COMMONWEALTH of VIRGINIA

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MEMORANDUM

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

FROM: **USHA KODURU**
Assistant Attorney General

DATE: **August 31, 2018**

SUBJECT: **12 VAC 30-120-360 Fast-Track Regulations for Medallion 3.0 Updates (4978/8178)**

I am in receipt of the attached regulations to incorporate changes into the Code of Federal Regulations related to the Medicaid Managed Care Final Rule, as well as changes to the Medallion 3.0 contract, and the appeals process. You asked the Office of the Attorney General to review and determine if DMAS has the legal authority to amend these regulation and if the regulations comport with state and federal law.

Based on my review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to promulgate these regulations subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Pursuant to Va. Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulations serving as the Notice of Intended Regulatory Action.

If you have any questions or need additional information about this regulation, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

Action:
Medallion Updates
Stage: Fast-Track
8/10/18 6:01 PM [latest]
Part VI
Medallion Mandatory Managed Care

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:. All other words and terms used in this part shall comply with the definitions in the contract and those identified 42 CFR 438.2:

~~"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).~~

"Adverse Benefit Determination" means, consistent with 42 C.F.R. 438.400, the denial or limited authorization of a requested service; the failure to take action or timely take action on a request for service; the reduction, suspension, or termination of a previously authorized service; denial in whole or in part of a payment for a covered service; failure to provide services within the timeframes required by the state, or for a resident of a rural exception area with only one MCO, the denial of a member s request to exercise his right under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside of the network; the denial of a member s request to dispute a financial liability 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.~~

"Appeal" (member) means, in accordance with 42 C.F.R. § 438.400, a request for review, by a member, of an MCO s internal appeal decision to uphold the contractor s adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO s one step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

"Appeal" (provider) means a request for review of an MCO s reconsideration decision. For providers, an appeal may only be requested after exhaustion of the MCO s reconsideration process. Provider appeals to DMAS will be conducted in accordance with the requirements set forth in § 2.2-4000 et. seq. and 12 VAC 30-20-500 et. seq.

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

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

"Day" means calendar day unless otherwise stated.

"Disenrollment" means the process of changing enrollment from one Managed Care Organization (MCO) plan to another MCO, if applicable.

"DMAS" means the Department of Medical Assistance Services.

~~"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.~~

"Early Intervention Services" means services that are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment

(EPSDT). Early intervention services are provided in the child s natural environment to the maximum extent appropriate. EI services are distinguished from similar rehabilitative services available through EPSDT to individuals aged three and older in that EI services are specifically directed towards children from birth to age three. (Children age 3 and older are not eligible for EI 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 furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an emergency medical condition.~~

"Emergency services" means those health care services that are rendered by participating or non-participating providers, after the sudden onset of 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: Placing the client s health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; serious impairment to bodily functions; or, serious dysfunction of any bodily organ or part.

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

"Exclude" means the removal of a member from the mandatory managed care program on a temporary or permanent basis.

"External quality review organization" or "EQRO" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality reviews, other external quality review related activities as set forth in 42 CFR 438.358, or both.

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

"Grievance" means, in accordance with 42 C.F.R. § 438.400, an expression of dissatisfaction about any matter other than an "adverse benefit determination". (Possible subjects for grievances include, but are not limited to: the quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member s rights.)

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

"Individual" or "individuals" means a person or persons who are eligible for Medicaid, who are not yet undergoing enrollment for mandatory managed care, and who are not enrolled in a mandatory managed care organization.

"Internal appeal" means a request to the MCO by a member, a member s authorized representative or provider, acting on behalf of the member and with the member s written consent, for review of a Contractor s adverse benefit determination, as defined in 42 CFR 438.400. The internal appeal is the only level of appeal with the MCO and must be exhausted by a member or deemed exhausted according to 42 CFR § 438.408(c)(3) before the member may initiate a state fair hearing with DMAS.

~~"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 mandatory managed care program. Covered services for mandatory managed care program individuals shall be as accessible (in terms of timeliness, amount, duration, and scope) as compared to other Medicaid individuals served within the geographic area.~~

"Managed care organization" or "MCO" means an organization which offers managed care health insurance plans (MCHIP), as defined by Code of Virginia § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) 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. Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in Va. Code § 38.2-3407 or preferred provider subscription contracts as defined in Va. Code § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, and in accordance with 42 C.F.R. § 438.2, an MCO means an entity that has qualified to provide the services covered in the Medallion program to qualifying Medallion members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served, and meets the solvency standards of 42 C.F.R. § 438.116.

