12 VAC 30-120-280. MEDALLION clients.

A. DMAS shall determine enrollment in MEDALLION. Enrollment in MEDALLION is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. Clients of MEDALLION shall be individuals receiving Medicaid as ABD, AFDC or AFDC-related categorically needy and medically needy (except those becoming eligible through spend-down) and except for foster care children, whether or not receiving cash assistance grants.

B. Exclusions.

1. The following individuals shall be excluded from participation in MEDALLION, or excluded from continued enrollment if any of the following apply:

a. Individuals who are inpatients in state mental hospitals and skilled nursing facilities, or reside in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a long-stay hospital;

b. Individuals who are enrolled in § 1915c home and community-based waivers, the family planning waiver, or the Family Access to Medical Insurance Security Plan (FAMIS);

c. Individuals who are participating in foster care or subsidized adoption programs, who are members of spend-down cases, or who are refugees or who receive client medical management services;

d. Individuals receiving Medicare~~.~~ *;*

e. Individuals who are enrolled in DMAS-authorized residential treatment or treatment foster care programs; ~~and~~

f. Individuals whose coverage is retroactive only~~.~~ ; and

g. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Code of Virginia § 38.2-5000, *et seq*.

2. A client may be excluded from participating in MEDALLION if any of the following apply:

a. The client is not accepted to the caseload of any participating PCP.

b. The client's enrollment in the caseload of assigned PCP has been terminated, and other PCPs have declined to enroll the client.

c. The individual receives hospice services in accordance with DMAS criteria.

C. Client enrollment process.

1. All ABD, AFDC or AFDC-related recipients excepting those meeting one of the exclusions of subsection B of this section shall be enrolled in MEDALLION.

2. Newly eligible individuals shall not participate in MEDALLION until completion of the Medicaid enrollment process. This shall include initial enrollment in the Medicaid program at the time of eligibility determination by Department of Social Services staff, or any subsequent reenrollment in the Medicaid program that may occur.

3. During the preassignment period and registration as MEDALLION clients, recipients shall be provided Medicaid-covered services via the fee-for-service delivery mechanism administered by DMAS.

4. Once clients are fully registered as MEDALLION clients, they will receive MEDALLION identification material in addition to the Medicaid card.

D. PCP selection. Clients shall be given the opportunity to select the PCP of their choice.

1. Clients shall notify DMAS of their PCP selection within 45 days of receiving their MEDALLION enrollment notification letter. If notification is not received by DMAS within that timeframe, DMAS shall select a PCP for the client.

2. The selected PCP shall be a MEDALLION enrolled provider.

3. The PCP will provide 24-hour, seven day/week access, which shall include as a minimum a 24-hour, seven day/week telephone number to be provided to each MEDALLION client.

4. DMAS shall review client requests in choosing a specific PCP for appropriateness and to ensure client accessibility to all required medical services.

5. Individuals who lose then regain eligibility for MEDALLION within 60 days will be reassigned to their previous PCP without going through the preassignment and selection process.

E. Mandatory assignment of PCP. The MEDALLION program enrolls clients with a primary care provider (PCP) who acts as a care coordinator, provides primary and preventive care, and authorizes most specialty services. The client is required to select a PCP from a list of available PCPs in his service area. If the client does not select a PCP, the client defaults to the department's pre-assignment option. Clients can access any program provider for specialty services if they obtain the necessary authorization from their PCP.

2. Each site having two or more separately identifiable provider groups shall be divided into separate regions for client assignment. Clients shall initially be assigned to a PCP

according to the region in which they reside. Should insufficient PCPs exist within the client's specific region, clients shall be assigned a PCP in an adjacent region.

3. Each PCP shall be assigned a client, or family group if appropriate, until the maximum number of clients the PCP has elected to serve or the PCP/client limit has been reached or until there are no more clients suitable for assignment to that PCP, or all clients have been assigned.

