COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **MARY-GRACE MENDOZA** MM
Assistant Attorney General

DATE: **November 12, 2013**

SUBJECT: **Fast-Track Submission - Repeal MEDALLION (12 VAC 30-120-260 to 12 VAC 30-120-350; 12 VAC 30-60-147; 12 VAC 30-60-200; 12 VAC 30-120-360; 12 VAC 30-120-370; 12 VAC 30-141-10; 12 VAC 30-141-20; 12 VAC 30-141-70; 12 VAC 30-141-200; 12 VAC 30-141-500; 12 VAC 30-141-570; 12 VAC 30-141-660; 12 VAC 30-141-670; 12 VAC 30-141-680; 12 VAC 30-141-730; 12 VAC 30-141-830; 12 VAC 30-141-850; and 12 VAC 30-141-880)**

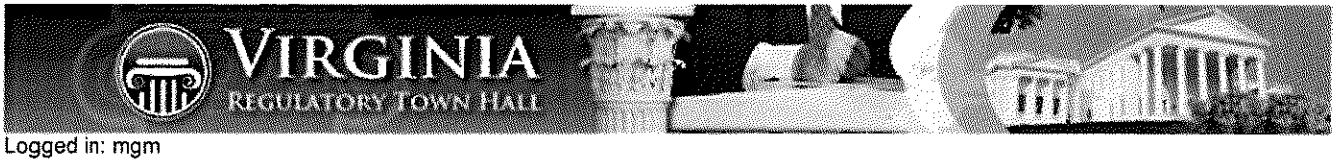
This memorandum responds to your request that this Office review the regulatory action, "Repeal MEDALLION," which repeals the MEDALLION primary care case management program (PCCM) regulations (12VAC 30-120-260 through 12 VAC 30-120-350) and amends regulations merely containing references to PCCM (12VAC 30-60-147; 12 VAC 30-60-200; 12 VAC 30-120-360; 12 VAC 30-120-370; 12 VAC 30-141-10; 12 VAC 30-141-20; 12 VAC 30-141-70; 12 VAC 30-141-200; 12 VAC 30-141-500; 12 VAC 30-141-570; 12 VAC 30-141-660; 12 VAC 30-141-670; 12 VAC 30-141-680; 12 VAC 30-141-730, 12 VAC 30-141-830, 12 VAC 30-141-850, and 12 VAC 30-141-880).

Based on my review, it is this Office's view that DMAS has the authority, subject to compliance with the provisions of Article 2 of the Administrative Process Act (APA), and has not exceeded that authority.

The change to the regulations is authorized by Va. Code §§ 32.1-325 and 32.1-324. Chapter 3 of the 2012 Acts of Assembly, Item 307 N, established the agency's authority to seek federal approval of changes to its MEDALLION waiver. As of June 21, 2012, the Centers for Medicare & Medicaid Services (CMS) has approved Virginia's request to expand its managed care program and repeal its PCCM program. Accordingly, it is my view that this action was properly promulgated under the fast-track rulemaking process pursuant to Va. Code § 2.2-4012.1 because the regulatory action is expected to be noncontroversial.

Please call me at (804) 786-6004 if you have any questions regarding this memorandum. Thank you.

cc: Kim F. Piner
Chief/Senior Assistant Attorney General



Proposed Text

Action: Repeal MEDALLION Primary Care Case Management Program

Stage: Fast-Track 11/5/13 2:01 PM [latest]

12VAC30-60-147

12VAC30-60-147. Substance abuse treatment services utilization review criteria.

A. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific [~~recipient~~ individual] needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.

1. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC30-50-510.

a. To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

b. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

c. Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

d. The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

e. The ISP shall be reviewed and updated every two weeks.

f. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

g. Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.

h. While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health/mental retardation/substance abuse rehabilitative services concurrently rendered to her.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

2. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:

a. The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.

b. The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the woman and ongoing training and consultation to the staff of the program.

c. In addition, the provider must provide access to the following services either through staff at the residential program or through contract:

(1) Psychiatric assessments as needed, which must be performed by a physician licensed to practice by the Virginia Board of Medicine.

(2) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., [~~Medallion or]~~ other Medicaid-sponsored primary health care [~~program)~~ programs)] .

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by [~~DMHMRSAS~~ DBHDS] to provide residential substance abuse services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Treatment Professionals of the Virginia

Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.

B. Substance abuse day treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to women, linkages to other programs tailored to specific needs, and program and staff qualifications.

1. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:

a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in 12VAC30-50-510.

b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II.1 (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II.1 (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.

c. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations, as well as the appropriate reauthorizations after absences.

d. Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.

e. The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30-day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

f. The ISP shall be reviewed and updated every four weeks.

g. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

h. Face-to-face therapeutic contact with the woman which is directly related to her ISP shall be documented at least once per week.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning shall seek to begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

j. While participating in this substance abuse day treatment program, the only other mental health, mental retardation or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.

2. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation.

a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.

b. The program must have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the women and ongoing training and consultation to the staff of the program.

c. In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):

(1) Psychiatric assessments, which must be performed by a physician licensed to practice by the Board of Medicine of the Virginia Department of Health Professions.

(2) Psychological assessments, as needed, which must be performed by clinical psychologist licensed to practice by the Virginia Board of Psychology.

(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Virginia Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., [~~Medallion or~~] other Medicaid-sponsored primary health care program).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by [~~DMHMRSAS~~ DBHDS] to provide either substance abuse outpatient services or substance abuse day treatment services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following appropriately licensed professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Virginia Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. The minimum ratio of clinical staff to women should ensure that adequate staff are available to address the needs of the women in the program.

12VAC30-60-200
12VAC30-60-200. Ticket to Work and Work Incentives Improvement Act (TWWIIA) basic coverage group: alternative benefits for Medicaid Buy-In program.

A. The state elects to provide alternative benefits under § 1937 of the Social Security Act. The alternative benefit package will be available statewide.

B. The population who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package consists of working individuals with disabilities enrolled pursuant to the Social Security Act, § 1902(a)(10)(A)(ii)(XV) (Ticket to Work and Work Incentives Improvement Act) covered group or who meet the income, resource and eligibility requirements for the § 1902(a)(10)(A)(ii)(XV) covered group.

C. Medicaid Buy-In: program outreach.

1. Future Medicaid Works solicitations will be geared towards individuals who are currently covered in the SSI and blind and disabled 80% federal poverty level groups; the letter will be an invitation to consider going to work, or to increase how much they work, and inform them that they will still be able to keep their Medicaid health care coverage.

2. They will be advised that this is voluntary and will enable them to earn higher income and retain more assets from their earnings. It will also explain that this option includes an alternative benefits package comprised of their regular Medicaid benefits plus personal assistance services for those who need personal assistance and related services in order to live and work in the community. It will

be clearly stated that this program is optional. Their local eligibility worker will be able to review the advantages and disadvantages of this option in order to assist individuals in making an informed choice.

3. Current Medicaid Works enrollees will each receive personal communication by mail advising them of the new alternative benefits package and the steps needed in order to access personal assistance services. Should an enrolled individual be dissatisfied with this option or be unable to continue to be employed, their eligibility worker will reevaluate eligibility for other covered groups pursuant to changing the individual back to regular Medicaid coverage and, if necessary, to accessing personal assistance and related services through the existing home- and community-based services waivers.

4. Brochures describing this work incentive opportunity and alternative benefits option shall be prominently displayed and readily available at local departments of social services.

D. Description of Medicaid Buy-In alternative benefit package.

1. The state will offer an alternative benefit package that the secretary determines provides appropriate coverage for the population served.