~~"Member" or "members" means people who have current Medicaid eligibility who are also enrolled in mandatory managed care.~~

"Member" or "members" means a person eligible for Medicaid or FAMIS who has been assigned to a Medicaid MCO.

"Network providers" means doctors, hospitals or other health care providers who participate or contract with an MCO contractor 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.

"PCP of record" means a primary care physician of record with whom the recipient has an established history and such history is documented in the individual's records.

"Reconsideration" means a provider s request to the MCO for review of an adverse benefit determination. The MCO s reconsideration decision is a pre-requisite to a provider s filing of an appeal, as provided for in 12VAC30-20-500 through 12VAC30-20-560, to DMAS Appeals Division.

"Retractions" means the departure of an enrolled managed care organization from any one or more localities as provided for in 12VAC30-120-370.

"Rural exception" means a rural area designated in the § 1915(b) managed care waiver, pursuant to § 1932(a)(3)(B) of the Social Security Act and 42 CFR § 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying mandatory managed care members are mandated to enroll in the one available contracted MCO.

"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. Medallion ~~Mandatory~~ mandatory managed care members.

A. DMAS shall determine enrollment in mandatory managed care. ~~Medicaid eligible persons not meeting the exclusion criteria set out in this section shall participate in the mandatory managed care program. Enrollment in mandatory managed care shall not be a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program.~~

1. Medicaid eligible persons not meeting the exclusion criteria set out in subsection B shall participate in the mandatory managed care program. Enrollment in mandatory managed care shall not be a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program.

~~1.~~ 2. DMAS reserves the right to exclude from participation in the mandatory managed care program any 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. Members excluded from mandatory managed care through this provision may appeal the decision to DMAS.

~~2. Qualifying individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver pursuant to Part IX (12VAC30-120-900 et seq.) of this chapter who do not meet any exclusions in subsection B of this section shall be required to enroll in managed care and shall receive all acute care services through the mandatory managed care delivery system. For these individuals, services provided under 12VAC30-120-380 A 2 shall continue to be provided through the DMAS fee-for-service system.~~

B. The following individuals shall be excluded (as defined in 12VAC30-120-360) from participating in Medallion mandatory managed care as defined in the § 1915(b) managed care waiver. Individuals excluded from Medallion mandatory managed care shall include the following:

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 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 (except eligible EDCD members)~~;

5. ~~Individuals~~ Prior to April 1, 2019, individuals under age 21 who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860;

~~6. 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 (i.e., physician, hospital, or midwife) does not participate with the member's assigned MCO. Exclusion requests made during the third trimester may be made by the 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;~~

~~7.~~ 6. 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;

~~8.~~ 7. Individuals who receive hospice services in accordance with DMAS criteria;

9. 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);

~~10.~~ 8. 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 members admitted to the hospital while already enrolled in a department-contracted MCO;

~~11.~~ 9. Individuals who request exclusion during assignment 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 individual's physician must certify the life expectancy;

~~12. Certain individuals between birth and age three certified by the Department of Behavioral Health and Developmental 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 managed care enrollment;~~

~~13.~~ 10. Individuals who have an eligibility period that is less than three months;

~~14. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program;~~

~~15.~~ 11. Individuals who have an eligibility period that is only retroactive; and

~~16.~~ 12. 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. Members enrolled with a MCO who subsequently meet one or more of the criteria of subsection 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 participants in the federal long-term care waiver programs, as otherwise defined elsewhere in this chapter, for home-based and community-based Medicaid coverage (IFDDS, ID, EDCD, Day Support, or Alzheimer's, or as may be amended from time to time). These 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 individuals no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.~~

D. Individuals who are enrolled in localities that qualify for the rural exception may meet exclusion criteria if their PCP of record, as defined in 12VAC30-120-360, cannot or will not participate with the one MCO in the locality. Individual requests to be excluded from MCO participation in localities meeting the qualification for the rural exception must be made to DMAS for consideration on a case-by-case basis. Members enrolled in MCO rural exception areas shall not have open enrollment periods and shall not be afforded the 90-day window after initial enrollment during which they may make a health plan or program change.

