeals to the Medicaid state fair hearing process must be filed with the DMAS Appeals Division within 60 days of the date of the participating plan's internal appeal decision, unless the time period is extended by DMAS upon a finding of good cause in accordance with state fair hearing regulations.

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

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

D. The date of filing shall be the date the request is postmarked, if mailed, or the date the request is received by the department, if delivered other than by mail.

E. Documents postmarked on or before a time limit's expiration shall be accepted as timely.

F. 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.

G. An extension of the 60-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include, but are not limited to, the following situations:

1. Appellant was seriously ill and was prevented by illness from contacting DMAS;

2. The participating plan's decision was not sent to the appellant. The plan may rebut this claim by evidence that the decision was mailed to the appellant's last known address or that the decision was received by the appellant.

3. Appellant sent the request for appeal to another government agency or another division within DMAS that is not the Appeals Division in good faith within the time limit; or

4. Unusual or unavoidable circumstances prevented a timely filing.

H. During the first year of the program, appeals shall be heard and decisions issued within 90 days of the postmark date (if delivered by U.S. mail) or receipt date (if delivered by any method other than U.S. mail).

I. The timeframes for issuing decisions will change to 75 days (during the second year of the program), and 30 days (during the third year of the program and thereafter).

J. Exceptions to standard appeal resolution timeframes. Decisions may be issued beyond the standard appeal resolution timeframes when the appellant or his 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 representative requests to reschedule or continue the hearing;

2. The appellant or 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 12VAC30-121-210;

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 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.

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

1. If an appellant or 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 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 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.

L. Post hearing delays requested or caused by an appellant or 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 representative with written notice of the reason for the decision delay and the delayed decision date, if applicable.

12VAC30-121-200. 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 12VAC30-121-195 or extended pursuant to 12VAC30-121-195 J, and the hearing officer sends a letter to the appellant for an explanation as to why the appeal request was not filed timely, and

1) the appellant did not reply to the hearing officer's request within 10 calendar days for an explanation that met good cause criteria, or

2) the appellant did reply and the hearing officer had sufficient facts to determine that the reply did not meet good cause criteria pursuant to 12VAC30-121-195.

b. the individual who filed the appeal (filer) is not the appellant, or parent of a minor appellant, and the hearing officer 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 hearing officer's request for authorization to represent the appellant within 10 calendar days, or

2) the filer did reply and the hearing officer determined that the authorization submitted was insufficient to allow the filer to represent the appellant under the provisions of 12VAC30-121-190 F.

2. A request for appeal may be administratively dismissed if

a. the participating plan'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 participating plan's internal appeal decision,

c. the action being appealed was not taken by DMAS or the participating plan.

d. the services denied or terminated were Medicare covered services, or

e. 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 representative of the date, time, and location of the hearing, the appellant or his representative failed to appear at the scheduled hearing, and the hearing officer 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 hearing officer's request within 10 calendar days for an explanation that met good cause criteria, or

2) the appellant did reply and the hearing officer 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 representative provide a telephone number at which he can be reached for a telephonic hearing, and the appellant or his representative failed to respond within 10 calendar days to the hearing officer's request for a telephone number at which he could be reached for a telephonic hearing.

c. the appellant or his representative withdraws the appeal request in writing.

d. the participating plan approves the full amount, duration, and scope of services requested.

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

B. The appellant shall have no opportunity to seek judicial review except in cases where the hearing officer receives and analyzes a response from the appellant or representative as described in A,1, a, 2; A, 1, b, 2; A,3, a, 2; and C of this subsection.

C. Remand to the participating plan. 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 participating plan obtains and develops additional information, documentation, or verification, the hearing officer may remand the case to the participating plan for action consistent with the hearing officer's written instructions pursuant to 12VAC30-121-210 I.

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

12VAC30-121-210. Hearing process and final decision.

A. All hearings must be scheduled at a reasonable time, date, and place, and the appellant and his representative shall be notified in writing at least 15 days before 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 (or 75-day or 30-day) deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-121-195 K.