2. This alternative benefits package includes all federally mandated and optional Medicaid State Plan services, as described and limited in 12VAC30-50, plus personal assistance services (PAS) for enrollees who otherwise meet the standards to receive PAS, defined as follows:

a. "Personal assistance services" or "PAS" means support services provided in home and community settings necessary to maintain or improve an individual's current health status. Personal care services are defined as help with activities of daily living, monitoring of self-administered medications, and the monitoring of health status and physical condition.

b. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. An additional component of PAS is work-related and postsecondary education personal services. This service will extend the ability of the personal assistance attendant to provide assistance in the workplace.

c. These services include filing, retrieving work materials that are out of reach; providing travel assistance for an individual with a mobility impairment; helping an individual with organizational skills; reading handwritten mail to an individual with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment.

d. This service is only available to individuals who also require personal assistance services to meet their ADLs. Workplace or school supports are not provided if they are services provided by the Department of Rehabilitative Services, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or § 504 of the Rehabilitation Act.

e. Following an individual's assessment of the need for PAS and development of a plan of care, the individual will decide whether to have PAS through a personal care agency or whether to self direct his care. For individuals who choose consumer-directed care, DMAS will provide for the services of a fiscal agent to perform certain tasks as an agent for the [~~recipient/employer~~ individual/employer] who is receiving consumer-directed services. The fiscal agent will handle certain responsibilities for the individual, including but not limited to, employment taxes.

f. All governmental and private PAS providers are reimbursed according to the same published fee schedule, located on the agency's website at the following address: http://www.dmas.virginia.gov/pr-fee_files.htm. The agency's rates, based upon one-hour increments, were set as of July 1, 2006, and are effective for services on or after said dates. The agency's rates are updated periodically.

E. Wrap-around/additional services.

1. The state assures that wrap-around or additional benefits will be provided for individuals under 21 who are covered under the state plan pursuant to § 1902(a)(10)(A) of the Social Security Act to ensure early and periodic screening, diagnostic and treatment (EPSDT) services are provided when medically necessary.

2. Wraparound benefits must be sufficient so that, in combination with the Medicaid Buy-In package, these individuals receive the full EPSDT benefit, as medically necessary. The wraparound services provided are described in 12VAC30-50-130.

F. Delivery system.

1. The alternative benefit package will be furnished through a combination of the following methods:

a. On a fee-for-service basis consistent with the requirements of § 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider;

~~[b. On a fee-for-service basis consistent with the requirements cited in subdivision 1 a of this subsection, except that it will be operated with a primary care case management system consistent with § 1915(b)(1);]~~

~~c.~~ b.] Through a managed care entity consistent with applicable managed care requirements; or

~~[d.~~ c.] Through premium assistance for benchmark-equivalent in employer-sponsored coverage.

2. Personal assistance services will always be fee-for-service, whereas all other Medicaid-covered services shall be through one of [~~three~~two] models: fee-for-service [~~, primary care case management]~~ or through managed care organizations.

G. Additional assurances.

1. The state assures that individuals will have access, through the Medicaid Buy-In alternative benefit package, to rural health clinic (RHC) services and federally qualified health center (FQHC) services as defined in subparagraphs (B) and (C) of § 1905(a)(2).

2. The state assures that payment for RHC and FQHC services is made in accordance with the requirements of § 1902(bb) of the Social Security Act.

H. Cost effectiveness of plans: the Medicaid Buy-In alternative benefit package and any additional benefits must be provided in accordance with economy and efficiency principles.

I. Compliance with the law: The state will continue to comply with all other provisions of the Social Security Act in the administration of the state plan under this title.

12VAC30-120-260

Part V
Medallion (Repealed.)

12VAC30-120-260. ~~Definitions.~~ (Repealed.)

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

~~"ABD" means aged, blind and disabled recipients of public assistance programs as defined by the Virginia Department of Social Services.~~

~~"Action" means a termination, suspension, or reduction of Medicaid eligibility or covered services, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service.~~

~~"AFDC" means the Aid to Families with Dependent Children program; this program was replaced by the Temporary Assistance to Needy Families (TANF) program. Medicaid utilizes AFDC rules in determining Medicaid eligibility for families and children.~~

~~"AFDC related" means those recipients eligible for assistance as an extension of the AFDC program, such as pregnant women and indigent children under specific ages. It shall not include foster care or spend-down medically needy clients.~~

~~"Ancillary services" means those services accorded to a client that are intended to support the diagnosis and treatment of that client. These services include, but are not necessarily limited to, laboratory, pharmacy, radiology, physical therapy, and occupational therapy.~~

~~"Appeal" means a request for review of an action; all enrollee appeals are subject to the regulations set forth in 12VAC30-110.~~

~~"Area of residence" means the recipient's address in the Medicaid eligibility file.~~

~~"Client" or "clients" means an individual or individuals having current Medicaid eligibility who is enrolled in or who shall be authorized to participate as a member or members of MEDALLION.~~

~~"Comparison group" means the group of Medicaid recipients whose utilization and costs will be compared against similar groups of MEDALLION clients.~~

~~"Covered services" means Medicaid services as defined in the State Plan for Medical Assistance.~~

~~"Covering provider" means a provider designated by the primary care provider to render health care services in the temporary absence of the primary provider.~~

~~"DMAS" means the Department of Medical Assistance Services.~~

~~"Eligible person" means any person eligible for Virginia Medicaid in accordance with the State Plan for Medical Assistance under Title XIX of the Social Security Act.~~

~~"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:~~

~~1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;~~

~~2. Serious impairment to bodily functions; or~~

~~3. Serious dysfunction of any bodily organ or part.~~

~~"Emergency services" means covered inpatient and outpatient services that are (i) furnished by a provider that is qualified to furnish these services under this title and (ii) needed to evaluate or stabilize an emergency medical condition.~~

~~"Enrollee" is a Medicaid recipient who is currently enrolled with a PCP in a given managed care program.~~

~~"Enrollment broker" means an independent contractor that enrolls recipients in MEDALLION and is responsible for the operation and documentation of a toll-free recipient service helpline. The responsibilities of the enrollment broker shall include, but not be limited to, recipient education, recipient enrollment, and tracking and resolving recipient complaints, and may include recipient marketing and outreach.~~

~~"EPSDT" means the Early and Periodic Screening, Diagnosis, and Treatment program.~~

~~"Exclusion from MEDALLION" means the denial of a Medicaid recipient from initially enrolling in MEDALLION or the removal of an enrollee from the MEDALLION program on a temporary or permanent basis.~~

~~"External Quality Review Organization (EQRO)" is an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality reviews, other EQR-related activities as set forth in 42 CFR 438.358, or both.~~

~~"Foster care" is a program in which a child receives either foster care assistance under Title IV-E of the Social Security Act or state and local foster care assistance.~~

~~"General practitioner" means a licensed physician who provides routine medical treatment, diagnosis, and advice to maintain a client's health and welfare.~~

~~"Grievance" is an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals and access to the state fair hearing process. Examples of subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships, such as rudeness of a provider or employee, or the failure to respect the enrollee's rights.~~

~~"Health care professional" means a provider who has appropriate clinical training in treating an enrollee's condition or disease, and as further defined in 42 CFR 438.2.~~

~~"Post-stabilization care services" means covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.~~

~~"Potential enrollee" means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet assigned to a specific primary care provider.~~

~~"Primary care case management" or "PCCM" means a system under which a primary care case manager contracts with the Commonwealth to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to those Medicaid recipients assigned to him.~~

~~"Primary care provider" or "PCP" means that MEDALLION provider responsible for the coordination of all medical care provided to a MEDALLION client and shall be recognized by DMAS as a Medicaid provider.~~

~~"School health services" means those physical therapy, occupational therapy, speech therapy, nursing, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC § 1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions, as described in 12VAC30-50-229.1.~~

~~"Site" means, for purposes of this part, the geographical areas that best represent the health care delivery systems in the Commonwealth. In certain areas (sites), there may be two or more identifiable health care delivery systems.~~

~~"Specialty" or "specialist services" means those services, treatments, or diagnostic tests intended to provide the patient with a higher level of medical care or a more definitive level of diagnosis than that routinely provided by the primary care provider.~~

~~"Spend-down" means the process of reducing countable income by deducting incurred medical expenses for medically needy individuals, as determined in the State Plan for Medical Assistance.~~

~~"State" means the Commonwealth of Virginia.~~

~~"TANF" means Temporary Assistance to Needy Families and is a public assistance program administered by the Department of Social Services providing financial assistance to needy citizens.~~

12VAC30-120-270
12VAC30-120-270. ~~Program purpose.~~ (Repealed.)

~~The purpose of MEDALLION shall be to provide management in the delivery of health care services by linking the primary care provider (PCP) with targeted clients. The PCP shall provide medical services as appropriate for clients' health care needs and shall coordinate clients' receipt of other health services. This shall include, but not be limited to, referral to specialty providers as medically appropriate.~~

~~12VAC30-120-280~~
12VAC30-120-280. ~~MEDALLION clients.~~ (Repealed.)