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

E. ~~Mandatory~~ Medallion mandatory managed care plans shall be offered to individuals, and individuals shall be enrolled in those plans. , ~~exclusively through an~~ DMAS has sole responsibility for determining enrollment in the contractor s plan. DMAS utilizes an independent enrollment broker under contract to DMAS to assist members with making plan choices after initial preassignment and during open enrollment.

F. Members shall be enrolled as follows:

1. All eligible individuals, except those meeting one of the exclusions of subsection B of this section, shall be enrolled in mandatory managed care.

2. 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 an assigned MCO, determined as provided in subsection F of this section, in which the member will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days. 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 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 a member of that same MCO for the newborn enrollment period.

a. This requirement does not preclude the member, once he is assigned a Medicaid identification number, from disenrolling from one MCO to enrolling with another in accordance with subdivision H 1 of this section.

b. 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. Newborns who remain eligible for participation in mandatory managed care will be reenrolled in an MCO through the assignment process upon receiving a Medicaid identification number.

c. Any newborn whose mother is enrolled in an MCO at the time of birth shall receive a Medicaid identification number prior to the end of the newborn enrollment period in order to maintain the newborn's enrollment in an MCO.

5. Individuals who lose then regain eligibility for mandatory managed care within 60 days will be reenrolled into their previous MCO without going through assignment and selection.

G. Individuals who do not select an MCO as described in subdivision F 3 of this section shall be assigned to an MCO as follows:

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

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

3. Individuals who live in rural exception areas as defined in 12VAC30-120-360 shall enroll with the one available MCO. These individuals shall receive an assignment notification for enrollment into the MCO. Individuals in rural exception areas who are assigned to the one MCO may request exclusion from MCO participation if their PCP of record, as defined in 12VAC30-120-360, cannot or will not participate with the one MCO in the locality. Individual requests to be excluded from MCO participation in rural exception localities must be made to DMAS for consideration on a case-by-case basis.

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

5. All eligible members are automatically assigned to a contracted MCO in their localities. Members are allowed 90 days after the effective date of ~~new or~~ initial enrollment to change to another MCO that participates in the geographic area where the member lives. Members residing in localities qualifying for a rural exception shall not be afforded the 90-day window after initial enrollment during which they may make a health plan or program change.

6. 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, retractions, or changes to member populations, geographical areas, procurements, or any or all of these; such alternate strategy shall comply with federal waiver requirements.

H. Following their initial enrollment into an MCO, members shall be restricted to the MCO 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~~ an initial MCO, a member may disenroll from that MCO to enroll into another MCO for any reason. Such disenrollment shall be effective no later than the first day of the second month after the month in which the member requests disenrollment.

2. During the remainder of the enrollment period, the member may only disenroll from one MCO into another MCO upon determination by DMAS that good cause exists as determined under subsection J of this section.

I. The department shall conduct an annual open enrollment for all mandatory managed care members with the exception of those members who live in a designated rural exception area. 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 member of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. Enrollment selections will be effective on the first day of the next month following the open enrollment period. Members who do not make a choice during the open enrollment period will remain with their current MCO selection.

J. Disenrollment for cause may be requested at any time~~.~~ and the disenrollment reasons shall be in accordance with 42 CFR 438.56 (d)(2)(v):

1. ~~After the first 90 days of enrollment in an MCO, members may request disenrollment from DMAS based on cause.~~ The request may be made orally or in writing to DMAS and shall cite the reason or reasons why the member wishes to disenroll. Cause for disenrollment shall be in accordance with 42 CFR 438.56(d)(2), which ~~include~~ includes the following reasons:

a. A member's desire to seek services from a federally qualified health center that is not under contract with the member's current MCO, and the member requests a change to another MCO that subcontracts with the desired federally qualified health center;

b. Performance or nonperformance of service to the member by an MCO or one or more of its networkproviders 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;

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

d. A member has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted MCO;

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

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

g. The member needs related services to be performed at the same time; not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the 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 member 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 member in accordance with the department's client appeals process at 12VAC30-110-10 through 12VAC30-110-370.

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

6. 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 excluded from Medallion as determined appropriate by DMAS~~, with the exception of those who subsequently become individuals participating in the IFDDS, ID, EDCD, Day Support, or Alzheimer's federal waiver programs for home-based and community-based Medicaid coverage. These 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~~.