F. Changing PCPs. MEDALLION clients will have the initial 90 calendar days following the effective date of enrollment with a MEDALLION PCP to change PCPs without cause. After the initial 90-day assignment period, the recipient will remain with the PCP for at least 12 months unless cause to change PCPs is shown pursuant to subdivision 1 or 2 of this subsection. After 12 months the recipient will have the option to select another PCP. Recipients will be given at least 60 days notice prior to the end of this enrollment period (and all future enrollment periods) during which time recipients can select another PCP. Open enrollment periods will occur annually.

1. Requests for change of PCP "for cause" are not subject to the 12-month limitation, but shall be reviewed and approved by DMAS staff on an individual basis. Examples of changing providers "for cause" may include but shall not be necessarily limited to:

a. Client has a special medical need which cannot be met in his service area or by his PCP.

b. Client has a pre-existing relationship with a Medicaid provider rendering care for a special medical need.

c. Mutual decision by both client and provider to sever the relationship.

d. Provider or client moves to a new residence, causing transportation difficulties for the client.

e. Provider cannot establish a rapport with the client.

f. Performance or nonperformance of service to the recipient by a provider that is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care.

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

2. The existing PCP shall continue to retain the client in the caseload, and provide services to the client until a new PCP is assigned or selected.

3. PCPs may elect to release MEDALLION clients from their caseloads for cause with review and approval by DMAS on a case-by-case basis. In such circumstances, subdivision F 2 of this section shall apply.

G. Prior authorization.

1. Clients shall contact their assigned PCP or designated covering provider to obtain authorization prior to seeking nonemergency care.

2. Emergency services and family planning services shall be provided without delay or prior authorization. However, the emergency nature of the treatment shall be documented by the provider providing treatment and should be reported to the PCP after treatment is provided. Clients should inform the PCP of any emergency treatment received.

H. Enrollee rights.

1. Each primary care provider must comply with any and all applicable federal and state laws and regulations regarding enrollee rights including, but not limited to, the applicable

sections of 42 CFR 438.100 et seq., Title VI of the Civil Rights Act of 1964, and other applicable laws regarding privacy and confidentiality, and ensure that their staff and affiliated providers take those rights into account when furnishing services to enrollees.

2. Each enrollee shall be free to exercise his rights, and the exercise of those rights shall not adversely affect the way the primary care provider or DMAS treats the enrollee.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

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

12 VAC 30-120-370. Medallion II enrollees.

A. DMAS shall determine enrollment in Medallion II. Enrollment in Medallion II is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. DMAS reserves the right to exclude from participation in the Medallion II managed care program any recipient who has been consistently noncompliant with the policies and procedures of managed care or who is threatening to providers, MCOs, or DMAS. There must be sufficient documentation from various providers, the MCO, and DMAS of these noncompliance issues and any attempts at resolution. Recipients excluded from Medallion II through this provision may appeal the decision to DMAS.

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

1. Individuals who are inpatients in state mental hospitals;

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

3. Individuals who are placed on spend-down;

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

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

6. Individuals under age 21 who are enrolled in DMAS authorized residential treatment or treatment foster care programs;

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

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

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

10. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);

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

12. Individuals who request exclusion during preassignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed

with a terminal condition and who have a life expectancy of six months or less. The client's physician must certify the life expectancy;

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

14. Individuals who have an eligibility period that is less than three months;

15. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program; and

16. Individuals who have an eligibility period that is only retroactive.;

17. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Code of Virginia § 38.2-5000, *et seq*.

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

D. Clients shall be enrolled as follows:

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

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

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

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

4. Any newborn whose mother is enrolled with an MCO at the time of birth shall be considered an enrollee of that same MCO for the newborn enrollment period. This requirement does not preclude the enrollee, once he is assigned a Medicaid identification number, from disenrolling from one MCO to another in accordance with subdivision F 1 of this section.