~~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 § 1915 c 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;~~

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

~~g. Birth Injury Fund (BIF).~~

~~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 30 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.~~

~~1. The MEDALLION program enrolls clients with a primary care provider (PCP) who acts as a care coordinator, provides primary and preventive care, and refers 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 referral from their PCP.~~

~~2. 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 in areas without managed care organizations (MCO) 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, unless cause to change PCPs is shown pursuant to subdivision 1 or 2 of this subsection, the recipient will remain with the PCP for up to 12 months, or until the next open enrollment period. During open enrollment, the recipient will have the option to select another PCP. Recipients will be given at least 60 days notice prior to the end of the current 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 client 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. PCP referral process.~~

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

~~2. Emergency services and family planning services shall be provided without delay or referral. 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.~~

~~12VAC30-120-290~~
12VAC30-120-290. ~~Providers of services.~~ (Repealed.)

~~Providers who may enroll to provide MEDALLION services include, but are not limited to, physicians of the following primary care specialties: general practice, family practice, internal medicine, and pediatrics. Federally qualified health centers and rural health clinics as defined in 42 CFR 405.2401), and certain clinics (as defined by 12VAC5-90-10) administered by local health departments may also serve as primary care providers. Exceptions may be as follows:~~

~~1. Providers specializing in obstetric/gynecologic care may enroll as MEDALLION providers if selected by clients as PCPs but only if the providers agree to provide or refer clients for primary care.~~

~~2. Physicians with subspecialties may enroll as MEDALLION providers if selected by clients as PCPs but only if the providers agree to provide or refer clients for primary care.~~

~~3. Other specialty physicians may enroll as PCPs under extraordinary, client-specific circumstances when DMAS determines with the provider's and recipient's concurrence that the assignment would be in the client's best interests. Such circumstances may include, but are not limited to, the usual and customary practice of general medicine by a board-certified specialist, maintenance of a pre-existing patient-physician relationship, or support of the special medical needs of the client.~~

~~4. DMAS or its designee shall review applications from physicians and other health care professionals to determine appropriateness of their participating as a MEDALLION PCP.~~

~~5. The PCP must have admitting privileges at a local hospital or must make arrangements acceptable to DMAS for admissions by a physician who does have admitting privileges.~~

~~12VAC30-120-300~~
12VAC30-120-300. ~~MEDALLION provider requirements.~~ (Repealed.)

~~A. PCPs must require their clients to present their currently effective MEDALLION identification material upon presentation for services.~~

~~B. PCPs shall function as "gatekeeper" for assigned clients. Specific requirements shall include but are not necessarily limited to:~~

~~1. Providing patient management for the following services: physician, pharmacy, hospital inpatient and outpatient, laboratory, ambulatory surgical center, radiology, and durable medical equipment and supplies.~~

~~2. Providing or arranging for physician coverage 24 hours per day, seven days per week.~~

~~3. Determining the need for and authorizing when appropriate, all nonemergency care.~~

~~4. Being an EPSDT provider, or having a referral relationship with one, and providing or arranging for preventive health services for children under the age of 21 in accordance with the periodicity schedule recommended in the Guidelines for Health Supervision of the American Academy of Pediatrics, 1991.~~

~~5. Making referrals when appropriate, conforming to standard medical practices, to medical specialists or services as required. The referral duration shall be at the discretion of the PCP, and must be fully documented in the patient's medical record.~~

~~6. Coordinating inpatient admissions either by personally ordering the admission, or by referring to a specialist who may order the admission.~~

~~7. Maintaining a legibly written, comprehensive, and unified patient medical record for each client consistent with documentation requirements set forth in DMAS' Physician Manual.~~

~~8. Documenting in each client's record all authorizations for referred services.~~

~~9. Providing education and guidance to assigned clients for the purpose of teaching correct methods of accessing the medical treatment system and promoting good health practices.~~

~~10. Tracking and documenting any emergency care provided to clients.~~

~~11. Shall not refuse an assignment to, or otherwise discriminate against, any enrollee or potential enrollee on the basis of health status or need for health care services, or on the basis of race, color, or national origin, and shall not use any policy or practice that has the effect of discrimination on the basis of race, color, or national origin.~~

~~C. A PCP may not knowingly be affiliated with any of the following:~~

~~1. Any individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (48 CFR 9.400 et seq.) or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~2. An individual who is an affiliate of a person described in subdivision C 1 of this subsection whose relationship is as follows:~~

~~a. A director, officer, or partner of the PCP;~~

~~b. A person with beneficial ownership of 5.0% or more of the PCP's equity;~~

~~c. A person with an employment, consulting, or other arrangement with the PCP for the provision of items and services that are significant and material to the PCP's obligations under its contract with the state.~~

~~12VAC30-120-310~~
12VAC30-120-310. ~~Services exempted from MEDALLION referral requirements.~~ (Repealed.)

~~A. The following services shall be exempt from the referral requirements of MEDALLION:~~

~~1. Obstetrical and gynecological services (pregnancy and pregnancy related);~~

~~2. Psychiatric and psychological services, to include but not be limited to mental health, mental retardation services;~~

~~3. Family planning services;~~

~~4. Routine newborn services;~~

~~5. Annual or routine vision examinations (under age 21);~~

~~6. Emergency services;~~

~~7. EPSDT well-child exams;~~

~~8. Immunizations (health departments only);~~

~~9. All school health services provided pursuant to the Individuals with Disabilities Education Act (IDEA);~~

~~10. Services for the treatment of sexually transmitted diseases;~~

~~11. Targeted case management services;~~

~~12. Transportation services;~~

~~13. Pharmacy services;~~

~~14. Substance abuse treatment services; and~~

~~15. MR waiver services and MH community rehabilitation services.~~

~~B. While reimbursement for these services may not require a referral, an authorization, or a referral and an authorization by the PCP, the PCP must continue to track and document them to ensure continuity of care.~~

12VAC30-120-320
12VAC30-120-320. ~~PCP payments.~~ (Repealed.)

~~A. DMAS shall pay for services rendered to MEDALLION clients through the existing fee-for-service methodology and a case management fee.~~

~~B. MEDALLION providers shall receive a monthly case management fee of $3.00 per client.~~

~~C. Individual PCPs and PCPs in Department of Health clinics may serve a maximum of 2,000 MEDALLION clients. Exceptions to this will be considered on a case-by-case basis predicated upon client needs.~~

~~D. Federally qualified health centers, rural health clinics, and Department of Health clinics enrolled as Medicaid providers are limited to no more than 10,000 enrolled recipients per clinic. Exceptions to this will be considered on a case-by-case basis predicated upon client needs.~~

~~12VAC30-120-330~~
12VAC30-120-330. ~~Utilization review.~~ (Repealed.)

~~DMAS shall review claims for services provided by or resulting from referrals by authorized PCPs. Claims review shall include, but not be limited to, review for the following:~~

~~1. Excessive or inappropriate services;~~

~~2. Unauthorized or excluded services; and~~

~~3. Analysis of possible trends in increases or reductions of services.~~

~~12VAC30-120-340~~
12VAC30-120-340. ~~Client and provider appeals.~~ (Repealed.)

~~A. Client appeals. Clients shall have the right of appeal of any adverse action taken by DMAS consistent with the provisions of Part I (12VAC30-110-10 et seq.) of 12VAC30-110.~~

~~B. Provider appeals. Providers shall have the right to appeal any adverse action taken by DMAS under this part pursuant to the provisions of the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia).~~

~~12VAC30-120-350~~
12VAC30-120-350. ~~Sanctions.~~ (Repealed.)