K. In accordance with 42 C.F.R.§§ 438.3(q)(5) and 438.56 (c)(2), a member has the right to disenroll from the Contractor s plan without cause at the following times:

1. During the 90 days following the date of the member s initial enrollment into the MCO or during the 90 days following the date DMAS sends the member notice of that enrollment, whichever is later.

2. At least once every twelve (12) months thereafter.

3. Upon automatic reenrollment under subsection G of this section, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.

4. When DMAS imposes the intermediate sanction specified in 42 CFR 438.702(a)(4).

12VAC30-120-380. Medallion MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written ~~DMAS~~ Federal and state regulations, the Medallion contract, policies and instructions, except as otherwise modified or excluded in this part.

1. Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the hospital emergency departments.

2. Services that shall be provided outside the MCO network shall include, but are not limited to, those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include dental and orthodontic services for children up to age 21; for all others, dental services (as described in 12VAC30-50-190) and school health services~~, community mental health services (12VAC30-50-130 and 12VAC30-50-226); early intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 (as defined in 12VAC30-50-131 and 12VAC30-50-415); and long-term care services provided under the § 1915(c) home-based and community-based waivers including related transportation to such authorized waiver services~~.

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

B. EPSDT services shall be covered by the MCO and defined by the contract between DMAS and the MCO. The MCO shall have the authority to determine the provider of service for EPSDT screenings.

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

D. Documentation requirements.

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

2. Each MCO shall ~~have written policies regarding member rights and shall comply with any applicable federal and state laws that pertain to member rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to members in accordance with 42 CFR 438.100.~~ comply with the enrollee rights and protections stipulated in the contract and as identified in 42 CFR 438 Subpart C.

E. The MCO shall comply with the contract and 42 CFR 438 Subparts E, and H to ensure that the health care provided to its members meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

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

G. The MCOs shall meet the standards specified in 42 CFR 438, Subpart D by DMAS for sufficiency of provider networks as specified in the contract between the Commonwealth and the MCO.

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

I. In accordance with 42 CFR 447.50 through ~~42 CFR 447.60~~ 42 CFR 447.90, MCOs shall not impose any cost sharing obligations on members except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his patient in accordance with 42 CFR 438.102.

K. An MCO that would otherwise be required to reimburse for or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR 438.102.

12VAC30-120-390. Payment rate for MCOs.

The payment rate to MCOs that participate in the mandatory managed care program shall be set by negotiated contracts and in accordance with ~~42 CFR 438.6~~ 42 CFR 438.4 42 CFR 438.8 and other pertinent federal regulations.

12VAC30-120-395. Preauthorized and emergency and post-stabilization services and ~~Payment~~payment rate for ~~preauthorized or emergency~~ care provided by out-of-network providers.

The MCOs shall pay for ~~preauthorized or emergency services when provided outside the MCO network~~ preauthorized, and emergency, and post stabilization services to members in compliance with the contract and 42 CFR 438.114. Preauthorized, and emergency and post stabilization ~~or emergency~~ services provided to a managed care member by a provider or facility not participating in the MCO's network will be reimbursed according to the current Medicaid fee schedule. This reimbursement shall be considered payment in full to the provider or facility of emergency services.

12VAC30-120-400. Quality control and utilization review.

A. DMAS shall rigorously monitor the quality of care provided by the MCOs. DMAS ~~may contract with one or more external quality review organizations to perform focused studies on the quality of care provided by the MCOs. The external organizations may utilize data or other tools to ensure contract compliance and quality improvement activities. Specifically,~~ and its MCOs shall comply with the contract and 42 CFR Subpart 438 E, entitled Quality Measurement and Improvement: External Quality Review and the MCO standards identified in 42 CFR 438 Subpart D, entitled MCO, PIHP, and PAHP Standards. DMAS shall monitor the MCOs to determine ~~if the MCO:~~ their compliance with the contract and 42 CFR Subpart A and all other relevant sections of 42 CFR Part 438 Managed Care as follows:

1. If the MCO ~~Fails~~ fails substantially to provide the medically necessary items and services required under law or under the contract to be provided to an enrolled recipient and the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual.