B. The hearing shall be conducted by one or more hearing officers or other impartial individuals who have not been directly involved in the initial determination of the action in question or in the participating plan's appeal decision process. The hearing officer shall review the complete record for all participating plan 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 representative at a convenient place and time before the date of the hearing, as well as during the hearing. The appellant and his 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 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 representative.

1. 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 department's expense 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 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 representative, the hearing officer shall send a copy of such evidence to the appellant and his representative, and give the appellant or his 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 either sustains or reverses the participating plan's action or remands the case to the participating plan 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 participating plan's decision, conclusions, and hearing officer's decision;

5. Further action, if any, to be taken by the participating plan to implement the decision;

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

7. A cover letter informing the appellant and his 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 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 representative with the hearing officer's decision, and upon request by the appellant or representative.

12VAC30-121-220. Division appeal records.

A. No person shall take from the division's custody any original record, paper, document, or exhibit that has been certified to the 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 participating plan, other entities for official purposes, and other persons named in a release of information authorization signed by an appellant or his representative.

C. The fees to be charged and collected for any copy of 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 division's custody, the required fee shall be waived if the copies are requested in connection with an enrollee's own appeal.

12VAC30-121-230. Provider appeals.

A. The Appeals Division maintains an appeal process for enrolled providers of Medicaid services who have rendered services and are requesting to challenge a participating plan's internal appeal of an adverse decision regarding payment. The participating plan's internal appeal process is a prerequisite to filing for an external appeal to the department's appeal process. The appeal process is available to (i) enrolled Medicaid service providers that have rendered services and have been denied payment in whole or part for Medicaid covered services and (ii) enrolled Medicaid service providers who have received a Notice of Program Reimbursement or overpayment demand from the department or its contractors.

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 participating plan or plans and not subject to further appeal by the participating plan or plans.

D. If the provider is successful in its appeal, then the MMP shall reimburse it for the appealed issue.

12VAC30-121-250. Marketing and enrollee communication standards for participating plans.

A. Participating plans shall be subject to rules governing their marketing and enrollee communications as specified under §§ 1851(h) and 1932(d)(2) of the Social Security Act; 42 CFR §§ 422.111, 42 CFR 422.2260 et. seq., 42 CFR 423.120(b) and (c), 42 CFR 423.128, and 42 CFR 423.2260 et. seq.; and the

Medicare Marketing Guidelines (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual).

1. Participating plans shall not be allowed to market directly to potential enrollees. Instead, plans may participate in group marketing events, provide general audience materials (such as general circulation brochures, and media and billboard advertisements), and provide responses to individual-initiated requests for enrollment.

2. Participating plans shall receive prior approval of all marketing and enrollee communications materials except those that are exempt pursuant to 42 CFR §§ 422.2262(b) and 423.2262(b).

3. Plans shall not begin marketing activity earlier than 90 days prior to the effective date of enrollment for the contract year.

B. At a minimum, participating plans will provide current and prospective enrollees the following materials, subject to the rules regarding content and timing of enrollee receipt as applicable under § 1851(h) of the Social Security Act: 42 CFR §§ 422.111, 42 CFR 422.2260 et. seq., 42 CFR 423.120(b) and (c), 42 CFR 423.128, 42 CFR 423.2260 et. seq., 42 CFR 438.10, 42 CFR 438.104, the three way contract, and the Medicare Marketing Guidelines.

C. Notification of formulary changes. The requirement at 42 CFR § 423.120(b)(5) that participating plans provide at least 60 days advance notice regarding Medicare Part D formulary changes also applies to participating plans for outpatient prescription or over-the-counter drugs or products covered under Medicaid or as additional benefits.

FORMS (12VAC30-121)

Agency or Consumer Direction Provider Plan of Care, DMAS-97A/B (rev. 3/10)

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-121)

Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (Commonwealth Coordinated Care), signed May 21, 2013

Medical Marketing Guidelines, Centers for Medicare & Medicaid Services, revised June 17, 2014