~~A. The sanctions, as described in § 1932(e)(1) of the Social Security Act (the Act) and listed in subsection B of this section, may be imposed by DMAS if the PCP:~~

~~1. Fails substantially to provide medically necessary services that the PCP is required to provide, under law or under its contract with DMAS, to an enrollee covered under the contract;~~

~~2. Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;~~

~~3. Acts to discriminate among enrollees on the basis of their health status or need for health care services;~~

~~4. Misrepresents or falsifies information furnished to the Commonwealth;~~

~~5. Misrepresents or falsifies information furnished to an enrollee, potential enrollee, or health care provider;~~

~~6. Has distributed directly or indirectly, through any agent or independent contractor, marketing materials that have not been approved by DMAS or that contain false or materially misleading information; or~~

~~7. Has violated any of the other applicable requirements of § 1932 or § 1905 (t)(3) of the Act and any implementing regulations.~~

~~B. Section 1932(e)(2) of the Act provides for the Commonwealth to impose the following civil money penalties and other sanctions:~~

~~1. A maximum of $25,000 for each determination of failure to provide services, misrepresentations or false statements to enrollees, potential enrollees, or health care providers, or marketing violations;~~

~~2. A maximum of $100,000 for each determination of discrimination or misrepresentation or false statements to the Commonwealth;~~

~~3. A maximum of $15,000 for each recipient the Commonwealth determines was not enrolled because of a discriminatory practice (subject to a $100,000 overall limit); and~~

~~4. Up to $25,000 or double the amount of the excess charges (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. DMAS shall deduct the excess amount charged from the penalty and return it to the affected enrollees.~~

~~5. Termination. Either the PCP or DMAS may terminate the PCP's enrollment in the MEDALLION program at any time if either party determines that the other party has failed to perform any of its functions or duties under the addendum to the provider agreement (hereafter referred to as the addendum) between DMAS and the PCP. In such event, the party exercising this option shall notify the other party in writing of the intent to terminate the addendum and shall give the other party 30 days to correct the identified violation, breach or nonperformance of the addendum. If such violation, breach or nonperformance of the addendum is not~~

~~satisfactorily addressed within this time period, the exercising party must notify the other party in writing of its intent to terminate the addendum at least 60 days prior to the proposed termination date. The termination date shall always be the last day of the month in which the 60th day falls. The addendum may be terminated by DMAS sooner than the time periods for notice specified in this subsection if DMAS determines that a recipient's health or welfare is jeopardized by continued enrollment under the care of the PCP. After DMAS notifies a PCP that it intends to terminate the contract, DMAS will give the entity's enrollees written notice of the state's intent to terminate the contract and will allow enrollees to disenroll immediately without cause.~~

~~6. Suspension of new enrollment, including default enrollment.~~

~~a. Whenever DMAS determines that the PCP is out of compliance with the addendum, it may suspend the PCP's right to enroll new recipients. DMAS, when exercising this option, shall notify the PCP in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DMAS, or may be indefinite. The suspension period may extend up to any expiration date of the addendum.~~

~~b. DMAS may also suspend new enrollment or disenroll recipients in anticipation of the PCP not being able to comply with federal or state laws at its current enrollment level. Such suspension shall not be subject to the 30-day notification requirement. DMAS may notify recipients of their PCP's noncompliance and provide an opportunity to enroll with another PCP.~~

~~7. Withholding of management or other payments and recovery of damage costs. DMAS may withhold portions of management or other fees or otherwise recover damages from the PCP as follows:~~

~~a. Whenever DMAS determines that the PCP has failed to perform an administrative function required under this contract, DMAS may withhold a portion of management or other fees to compensate for the damages which this failure has entailed. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services.~~

~~b. In any case under this contract where DMAS has the authority to withhold management or other fees, DMAS also shall have the authority to use all other legal processes for the recovery of damages.~~

~~8. Department initiated disenrollment. DMAS may reduce the maximum enrollment level or number of current enrollees whenever it determines that the PCP has:~~

~~a. Failed to provide or arrange for the provision of one or more of the services required under the addendum to the provider agreement, or~~

~~b. Failed to maintain or make available any records or reports required under the addendum which DMAS requires to determine whether the PCP is providing services as required. The PCP shall be given at least 30 days notice prior to DMAS taking any action set forth in this subsection.~~

~~9. Inappropriate service delivery. PCPs demonstrating a pattern of inappropriate provision of services may be subject to suspension of new enrollments, withholding, in full or in part, of management fees, addendum termination, or refusal to be offered the opportunity to participate as a PCP in a future time period.~~

~~12VAC30-120-360~~
Part VI
Medallion II

12VAC30-120-360. Definitions.

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

"Action" means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; or the failure of an MCO to act within the timeframes provided in 42 CFR 438.408 (b).

"Appeal" means a request for review of an action, as "action" is defined in this section.

"Area of residence" means the [~~recipient's~~individual's] address in the Medicaid eligibility file.

"Capitation payment" means a payment the department makes periodically to a contractor on behalf of each [~~recipient~~ individual] enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular [~~recipient~~ individual] receives services during the period covered by the payment.

~~["Client," "clients," "recipient," "enrollee," or "participant" means an individual or individuals having current Medicaid eligibility who shall be authorized by DMAS to be a member or members of Medallion II.]~~

"Covered services" means Medicaid services as defined in the State Plan for Medical Assistance.

"Disenrollment" means the process of changing enrollment from one Medallion II Managed Care Organization (MCO) plan to another MCO [~~or to the Primary Care Case Management (PCCM) program]~~, if applicable.

"DMAS" means the Department of Medical Assistance Services.

["Enrollee" or "enrollees" means people having current Medicaid eligibility who shall be in the process of being authorized by DMAS to be enrolled in Medallion II.]

"Early Intervention" means EPSDT Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 as set forth in 12VAC30-50-131.

"Eligible person" means any person eligible for Virginia Medicaid in accordance with the State Plan for Medical Assistance under Title XIX of the Social Security Act.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part.

"Emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency medical condition.

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

"Exclusion from Medallion II" means the removal of an enrollee from the Medallion II program on a temporary or permanent basis.

"External Quality Review Organization" (EQRO) is an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality reviews, other EQR related activities as set forth in 42 CFR 438.358, or both.

"Foster care" is a program in which a child receives either foster care assistance under Title IV-E of the Social Security Act or state and local foster care assistance.

"Grievance" means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.

"Health care plan" means any arrangement in which any managed care organization undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

"Health care professional" means a provider as defined in 42 CFR 438.2.

["Individual" or "individuals" are people who are eligible for Medicaid but not yet undergoing enrollment nor are enrolled in a managed care organization.]

"Managed care organization" or "MCO" means an entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed contractual agreement with DMAS to provide services covered under the Medallion II program. Covered services for Medallion II individuals must be as accessible (in terms of timeliness, amount, duration, and scope) as compared to other Medicaid [~~recipients~~ individuals] served within the area.

["Member" or "members" means people who have current Medicaid eligibility who are also enrolled in Medallion II managed care.]

"Network" means doctors, hospitals or other health care providers who participate or contract with an MCO and, as a result, agree to accept a mutually-agreed upon sum or fee schedule as payment in full for covered services that are rendered to eligible participants.

"Newborn enrollment period" means the period from the child's date of birth plus the next two calendar months.

"Nonparticipating provider" means a health care entity or health care professional not in the contractor's participating provider network.

["Participant" or "participants" means an individual or individuals having current Medicaid eligibility who shall be authorized by DMAS to be a member or members of Medallion II.]

"Post-stabilization care services" means covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

"Potential enrollee" means a Medicaid [~~recipient~~individual] who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO ~~or PCCM~~.

~~["Primary care case management" or "PCCM" means a system under which a primary care case manager contracts with the Commonwealth to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid recipients.]~~

"School health services" means those physical therapy, occupational therapy, speech therapy, nursing, psychiatric and psychological services rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC § 1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions, as described in 12VAC30-50-229.1.

"Spend-down" means the process of reducing countable income by deducting incurred medical expenses for medically needy individuals, as determined in the State Plan for Medical Assistance.

12VAC30-120-370
12VAC30-120-370. Medallion II enrollees.

A. DMAS shall determine enrollment in Medallion II. Enrollment in Medallion II is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. DMAS reserves the right to exclude from participation in the Medallion II managed care program any [~~recipient~~ member] 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~~ Members] excluded from Medallion II through this provision may appeal the decision to DMAS.