2. If the MCO ~~Engages~~ engages in any practice that discriminates against individuals on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, or any practice that could reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by § 1903(m) of the Social Security Act (42 USC § 1396b(m))) by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services.

3. If the MCO ~~Misrepresents~~ misrepresents or falsifies information that it furnishes, under § 1903(m) of the Social Security Act (42 USC § 1396b(m)) to CMS, DMAS, an individual, or any other entity.

4. If the MCO ~~Fails~~ fails to comply with the requirements of 42 CFR 417.479(d) through (g) relating to physician incentive plans, or fails to submit to DMAS its physician incentive plans as required or requested in 42 CFR 434.70.

5. If the MCO ~~Imposes~~ imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

B. DMAS shall ensure that data on performance and patient results are collected.

C. DMAS shall ensure that quality outcomes information is provided to MCOs. DMAS shall ensure that changes which are determined to be needed as a result of quality control or utilization review are made.

12VAC30-120-410. Sanctions.

A. If DMAS determines that an MCO is not in compliance with applicable state or federal laws, regulations (including but not limited to the requirements of or pursuant to Section 1932(e)(1) of the Social Security Act ("the Act"), ~~12VAC30-120-380 E~~ 12VAC30-120-380 or 42 CFR 438, Subpart I), or the MCO contract, DMAS may impose sanctions on the MCO pursuant to Section 1932(e) of the Act and 12VAC30-120-410. The sanctions may include, but are not limited to:

1. Limiting enrollments in the MCO by freezing voluntary member enrollments;

2. Freezing DMAS assignment of members to the MCO;

3. Limiting MCO enrollment to specific areas;

4. Denying, withholding, or retracting payments to the MCO;

5. Terminating the MCO's contract as provided in Section 1932(e)(4) of the Act;

~~6. Intermediate sanctions including, but not limited to, the maximum civil money penalties specified in 42 CFR Part 438, Subpart I, for the violations set forth therein, or in accordance therewith; and~~

~~7.~~ 6. Civil monetary penalties as specified in 42 CFR 438.704.~~;~~ and

7. Appointment of temporary management for an MCO as provided in 42 CFR 438.706.

B. In the case of an MCO that has repeatedly failed to meet the requirements of §§ 1903(m) and ~~1932~~1932(e) of the Social Security Act, DMAS shall, regardless of what other sanctions are imposed, impose the following sanctions:

1. Appoint a temporary manager to:

a. Oversee the operation of the Medicaid managed care organization upon a finding by DMAS that there is continued egregious behavior by the organization or there is a substantial risk to the health of members; or

b. Assure the health of the organization's members if there is a need for temporary management while (i) there is an orderly termination or reorganization of the organization or (ii) improvements are made to remedy the violations found under subsection A of this section. Temporary management under this subdivision may not be terminated until DMAS has determined that the MCO has the capability to ensure that the violations shall not recur.

2. Permit members who are enrolled with the MCO to disenroll without cause. If this sanction is imposed, DMAS shall be responsible for notifying such members of the right to disenroll.

C. Prior to terminating a contract as permitted under ~~subdivision A 5 of this section~~, Section 1932(e)(4) of the Act, DMAS shall provide the MCO with a hearing. DMAS shall not provide an MCO with a ~~pretermination~~ pre-determination hearing before the appointment of a temporary manager under subdivision B 1 of this section.

D. Prior to imposing any sanction other than termination of the MCO's contract, DMAS shall provide the MCO with notice, develop procedures with which the MCO must comply to eliminate specific sanctions, and provide such other due process protections as the Commonwealth may provide.

~~E. In accordance with the terms of the contract, MCOs shall have the right to appeal any adverse action taken by DMAS. For appeal procedures not addressed by the contract, the MCO shall proceed in accordance with the appeals provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq. of the Code of Virginia). Pursuant to §§ 2.2-4364 and 2.2-4365 of the Code of Virginia, DMAS shall establish an administrative appeals procedure through which the MCO may elect to appeal decisions on disputes arising during the performance of its contract. Pursuant to § 2.2-4365 of the Code of Virginia, such appeal shall be heard by a hearing officer; however, in no event shall the hearing officer be an employee of DMAS. In conducting the administrative appeal, the hearing officer shall follow the hearing procedure used in § 2.2-4020 of the Code of Virginia.~~

