COMMONWEALTH of VIRGINIA

Office of the Attorney General

William C. Mims
Attorney General

900 East Main Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120
7-1-1

MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory and Manual Section Manager
Department of Medical Assistance Services

FROM: **ELIZABETH A. MCDONALD**
Special Counsel to DMAS

DATE: **October 19, 2009**

SUBJECT: **Emergency Regulations Regarding Medallion II Rural Exception**

I have reviewed the attached emergency regulations that would add an exception to the Medallion II program in rural areas where there is only one contracted MCO.

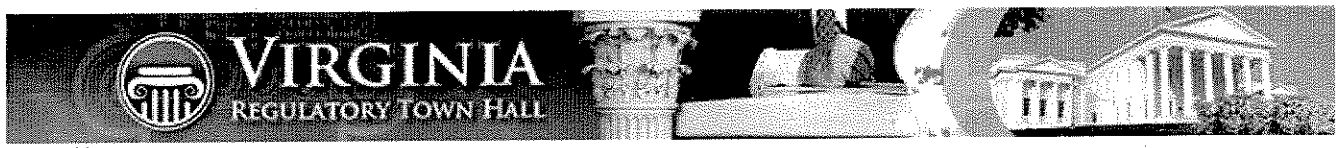
Based on that review, it is this Office's view that the Director of the Department of Medical Assistance Services ("DMAS"), acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and has not exceeded that authority.

The authority for this emergency action is found in Virginia Code § 2.2-4011, which provides that an "emergency situation" is a "situation in which Virginia statutory law, the Virginia appropriations act, or federal law requires that a regulation shall be effective in 280 days or less from its enactment..." The amendments to the regulations will enable the Director, in lieu of the Board of Medical Assistance Services, to comply with the *Acts of Assembly* Chapter 781, Item 306(M)(1) and (M)(2).

Accordingly, with the prior approval of the Governor, these regulations will qualify for the "emergency" exemption from Article 2 requirements. Please be advised, however, that under Virginia Code §2.2-4011(A), the Department must state in writing the nature of and necessity for such emergency actions, and this appears to have been accomplished in the "Agency Background Document." In addition, the regulations shall be effective for no more than 12 months. If the Department intends to continue regulating the subject matter governed by this emergency regulation beyond 12 months, it will be necessary to replace these emergency regulations with regulations duly promulgated under Article 2 of the APA. A Notice of Intended Regulatory Action relating to the proposed replacement regulations must be filed with the Register within 60 days of the effective date of the emergency regulations. The proposed regulations must be filed with the Register within 180 days after the effective date of the emergency regulations.

If you have any questions or need any additional information, please feel free to contact me at 786-7363.

cc: Kim F. Piner
Senior Assistant Attorney General



Logged in: eam

Emergency Text

Action: MCO Rural Exception

Stage: Emergency 10/16/09 4:58 PM [latest]

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 address in the Medicaid eligibility file.

"Capitation payment" means a payment the department makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular recipient 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.

"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 in the contractor's plan and is responsible for the operation and documentation of a toll-free recipient service helpline. The responsibilities of the enrollment broker include, but shall not be limited to, recipient education and MCO enrollment, assistance with and tracking of recipients' complaints resolutions, and may include recipient 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.

"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 served within the area.

"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.

"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 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.

"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.

"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 Medallion II enrollees are mandated to enroll in the one available contracted MCO."

"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. Medallion II enrollees.

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

B. The following individuals shall be excluded (as defined in 12VAC30-120-360) from participating in Medallion II as defined in the 1915(b) managed care waiver ~~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~~. Individuals excluded from Medallion II 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 the mentally retarded;

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~~ enrollee'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, 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 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~~ 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 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 enrolled with a MCO who subsequently meet one or more of the aforementioned criteria during MCO enrollment shall be excluded from MCO participation as determined by DMAS, with the exception of those who subsequently become recipients 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~~ Alzheimer's 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 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 herein defined, can not 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. Recipients 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.

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

~~E.~~ F. Clients shall be enrolled as follows:

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

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

3. Once individuals are enrolled in Medicaid, they will receive a letter indicating that they may select one of the contracted MCOs. These letters shall indicate a preassigned MCO, determined as provided in subsection F of this section, in which the client will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days. Recipients 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 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 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, 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 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.~~ G. Clients who do not select an MCO as described in subdivision ~~E 3~~ F 3 of this section shall be assigned to an MCO as follows:

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

with a contracted MCO.

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

3. Clients who live in rural exception areas as defined in 12VAC30-120-360 must enroll with the one available MCO. These recipients shall receive a pre-assignment notification for enrollment into the MCO.

~~3.~~ 4. All other clients shall be assigned to an MCO on a basis of approximately equal number by MCO in each locality.

~~4.~~ 5. In areas where there is only one contracted MCO or contracted PCCM program, recipients have a choice of enrolling with the contracted MCO or the PCCM program. All eligible recipients in these areas ~~where one contracted MCO exists, however~~, are automatically assigned to the contracted MCO. Individuals, with the exception of those residing in localities qualifying for the rural exception, 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.

~~5.~~ 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 ~~new~~ client populations, ~~new~~ geographical areas, ~~expansion through procurement~~ procurements, or any or all of these; such alternate strategy shall comply with federal waiver requirements .

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

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

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

~~H.~~ I. The department shall conduct an annual open enrollment for all Medallion II participants with the exception of those clients 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 recipient of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. In areas with only one contracted MCO and where the PCCM program is available, recipients will be given the opportunity to select either the MCO or the PCCM program. Enrollment selections will be effective on the first day of the next month following the open enrollment period. Recipients who do not make a choice during the open enrollment period will remain with their current MCO selection.

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

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

a. A recipient's desire to seek services from a federally qualified health center which is not under contract with the recipient's current MCO, and the recipient (i)

requests a change to another MCO that subcontracts with the desired federally qualified health center or (ii) requests a change to the PCCM, if the federally qualified health center is contracting directly with DMAS as a PCCM;

b. Performance or nonperformance of service to the recipient by an MCO or one or more of its providers which is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care;

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

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

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

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

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

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

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

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

4. The DMAS determination concerning cause for disenrollment may be appealed by the client in accordance with the department's client appeals process at 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 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~~ excluded as appropriate by DMAS, with the exception of those who subsequently become recipients into the AIDS, IFDDS, MR, EDCD, Day Support, or Alzheimer's federal waiver programs for home-based and community-based Medicaid coverage. 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 no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.~~

12VAC30-120-380. Medallion II 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 regulations, 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 emergency departments.

2. Services that shall be provided outside the MCO network shall include those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include, but shall not be limited to, dental and orthodontic services for children up to age 21; for all others, dental services (as described in 12VAC30-50-190), school health services (as defined in 12VAC30-120-360), community mental health services (rehabilitative, targeted case management and substance abuse services) and long-term care services provided under the § 1915(c) home-based and community-based waivers including related transportation to such authorized waiver services. Services that may be provided outside the MCO network shall be defined by the contract between DMAS and the MCO.

3. The MCOs shall pay for emergency services and family planning services and supplies whether they 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 clients, 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. 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 enrollee rights and shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees in accordance with 42 CFR 438.100.

E. The MCO shall ensure that the health care provided to its clients 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 state and the contractor. 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 must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor.

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 enrollee'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, MCOs shall not impose any cost sharing obligations on enrollees 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 an enrollee 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.