B. The following individuals shall be excluded (as defined in 12VAC30-120-360) from participating in Medallion II or will be disenrolled from Medallion II if any of the following apply. 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~~ individuals with intellectual disabilities] ;

3. Individuals who are placed on spend-down;

4. Individuals who are participating in the family planning waiver, or in federal waiver programs for home-based and community-based Medicaid coverage prior to managed care enrollment;

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

6. Individuals under age 21 who are either enrolled in DMAS authorized treatment foster care programs as defined in 12VAC30-60-170 A, or who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860;

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 (e.g., physician, hospital, midwife) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the [~~recipient~~ member] , 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 MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to [~~recipients~~ members] admitted to the hospital while already enrolled in a department-contracted MCO;

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;

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

17. Children 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.

C. [~~Individuals~~ Members] enrolled with a MCO who subsequently meet one or more of the aforementioned criteria in subsection A and B of this section during MCO enrollment shall be excluded from MCO participation as determined by DMAS, with the exception of those who subsequently become [~~recipients~~ participants] in the federal long-term care waiver programs, as otherwise defined elsewhere in this chapter, for home-based and community-based Medicaid coverage (AIDS, IFDDS, MR, EDCD, Day Support, or Alzheimers, or as may be amended from time to time). These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When [~~enrollees~~ individuals] no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

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

E. Clients shall be enrolled as follows:

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

2. [~~Clients~~ Individuals] 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 F of this section, in which the [~~client~~ individual] will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days. [~~Recipients~~ Members] who are enrolled in one mandatory MCO program who immediately become eligible for another mandatory MCO program are able to maintain consistent enrollment with their currently assigned MCO, if available. These [~~recipients~~ members] will receive a notification letter including information regarding their ability to change health plans under the new program.

4. Any newborn whose mother is enrolled with an MCO at the time of birth shall be considered [~~an enrollee~~ a member] of that same MCO for the newborn enrollment period. The newborn enrollment period is defined as the birth month plus two months following the birth month. This requirement does not preclude the [~~enrollee~~ member] , once he is assigned a Medicaid identification number, from disenrolling from one MCO to another in accordance with subdivision G 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~~ Children] 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.

F. [~~Clients~~ Individuals] who do not select an MCO as described in subdivision E 3 of this section shall be assigned to an MCO as follows:

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

2. [~~Clients~~ Individuals] 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~~ individuals] 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,]~~ members are automatically assigned to [~~the~~ a] contracted MCO [in their localities. ~~Individuals~~Members] 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~~ change to another MCO that participates in the geographic area where the member lives.]

5. DMAS shall have the discretion to utilize an alternate strategy for enrollment or transition of enrollment from the method described in this section for expansions to new client populations, new geographical areas, expansion through procurement, or any or all of these; such alternate strategy shall comply with federal waiver requirements .

G. Following their initial enrollment into an MCO [~~or PCCM program~~], [~~recipients~~ members] shall be restricted to the MCO [~~or PCCM program~~] until the next open enrollment period, unless appropriately disenrolled or excluded by the department (as defined in 12VAC30-120-360).

1. During the first 90 calendar days of enrollment in a new or initial MCO, a [~~client~~ member] 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~~ member] requests disenrollment.

2. During the remainder of the enrollment period, the [~~client~~ member] 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 I of this section.

H. The department shall conduct an annual open enrollment for all Medallion II [~~participants~~ members] . 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~~ member] 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~~ Members] who do not make a choice during the open enrollment period will remain with their current MCO selection.

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

1. After the first 90 days of enrollment in an MCO, [~~clients~~ members] 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~~ member] wishes to disenroll. Cause for disenrollment shall include the following:

a. [~~A recipient's~~ A member's] desire to seek services from a federally qualified health center which is not under contract with the [~~recipient's~~ member's] current MCO, and the [~~recipient [(i)~~ member] 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~~ member] 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~~ member] 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~~ member] moves out of the MCO's service area;

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

g. The [~~enrollee~~ member] needs related services to be performed at the same time; not all related services are available within the network, and the [~~enrollee's~~member's] primary care provider or another provider determines that receiving the services separately would subject the [~~enrollee~~member] 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~~ member] in accordance with the department's client appeals process at 12VAC30-110-10 through 12VAC30-110-380.

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

6. [~~Individuals~~ Members] enrolled with a MCO who subsequently meet one or more of the exclusions in subsection B of this section during MCO enrollment shall be disenrolled as appropriate by DMAS, with the exception of those who subsequently become [~~recipients~~ individuals ~~into the AIDS~~], [participating in the] IFDDS, MR, EDCD, Day Support, or Alzheimer's federal waiver programs for home-based and community-based Medicaid coverage. These [~~individuals~~ members] shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When [~~enrollees~~ members] no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

12VAC30-141-10
Part I
General Provisions

12VAC30-141-10. Definitions.

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

"Act" means the Social Security Act.

"Adult caretaker relative" or "caretaker relative" means an individual who is age 18 or older, who is not the parent of, but who is related to, the child by blood or marriage, and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.

"Adverse action" means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment; or delay, denial, reduction, suspension, or termination of health services, in whole or in part; provided, however, that determination of eligibility to participate in and termination

of participation in the FAMIS Select program shall not constitute an adverse action.

"Agency" means a local department of social services, the central processing unit, or other entity designated by DMAS to make eligibility determinations for FAMIS.

"Agency error" means a person or persons received benefits to which they were not entitled as a result of an error on the part of an eligibility worker at a local department of social services or the central processing unit.

"Agent" means an individual designated in writing to act on behalf of a FAMIS Plan applicant or enrollee during the administrative review process.

"Applicant" means a child who has filed an application (or who has an application filed on his behalf) for child health insurance and is awaiting a determination of eligibility. A child is an applicant until his eligibility has been determined.

"Application for health insurance" means the form or forms developed and approved by the Department of Medical Assistance Services that are used for determining eligibility for Family Access to Medical Insurance Security Plan (FAMIS), FAMIS Plus (Children's Medicaid), for Medicaid for pregnant women, and for FAMIS MOMS.

"Authorized representative" means a person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

"Board" or "BMAS" means that policy board created by § 32.1-324 of the Code of Virginia to administer the plans established by the Social Security Act.

"CMSIP" means that original child health insurance program that preceded FAMIS.

"Central processing unit" or "CPU" means the private contractor that will determine eligibility for and administer part of the Family Access to Medical Insurance Security Plan or FAMIS.

"Child" means an individual under the age of 19 years.

"Competent individual" means a person who has not been judged by a court to be legally incapacitated.

"Comprehensive health insurance coverage" means health benefits coverage, which includes the following categories of services at a minimum: inpatient and outpatient hospital services; physician's surgical and medical services; and laboratory and radiological services.

"Conservator" means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

"Continuation of enrollment" means ensuring an enrollee's benefits are continued until completion of the review process, with the condition that should the enrollee not prevail in the review process, the enrollee shall be liable for the repayment of all benefits received during the review process.

"Director" means the individual, or his designee, specified in § 32.1-324 of the Code of Virginia with all of the attendant duties and responsibilities to administer the State Plan for Medical Assistance and the State Plan for FAMIS.

"DMAS" or "department" means the Department of Medical Assistance Services.

"Enrollee" means a child who has been determined eligible to participate in FAMIS and is enrolled in the FAMIS program.

"External Quality Review Organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS.

"Family" means parents, including adoptive and stepparents, and their children under the age of 19, who are living in the same household. Family shall not mean grandparents, other relatives, or legal guardians.

"Family," when used in the context of the FAMIS Select component, means a unit or group that has access to an employer's group health plan. Thus, it includes the employee and any dependents who can be covered under the employer's plan.

"Family income" means the total income of all family members in a household. Income includes, but is not necessarily limited to, before-tax earnings from a job, including cash, wages, salary, commissions, tips, self-employment net profits, Social Security, Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions, retirement benefits, settlement benefits, rental income, and lottery/bingo winnings. Income excludes public assistance program benefits such as SSI and TANF payments, foster care payments, general relief, loans, grants, or scholarships for educational expenses or earned income of a child who is a student.

"FAMIS" means the Family Access to Medical Insurance Security Plan.

"FAMIS Select" means an optional program available to children determined eligible for FAMIS, whereby DMAS provides premium assistance to the family to cover the child through a private or employer-sponsored health plan instead of directly through the FAMIS program.

"Federal poverty level" or "FPL" means that income standard as published annually by the U.S. Department of Health and Human Services in the Federal Register.

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

"Fixed premium assistance amount" means a predetermined amount of premium assistance that DMAS will pay per child to a family who chooses to enroll its FAMIS eligible child in a private or employer-sponsored health plan. The fixed premium assistance amount will be determined annually by DMAS to ensure that the FAMIS Select program is cost-effective as compared to the cost of covering a child directly through the FAMIS program.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"Group health plan" or "health insurance coverage" means that health care coverage as defined in § 2791 of the Public Health Services Act (42 USC § 300gg-91(a) and (b)(1)).