~~F. When DMAS determines that an MCO committed one of the violations specified in 12VAC30-120-400 A, DMAS shall implement the provisions of 42 CFR 434.67.~~

~~1. Any sanction imposed pursuant to this subsection shall be binding upon the MCO.~~

~~2. The MCO shall have the appeals rights for any sanction imposed pursuant to this subsection as specified in 42 CFR 434.67.~~

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

A. The MCOs shall, ~~whenever a member's request for covered services is reduced, denied or terminated, or payment for services is denied, provide a written notice in accordance with the notice provisions specified in 42 CFR 438.404 and 42 CFR 438.210(c), as defined by~~ comply with the Grievance and Appeal System as identified in 42 CFR 438 Subpart F and the Enrollee Rights and Protections requirements in 42 CFR Subpart C, and the Medallion contract between DMAS and the MCO, and any other applicable state or federal statutory or regulatory requirements.

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

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

1. The member, provider, or representative acting on behalf of the member with the member's written consent may file an oral or written grievance or internal appeal with the MCO. The MCO must accept grievances ~~or~~ filed at any time. Internal ~~appeals~~ appeal requests must be submitted within ~~30~~ 60 days from the date of the notice of adverse ~~action~~ benefit determination. Oral requests for internal appeals must be followed up in writing ~~within 10 business days~~ by the member, provider, or the representative acting on behalf of the member with the member's consent, unless the request is for an expedited internal appeal. ~~The member may also file a written request for a standard or expedited appeal with the DMAS Appeals Division within 30 days of the member's receipt of the notice of adverse action, in accordance with 42 CFR 431, Subpart E; 42 CFR Part 438, Subpart F; and 12VAC30-110-10 through 12VAC30-110-370.~~

2. The member must exhaust the MCO s internal appeals process before appealing to DMAS Appeals Division. The member may also file a written request for a standard or expedited internal appeal of the MCO s adverse benefit determination with the DMAS Appeals Division within 120 days of the member s receipt of the MCO s internal appeal decision, in accordance with 42 CFR 431, Subpart E; 42 CFR Part 438, Subpart F; and 12VAC30-110-10 through 12VAC30-110-370.

~~2.~~ 3. As specified in 12VAC30-110-100, pending the resolution of a grievance, internal appeal, or appeal filed by a member or his representative (including a provider acting on behalf of the member), prior to the effective date of the adverse benefit determination, coverage shall not be terminated or reduced for the member for any reason ~~which~~ that is the subject of the grievance or appeal.

~~3.~~ 4. The MCO shall ensure that ~~the employees or agents who make decisions on MCO grievances and appeals were not involved in any previous level of review or decision making, and~~ neither the individuals nor agents, nor a subordinate of any such individual, who makes decisions on grievances were involved in any previous level of review or decision making. Additionally, where the reason for the grievance or appeal involves clinical issues, relates to a denial ~~or~~ of a request for an expedited appeal, or where the appeal is based on a lack of medical necessity, shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease.

5. The MCO shall provide the member and any representative a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments in accordance with 42 CFR 438.406(b)(4). The MCO shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals in accordance with 42 CFR 438.406(b)(4).

6. The MCO shall provide the member and any representative the member s case file, including medical records, and any new or additional evidence considered, relied upon, or generated by the MCO in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals in accordance with 42 CFR 438.406(b)(5).

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

E. The MCO shall maintain a recordkeeping, reporting, and tracking system for complaints, grievances, and appeals that ~~includes~~ complies with the Medallion contract between DMAS and the MCO. The system shall include a copy of the original complaint, grievance, or appeal; the decision; ~~and~~ the nature of the decision; and data on the number of internal appeals filed, the average time to resolve internal appeals, and the total number of internal appeals open as of the reporting date. This system shall distinguish Medicaid from commercial members, if the MCO does not have a separate system for Medicaid members.

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

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

~~2. Members have the right to appeal directly to DMAS; and~~

2. Members have the right to request an expedited internal appeal;

3. Members shall exhaust their appeals with the MCO before being given the right to appeal to DMAS; and

~~3.~~ 4. The MCO shall promptly provide grievance or appeal forms, reasonable assistance and written procedures to members who wish to register written grievances or appeals, including auxiliary aids and services upon request such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

G. The MCO shall issue ~~grievance/appeal~~ grievance or internal appeal decisions as defined by 42 CFR 438.408 and the contract between DMAS and the MCO. Oral grievance decisions are not required to be in writing.