The newborn's continued enrollment with the MCO is not contingent upon the mother's enrollment. Additionally, if the MCO's contract is terminated in whole or in part, the MCO shall continue newborn coverage if the child is born while the contract is active, until the newborn receives a Medicaid number or for the newborn enrollment period, whichever timeframe is earlier. Infants who do not receive a Medicaid identification number prior to the end of the newborn enrollment period will be disenrolled. Newborns who remain eligible for participation in Medallion II will be reenrolled in an MCO through the preassignment process upon receiving a Medicaid identification number.

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Performance or nonperformance of service to the recipient by an MCO or one or more of its providers which is deemed by the department's external quality review

organizations to be below the generally accepted community practice of health care. This may include poor quality care;

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

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

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

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

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

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

2. DMAS shall determine whether cause exists for disenrollment. Written responses shall be provided within a timeframe set by department policy; however, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the enrollee files the request, in compliance with 42 CFR 438.56.

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

4. The DMAS determination concerning cause for disenrollment may be appealed by the client in accordance with the department's client appeals process at 12 VAC 30-110-10 through 12 VAC 30-110-380.

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

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

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

12VAC30-141-660. Assignment to managed care.

A. Except for children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Code of Virginia § 38.2-5000, *et seq*., all ~~All~~ eligible enrollees shall be assigned in managed care through the department or the central processing unit (CPU) under contract to DMAS. FAMIS recipients, during the pre-assignment period to a PCP or MCHIP, shall receive Title XXI benefits via fee-for-service utilizing a FAMIS card issued by DMAS. After assignment to a PCP or MCHIP, benefits and the delivery of benefits shall be administered specific to the type of managed care program in which the recipient is enrolled.

1. MCHIPs shall be offered to enrollees in certain areas.

2. In areas with one contracted MCHIP, all enrollees shall be assigned to that contracted MCHIP.

3. In areas with multiple contracted MCHIPs or in PCCM areas without contracted MCHIPs, enrollees shall be assigned through a random system algorithm; provided however, all children within the same family shall be assigned to the same MCHIP or primary care provider (PCP), as is applicable.

4. In areas without contracted MCHIPs, enrollees shall be assigned to the primary care case management program (PCCM) or into the fee-for-service component. All children

enrolled in the Virginia Birth-Related Neurological Injury Compensation Program shall be assigned to the fee-for-service component.

5. Enrolled individuals residing in PCCM areas without contracted MCHIPs or in areas with multiple MCHIPs, will receive a letter indicating that they may select one of the contracted MCHIPs or primary care provider (PCP) in the PCCM program, in each case, which serve such area. Enrollees who do not select an MCHIP/PCP as described above, shall be assigned to an MCHIP/PCP as described in subdivision 3 of this section.

6. Individuals assigned to an MCHIP or a PCCM who lose and then regain eligibility for FAMIS within 60 days will be re-assigned to their previous MCHIP or PCP.

B. Following their initial assignment to a MCHIP/PCP, those enrollees shall be restricted to that MCHIP/PCP until their next annual eligibility redetermination, unless appropriately disenrolled by the department.

1. During the first 90 calendar days of managed care assignment, an enrollee may request re-assignment for any reason from that MCHIP/PCP to another MCHIP/PCP serving that geographic area. Such re-assignment shall be effective no later than the first day of the second month after the month in which the enrollee requests re-assignment.

2. Re-assignment is available only in areas with the PCCM program or where multiple MCHIPs exist. If multiple MCHIPs exist, enrollees may only request re-assignment to

another MCHIP serving that geographic area. In PCCM areas, an enrollee may only request re-assignment to another PCP serving that geographic area.

3. After the first 90 calendar days of the assignment period, the enrollee may only be re-assigned from one MCHIP/PCP to another MCHIP/PCP upon determination by DMAS that good cause exists pursuant to subsection C of this section.

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

1. After the first 90 days of assignment in managed care, enrollees may request disenrollment from DMAS based on good cause. The request must be made in writing to DMAS and cite the reasons why the enrollee wishes to be re-assigned. The department shall establish procedures for good cause re-assignment through written policy directives.

2. DMAS shall determine whether good cause exists for re-assignment.

CERTIFIED: I hereby certify that these regulations are full, true, and correctly dated.

Date

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