"Guardian" means a person appointed by a court of competent jurisdiction to be responsible for the affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

"Incapacitated individual" means a person who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating

information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian, or (ii) manage property or financial affairs or provide for his support or for the support of his legal dependents without the assistance or protection of a conservator.

"Legally emancipated" means that the parents and child have gone through the court and a judge has declared that the parents have surrendered the right to care, custody, and earnings of the child and have renounced parental duties. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

"LDSS" or "local department" means the local department of social services.

"Managed care health insurance plan" or "MCHIP" as defined in § 32.1-137.1 of the Code of Virginia means an arrangement for the delivery of health care in which a health carrier means under contract with DMAS for Title XXI delivery systems, undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis, which contains one or more incentive arrangements, including any credential requirements intended to influence the cost of the health care services between the health carrier and one or more providers and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

"Maternal and child health insurance application" means the form or forms developed and approved by the Department of Medical Assistance Services that are used by local departments of social services and the FAMIS CPU for determining eligibility for Medicaid for poverty-level children and for the Family Access to Medical Insurance Security Plan (FAMIS).

"Member of a family," for purposes of determining whether the child is eligible for coverage under a state employee health insurance plan, means a parent or parents, including stepparents with whom the child is living if the stepparent claims the child as a dependent on the employee's federal tax return.

"Premium assistance" means the portion of the family's cost of participating in a private employer's health plan that DMAS will pay to cover the FAMIS-eligible children under the private or employer-sponsored plan if DMAS determines it is cost effective to do so.

~~["Primary care case management (PCCM)" means a system under which a physician acting as a primary care case manager furnishes case management services to FAMIS enrollees pursuant to a contract with DMAS.]~~

~~["Primary care provider" or "PCP" means a physician enrolled in the PCCM program as a primary case manager.]~~

"Private" or "employer-sponsored health insurance coverage"~~1~~ means a health insurance policy that is either purchased by an individual directly or through an employer. This component of FAMIS refers to the ability of DMAS to provide coverage to FAMIS-eligible children by providing premium assistance to families who enroll the FAMIS-eligible children in a private or employer-sponsored health plan.

"Provider" means the individual, facility or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCHIP [~~, a PCCM,]~~ or in fee-for-service to render services to FAMIS enrollees eligible for services.

"Supplemental coverage" means coverage provided to FAMIS-eligible children covered under the FAMIS Select component so that they can receive all childhood immunizations included in the FAMIS benefits.

"Title XXI" means the federal State Children's Health Insurance Program as established by Subtitle J of the Balanced Budget Act of 1997.

"Virginia State Employee Health Insurance Plan" means a health insurance plan offered by the Commonwealth of Virginia to its employees.

~~[1So in original.]~~

12VAC30-141-20
12VAC30-141-20. Administration and general background.

A. The state shall use funds provided under Title XXI for obtaining coverage that meets the requirements for a State Child Health Insurance Plan (also known as Title XXI).

B. The DMAS director will have the authority to contract with entities for the purpose of establishing a centralized processing site, determining eligibility, enrolling eligible children into health plans, performing outreach, data collection, reporting, and other services necessary for the administration of the Family Access to Medical Insurance Security Plan and for employing state staff to perform Medicaid eligibility determinations on children referred by FAMIS staff.

C. Health care services under FAMIS shall be provided through MCHIPs [~~, PCCMs,]~~ and through fee-for-service or through any other [~~heath~~ health] care delivery system deemed appropriate by the Department of Medical Assistance Services.

12VAC30-141-70
12VAC30-141-70. Review procedures.

A. At a minimum, the MCHIP review shall be conducted pursuant to written procedures as defined in § 32.1-137.6 of the Code of Virginia and as may be further defined by DMAS. Such procedures shall be subject to review and approval by DMAS.

B. The DMAS review shall be conducted pursuant to written procedures developed by DMAS.

C. The procedures in effect on the date a particular request for review is received by the MCHIP or DMAS shall apply throughout the review.

D. Copies of the procedures shall be promptly mailed by the MCHIP or DMAS to applicants and enrollees upon receipt of timely requests for review. Such written procedures shall include but not be limited to the following:

1. The right to representation by an attorney or other agent of the applicant's or enrollee's choice, but at no time shall the MCHIP, local department of social services, DSS, or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;

2. The right to timely review of their files and other applicable information relevant to the review of the decision;

3. The right to fully participate in the review process, whether the review is conducted in person or in writing, including the presentation of supplemental information during the review process;

4. The right to have personal and medical information and records maintained as confidential; and

5. The right to a written final decision within 90 calendar days of receipt of the request for review, unless the applicant or enrollee requests or causes a delay.

6. For eligibility and enrollment matters, if the applicant's or enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain, or regain maximum function, an applicant or enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written final decision within three business days after DMAS receives, from the physician or health plan, the case record and information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain or regain maximum function, unless the applicant or enrollee or his authorized representative causes a delay.

7. For health services matters for FAMIS enrollees receiving services through MCHIPs, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision by the external quality review organization within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

8. For health services matters for FAMIS enrollees receiving services through fee-for-service [~~and PCCM~~], if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

12VAC30-141-200
Part V
Benefits and Reimbursement

12VAC30-141-200. Benefit packages.

The Commonwealth's Title XXI State Plan utilizes two benefit packages within FAMIS as set forth in the FAMIS State Plan, as may be amended from time to time. One package is a modified Medicaid look-alike component offered through a fee-for-service program [~~and a primary care case management (PCCM) program~~]; the other package is modeled after the state employee health plan and delivered by contracted MCHIPs.

12VAC30-141-500
12VAC30-141-500. Benefits reimbursement.

A. Reimbursement for the services covered under FAMIS fee-for-service [~~and PCCM~~] and MCHIPs shall be as specified in this section.

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical

equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, school-based health services, and certain community-based mental health services shall be based on the Title XIX rates.

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and outpatient rehabilitation facilities and for home health skilled nursing visits. Prior authorization is required after 26 visits for outpatient mental health visits in the first year of service and prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, including Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. Prior authorization for dental services will be based on the Title XIX prior authorization requirements for dental services.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

3. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital. Payments made will be final and there will be no retrospective cost settlements.

4. Reimbursement for inpatient mental health services other than by free standing psychiatric hospitals will be based on the Title XIX rates in effect for each hospital. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each rehabilitation agency. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages 6 through 18. Payments made will be final and there will be no retrospective cost settlements.

7. Reimbursement for prescription drugs will be based on the Title XIX rates in effect. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

8. Reimbursement for covered prescription drugs for noninstitutionalized FAMIS recipients receiving the fee-for-service [~~or PCCM~~] benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12VAC30-50-210 A 7.

12VAC30-141-570

12VAC30-141-570. Utilization control.

A. Each MCHIP shall implement a utilization review system as determined by contract with DMAS, or administered by DMAS.

B. For [~~both~~] the fee-for-service [~~and PCCM programs~~ program] , DMAS shall use the utilization controls already established and operational in the State Plan for Medical Assistance.

C. DMAS may collect and review comprehensive data to monitor utilization after receipt of services.

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

A. Except for children 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, all eligible enrollees shall be assigned in managed care through the department or the central processing unit (CPU) under contract to DMAS. FAMIS [~~recipients~~individuals] , during the preassignment period to [~~a PCP or~~ an] MCHIP, shall receive Title XXI benefits via fee-for-service utilizing a FAMIS card issued by DMAS. After assignment to [~~a PCP or~~ an] MCHIP, benefits and the delivery of benefits shall be administered specific to the [~~type of~~] managed care program in which the [~~recipient~~ individual] is enrolled. DMAS shall contract with MCHIPs to deliver health care services for infants born to mothers enrolled in FAMIS for the month of birth plus two additional months regardless of the status of the newborn's application for FAMIS. If federal funds are not available for those months of coverage, DMAS shall use state funding only.

1. MCHIPs shall be offered to enrollees in [~~certain~~all] areas.

2. [~~In areas with one contracted MCHIP, all~~ All] enrollees shall be assigned to [~~that~~ the] contracted [~~MCHIP~~ MCHIPs] .