H. The MCO shall issue standard internal appeal decisions within 30 days from the date of initial receipt of the internal appeal in accordance with 42 CFR 438.408 and as defined by the Medallioncontract between DMAS and the MCO. This timeframe may be extended by up to 14 days under the requirements of 42 CFR 438.408. The internal appeal decision shall be in writing and shall include, but shall not be limited to, the following:

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

2. The reasons for the decision;

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

4. ~~A clear explanation of further appeal rights and a timeframe for filing an appeal; and~~ For appeals not resolved wholly in favor of the member:

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

b. the right to continue to receive benefits in accordance with 42 CFR 438.420 pending a hearing, and how to request continuation of benefits.

c. The member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor s adverse benefit determination.

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

I. An expedited appeal decision shall be issued as expeditiously as the member's condition requires and within ~~three business days~~ 72 hours from receipt of the internal appeal request in cases of medical emergencies in which delay could result in death or serious injury to a member. Extensions to these timeframes shall be allowed in accordance with 42 CFR 438.408 and as defined by the contract between DMAS and the MCO. Written confirmation of the decision shall promptly follow the verbal notice of the expedited decision.

J. If the MCO fails to adhere to the internal appeals notice and timing requirements of this section, the member is deemed to have exhausted the MCO s appeals process and may file an appeal with DMAS.

~~J.~~ K. Any adverse benefit determination upheld in whole or in part by the internal appeal decision issued by the MCO may be appealed by the member to DMAS in accordance with the department's Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-370. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-370 and shall not base any appealed decision on the record established by any internalappeal decision of the MCO. The MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the MCO.

~~K.~~ L. The MCO shall provide information necessary for any DMAS appeal within timeframes established by DMAS.

12VAC30-120-430 ~~to 12VAC30-120-440. [Reserved]~~ Provider grievances, reconsiderations, and appeals.

A. The MCOs shall comply with the requirements of the Administrative Process Act, Virginia Code §§2.2-4000 et seq., the Provider Appeals regulations, 12VAC30-20-500 through 12VAC30-20-560, the Medallion contract between DMAS and the MCO, and any other applicable State or Federal statutory or regulatory requirements.

B. The MCOs shall have a grievance system established to respond to grievances made by network providers. Network provider grievances are not appealable to the DMAS Appeals Division.

C. MCOs shall, at the initiation of new network provider contracts, provide to every network provider the information described in this section concerning grievance/appeal rights and procedures.

D. Disputes between the MCO and the network provider concerning any aspect of reimbursement shall be resolved through a verbal or written grievance/reconsideration process operated by the MCO or through the DMAS appeals process. A network provider, or representative that is authorized by the network provider, may act on behalf of a network provider in the MCO grievance/reconsideration or the DMAS appeals process.

E. Disputes arising solely from the MCO s denial or termination of a provider s enrollment in the MCO s network are not appealable to the DMAS Appeals Division.

F. If a network provider has rendered services to a member and has either been denied authorization/reimbursement for the services or has received reduced authorization/ reimbursement, that provider may request a reconsideration of the denied or reduced authorization/ reimbursement. Before appealing to DMAS, network providers must first exhaust all MCO reconsideration processes. The MCO s final denial letter must include a statement that the provider has exhausted its internal appeal rights with the MCO and that the next level of appeal is with DMAS. The final denial letter must include the appeal rights to DMAS in accordance with the Provider Appeals regulations 12VAC30-20-500 through 12VAC30-20-560.

G. All network provider appeals to DMAS must be submitted to the DMAS Appeals Division in writing and within thirty (30) days of the MCO s last date of denial.

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

I. The MCO shall comply with the DMAS appeal decision. A DMAS appeal decision is not appealable by the MCO.

J. The MCO shall maintain a recordkeeping, reporting, and tracking system for complaints, grievances, and reconsiderations that complies with the Medallion contract between DMAS and the MCO. The system shall include, but shall not limited to, a copy of the original complaint, grievance, or reconsideration; the decision; the nature of the decision; and data on the number of reconsiderations filed, the average time to resolve reconsiderations, and the total number of reconsiderations open as of the reporting date.