3. [~~In areas with multiple contracted MCHIPs or in PCCM areas without contracted MCHIPs, enrollees~~ 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~~ that] serve such area. Enrollees who do not select an [~~MCHIP/PCP~~ MCHIP] as described above, shall be assigned to an [~~MCHIP/PCP~~ MCHIP] 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~~ an MCHIP] , those enrollees shall be restricted to that [~~MCHIP/PCP~~ MCHIP] 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 reassignment for any reason. Such reassignment shall be effective no

later than the first day of the second month after the month in which the enrollee requests reassignment.

2. [~~If multiple MCHIPs exist, enrollees~~ Enrollees] may only request reassignment to another MCHIP serving that geographic area. [~~In PCCM areas, an enrollee may only request reassignment to another PCP serving that geographic area. In areas with only one MCHIP, enrollees may request reassignment to fee-for-service.~~]

3. After the first 90 calendar days of the assignment period, the enrollee may only be reassigned from one [~~MCHIP/PCP~~ MCHIP] to another [~~MCHIP/PCP or to fee-for-service in areas with only one~~] MCHIP 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 reassigned. The department shall establish procedures for good cause reassignment through written policy directives.

2. DMAS shall determine whether good cause exists for reassignment.

12VAC30-141-670
Part VII
FAMIS MOMS

12VAC30-141-670. Definitions.

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

"Act" means the Social Security Act.

"Adult caretaker relative" or "caretaker relative" means an individual who is age 18 or older, who is not the parent of but who is related to the child applicant by blood or marriage, and who lives with and assumes responsibility for day-to-day care of the child applicant in a place of residence maintained as his or their own home.

"Adverse action" means the denial of eligibility; failure to make a timely determination of eligibility; suspension or termination of enrollment; or delay, denial, reduction, suspension, or termination of health services, in whole or in part.

"Agency" means a local department of social services, the central processing unit, or other entity designated by DMAS to make eligibility determinations for FAMIS MOMS.

"Agency error" means a person or persons received benefits to which they were not entitled as a result of an error on the part of an eligibility worker at a local department of social services or the central processing unit.

"Agent" means an individual designated in writing to act on behalf of a FAMIS MOMS Plan applicant or enrollee during the administrative review process.

"Applicant" means a pregnant woman who has filed an application (or who has an application filed on her behalf) for health insurance and is awaiting a determination of eligibility. A pregnant woman is an applicant until her eligibility has been determined.

"Application for health insurance" means the form or forms developed and approved by the Department of Medical Assistance Services that are used for determining eligibility for Medicaid for poverty level children, for the Family Access

to Medical Insurance Security Plan (FAMIS) for children, for Medicaid for pregnant women, and for FAMIS MOMS coverage for pregnant women.

"Authorized representative" means a person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

"Board" or "BMAS" means that policy board created by § 32.1-324 of the Code of Virginia to administer the plans established by the Social Security Act.

"Central processing unit" or "CPU" means the private contractor that will determine eligibility for and administer part of the FAMIS MOMS Plan.

"Child" means an individual under the age of 19 years.

"Competent individual" means a person who has not been judged by a court to be legally incapacitated.

"Comprehensive health insurance coverage" means health benefits coverage, which includes the following categories of services at a minimum: inpatient and outpatient hospital services, physician's surgical and medical services, and laboratory and radiological services.

"Conservator" means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

"Continuation of enrollment" means ensuring an enrollee's benefits are continued until completion of the review process, with the condition that should the enrollee not prevail in the review process, the enrollee shall be liable for the repayment of all benefits received during the review process.

"Director" means the individual, or his designee, specified in § 32.1-324 of the Code of Virginia with all of the attendant duties and responsibilities to administer the State Plan for Medical Assistance and the State Plan for Title XXI.

"DMAS" or "department" means the Department of Medical Assistance Services.

"Enrollee" means a pregnant woman who has been determined eligible to participate in FAMIS MOMS and is enrolled in the FAMIS MOMS program.

"External quality review organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS MOMS.

"Family" for a pregnant woman under the age of 21, means parents, including adoptive parents, if they are all residing together and the spouse of the pregnant woman if the woman is married and living with her spouse, as well as any children under the age of 21 the woman may have.

For a pregnant woman over the age of 21, "family" means her spouse, if married and living together, as well as any children under the age of 21 the pregnant woman may have.

"Family income" means the total income of all family members in a household. Income includes, but is not necessarily limited to, before-tax earnings from a job, including cash, wages, salary, commissions, tips, self-employment net profits, Social Security, Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions, retirement benefits, settlement benefits, rental income, and lottery/bingo winnings. Income excludes public assistance program benefits such as SSI and TANF payments, foster care payments, general relief, loans, grants, or scholarships for educational expenses or earned income of a child who is a student.

"FAMIS" means the Family Access to Medical Insurance Security Plan.

"FAMIS MOMS" means the Title XXI program available to eligible pregnant women.

"Federal poverty level" or "FPL" means that income standard as published annually by the U.S. Department of Health and Human Services in the Federal Register.

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

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

"Group health plan" or "health insurance coverage" means that health care coverage as defined in § 2791 of the Public Health Services Act (42 USC § 300gg-91(a) and (b)(1)).

"Guardian" means a person appointed by a court of competent jurisdiction to be responsible for the affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and, if not inconsistent with an order of commitment, residence.

"Incapacitated individual" means a person who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (i) meet the essential requirements of her health, care, safety, or therapeutic needs without the assistance or protection of a guardian, or (ii) manage property or financial affairs or provide for her support or for the support of her legal dependents without the assistance or protection of a conservator.

"Legally emancipated" means that the parents and child have gone through the court and a judge has declared that the parents have surrendered the right to care, custody, and earnings of the child and have renounced parental duties. A married minor is not emancipated unless a court has declared the married minor emancipated from her parents.

"LDSS" or "local department" means the local department of social services.

"Managed care health insurance plan" or "MCHIP" as defined in § 32.1-137.1 of the Code of Virginia means an arrangement for the delivery of health care in which a health carrier under contract with DMAS for Title XXI delivery systems undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis, which contains one or more incentive arrangements, including any credential requirements intended to influence the cost of the health care services between the health carrier and one or more providers and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

"Member of a family," for purposes of determining whether the applicant is eligible for coverage under a state employee health insurance plan, means a spouse, parent or parents, including stepparents with whom the child is living if the stepparent claims the child as a dependent on the employee's federal tax return.

"Pregnant woman" means a woman of any age who is medically determined to be pregnant. The pregnant woman definition is met from the first day of the earliest month that the medical practitioner certifies as being a month in which the woman was pregnant, through the last day of the month in which the 60th day occurs, following the last day of the month in which her pregnancy ended, regardless of the reason the pregnancy ended.

~~["Primary care case management (PCCM)" means a system under which a physician acting as a primary care case manager furnishes case management services to FAMIS MOMS enrollees pursuant to a contract with DMAS.]~~

~~["Primary care provider" or "PCP" means a physician enrolled in the PCCM program as a primary case manager.]~~

"Provider" means the individual, facility, or other entity registered, licensed, or certified, as appropriate, and enrolled by an MCHIP [~~, a PCCM,]~~ or in fee-for-service to render services to FAMIS MOMS enrollees eligible for services.

"Title XXI" means the federal State Children's Health Insurance Program as established by Subtitle J of the Balanced Budget Act of 1997.

"Virginia State Employee Health Insurance Plan" means a health insurance plan offered by the Commonwealth of Virginia to its employees.

12VAC30-141-680
12VAC30-141-680. Administration and general background.

A. The state shall use funds provided under Title XXI for obtaining coverage that meets the requirements of Title XXI of the Social Security Act and any waiver of federal regulations approved by the Centers for Medicare and Medicaid Services.

B. The DMAS director will have the authority to contract with entities for the purpose of establishing a centralized processing site, determining eligibility, enrolling eligible pregnant women into health plans, performing outreach, data collection, reporting, and other services necessary for the administration of the FAMIS MOMS program; and for employing state staff to perform Medicaid eligibility determinations on pregnant women referred by the contractor's staff.

C. Health care services under FAMIS MOMS shall be provided through MCHIPs [~~, PCCMs,]~~ and fee-for-service or through any other [~~heath~~ health] care delivery system deemed appropriate by the Department of Medical Assistance Services.

12VAC30-141-730
12VAC30-141-730. Review procedures.

A. At a minimum, the MCHIP review shall be conducted pursuant to written procedures as defined in § 32.1-137.6 of the Code of Virginia and as may be further defined by DMAS. Such procedures shall be subject to review and approval by DMAS.

B. The DMAS review shall be conducted pursuant to written procedures developed by DMAS.

C. The procedures in effect on the date a particular request for review is received by the MCHIP or DMAS shall apply throughout the review.

D. Copies of the procedures shall be promptly mailed by the MCHIP or DMAS to applicants and enrollees upon receipt of timely requests for review. Such written procedures shall include but not be limited to the following:

1. The right to representation by an attorney or other agent of the applicant's or enrollee's choice, but at no time shall the MCHIP, local department of social

services, DSS, or DMAS be required to obtain or compensate attorneys or other agents acting on behalf of applicants or enrollees;

2. The right to timely review of their files and other applicable information relevant to the review of the decision;

3. The right to fully participate in the review process, whether the review is conducted in person or in writing, including the presentation of supplemental information during the review process;

4. The right to have personal and medical information and records maintained as confidential; and

5. The right to a written final decision within 90 calendar days of receipt of the request for review, unless the applicant or enrollee requests or causes a delay.

E. For eligibility and enrollment matters, if the applicant's or enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain, or regain maximum function, an applicant or enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written final decision within three business days after DMAS receives, from the physician or health plan, the case record and information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the applicant's or enrollee's life or health or ability to attain, maintain or regain maximum function, unless the applicant or enrollee or her authorized representative causes a delay.

F. For health services matters for FAMIS MOMS enrollees receiving services through MCHIPs, if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision by the external quality review organization within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

G. For health services matters for FAMIS MOMS enrollees receiving services through fee-for-service [~~or PCCM~~], if the enrollee's physician or health plan determines that the 90-calendar-day timeframe could seriously jeopardize the enrollee's life, health or ability to attain, maintain, or regain maximum function, an enrollee will have the opportunity to expedited review. Under these conditions, a request for review shall result in a written decision within 72 hours from the time an enrollee requests expedited review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If a delay is requested or caused by the applicant, enrollee, or authorized representative, then expedited review may be extended up to 14 calendar days.

12VAC30-141-830
12VAC30-141-830. Benefits reimbursement.

A. Reimbursement for the services covered under FAMIS MOMS fee-for-service [~~and PCCM~~] and MCHIPs shall be as specified in this section.

B. Reimbursement for physician services, surgical services, clinic services, prescription drugs, laboratory and radiological services, outpatient mental health services, early intervention services, emergency services, home health services, immunizations, mammograms, medical transportation, organ transplants, skilled nursing services, well baby and well child care, vision services, durable medical

equipment, disposable medical supplies, dental services, case management services, physical therapy/occupational therapy/speech-language therapy services, hospice services, school-based health services, and certain community-based mental health services shall be based on the Title XIX rates.

C. Reimbursement to MCHIPs shall be determined on the basis of the estimated cost of providing the MCHIP benefit package and services to an actuarially equivalent population. MCHIP rates will be determined annually and published 30 days prior to the effective date.

D. Exceptions.

1. Prior authorization is required after five visits in a fiscal year for physical therapy, occupational therapy and speech therapy provided by home health providers and outpatient rehabilitation facilities and for home health skilled nursing visits. Prior authorization is required after five visits for outpatient mental health visits in the first year of service and prior authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging, Computer Axial Tomography scans, or Positron Emission Tomography scans.

2. Reimbursement for inpatient hospital services will be based on the Title XIX rates in effect for each hospital. Reimbursement shall not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made shall be final and there shall be no retrospective cost settlements.

3. Reimbursement for outpatient hospital services shall be based on the Title XIX rates in effect for each hospital. Payments made will be final and there will be no retrospective cost settlements.

4. Reimbursement for inpatient mental health services other than by free standing psychiatric hospitals will be based on the Title XIX rates in effect for each hospital. Reimbursement will not include payments for disproportionate share or graduate medical education payments made to hospitals. Payments made will be final and there will be no retrospective cost settlements.

5. Reimbursement for outpatient rehabilitation services will be based on the Title XIX rates in effect for each rehabilitation agency. Payments made will be final and there will be no retrospective cost settlements.

6. Reimbursement for outpatient substance abuse treatment services will be based on rates determined by DMAS for children ages 6 through 18. Payments made will be final and there will be no retrospective cost settlements.

7. Reimbursement for prescription drugs will be based on the Title XIX rates in effect. Reimbursements for Title XXI do not receive drug rebates as under Title XIX.

8. Reimbursement for covered prescription drugs for non-institutionalized FAMIS MOMS [~~recipients~~ individuals] receiving the fee-for-service [~~or PCCM~~] benefits will be subject to review and prior authorization when their current number of prescriptions exceeds nine unique prescriptions within 180 days, and as may be further defined by the agency's guidance documents for pharmacy utilization review and the prior authorization program. The prior authorization process shall be applied consistent with the process set forth in 12VAC30-50-210 A 7.

12VAC30-141-850
12VAC30-141-850. Utilization control.

A. Each MCHIP shall implement a utilization review system as determined by contract with DMAS, or administered by DMAS.

B. For [~~both~~] the fee-for-service [~~and PCCM programs~~ program] , DMAS shall use the utilization controls already established and operational in the State Plan for Medical Assistance.

C. DMAS may collect and review comprehensive data to monitor utilization after receipt of services.

12VAC30-141-880
12VAC30-141-880. Assignment to managed care.

A. All eligible enrollees shall be assigned in managed care through the department or the central processing unit (CPU) under contract to DMAS. FAMIS MOMS [~~recipients~~ individuals] , during the preassignment period to [~~a PCP or~~ an] MCHIP, shall receive Medicaid-like benefits via fee-for-service utilizing a FAMIS MOMS card issued by DMAS. After assignment to [~~a PCP or~~ an] MCHIP, benefits and the delivery of benefits shall be administered specific to the [~~type of~~] managed care program in which the [~~recipient~~ individual] is enrolled.

1. MCHIPs shall be offered to enrollees in [~~certain~~all] areas.

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

3. [~~In areas with multiple contracted MCHIPs or in PCCM areas without contracted MCHIPs, enrollees~~ Enrollees] shall be assigned through a random system algorithm.

~~[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.]~~

~~[5.~~ 4.] 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~~ that] serve such area. Enrollees who do not select an [~~MCHIP/PCP~~ MCHIP] as described above, shall be assigned to an [~~MCHIP/PCP~~ MCHIP] as described in subdivision 3 of this subsection.

6. Individuals assigned to an MCHIP [~~or a PCCM~~] who lose and then regain eligibility for FAMIS MOMS within 60 days will be reassigned to their previous MCHIP [~~or PCP~~].

B. Following their initial assignment to [~~a MCHIP/PCP~~ an MCHIP] , those enrollees shall be restricted to that [~~MCHIP/PCP~~ MCHIP] 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 reassignment for any reason from that [~~MCHIP/PCP~~MCHIP] to another [~~MCHIP/PCP~~ MCHIP] serving that geographic area. Such reassignment shall be effective no later than the first day of the second month after the month in which the enrollee requests reassignment.

~~[2. Reassignment is available only in areas with the PCCM program or where multiple MCHIPs exist. If multiple MCHIPs exist, enrollees may only request reassignment to another MCHIP serving that geographic area. In PCCM areas, an enrollee may only request reassignment to another PCP serving that geographic area.]~~

~~[3.~~ 2.] After the first 90 calendar days of the assignment period, the enrollee may only be reassigned from one [~~MCHIP/PCP~~MCHIP] to another [~~MCHIP/PCP~~ MCHIP] 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 reassigned. The department shall establish procedures for good cause reassignment through written policy directives.

2. DMAS shall determine whether good cause exists for reassignment.

D. Exclusion for assignment to a MCHIP. The following individuals shall be excluded from assignment to a MCHIP. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified time frame of the effective date of their MCHIP enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with the enrollee's assigned MCHIP. Exclusion requests made during the third trimester may be made by the enrollee, MCHIP, or provider. DMAS shall determine if the request meets the criteria for exclusion.