COMMONWEALTH of VIRGINIA
Office of the Attorney General

Mark R. Herring
Attorney General

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

MEMORANDUM

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

FROM: **USHA KODURU** UK
Assistant Attorney General

DATE: **February 23, 2021**

SUBJECT: **12VAC30-135-400 through 498-Repeal of GAP-SMI Regulations (5657/9146)**

I am in receipt of the attached action to repeal regulations addressing the Governor's Access Plan (GAP) to provide low income individuals with a serious mental illness (SMI) access to medical and behavioral health care. The majority of enrolled individuals were included in the expansions of Medicaid and the remaining individuals who were not eligible were transitioned to community services boards for continuing care. You asked the Office of the Attorney General to review and determine if DMAS has the legal authority to repeal these regulations and if it ccomports 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 repeal these regulations subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority. This action the State Plan and approval by the Centers for Medicare and Medicaid Services must be granted.

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 regulation serving as the Notice of Intended Regulatory Action.

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

cc: Kim F. Piner, Esquire

Attachment

Proposed Text

12VAC30-120-9998 ~~FORMS (12VAC30-120).~~ (Repealed.)
~~Virginia Uniform Assessment Instrument (UAI) (1994)~~

~~Consent to Exchange Information, DMAS-20 (rev. 4/2003)~~

~~Provider Aide Record (Personal/Respite Care), DMAS-90 (rev. 6/2012)~~

~~LPN Skilled Respite Record, DMAS-90A (eff. 7/2005)~~

~~Personal Assistant/Companion Timesheet, DMAS-91 (rev. 8/2003)~~

~~Questionnaire to Assess an Applicant's Ability to Independently Manage Consumer-Directed Services, DMAS-95 Addendum (rev. 8/2005)~~

~~Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 8/2012)~~

~~Individual Choice - Institutional Care or Waiver Services Form, DMAS-97 (rev. 8/2012)~~

~~Agency or Consumer Direction Provider Plan of Care, DMAS-97A/B (rev. 3/2010)~~

~~Community-Based Care Recipient Assessment Report, DMAS-99 (rev. 9/2009)~~

~~Community-Based Care Level of Care Review Instrument, DMAS-99LOC (undated)~~

~~Medicaid LTC Communication Form, DMAS-225 (rev.10/2011)~~

~~Technology Assisted Waiver Provider RN Initial Home Assessment, DMAS-116 (11/2010)~~

~~Technology Assisted Waiver/EPSDT Nursing Services Provider Skills Checklist for Individuals Caring for Tracheostomized and/or Ventilator Assisted Children and Adults, DMAS-259 (undated)~~

~~Home Health Certification and Plan of Care, CMS-485 (rev. 2/1994)~~

~~IFDDS Waiver Level of Care Eligibility Form (eff. 5/2007)~~

~~Request for Screening for Individual and Family Developmental Disabilities Support Waiver (DD Waiver), DMAS 305 (rev. 3/2009)~~

~~DD Medicaid Waiver - Level of Functioning Survey Summary Sheet, DMAS-458 (undated)~~

~~Technology Assisted Waiver Adult Aide Plan of Care, DMAS 97 T (rev. 6/2008)~~

~~Technology Assisted Waiver Supervisory Monthly Summary, DMAS 103 (rev. 4/2008)~~

~~Technology Assisted Waiver Adult Referral, DMAS-108 (rev. 1/2017)~~

~~Technology Assisted Waiver Pediatric Referral, DMAS-109 (rev. 1/2017)~~

12VAC30-120-9999 ~~DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-120).~~ (Repealed.)
~~Intellectual Disability: Definition, Classification, and Systems of Supports, 11th edition, 2010, American Association on Intellectual and Developmental Disabilities, 501 3rd Street, NW, Suite 200, Washington, DC 20001-2760~~

~~Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), 2000, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, Virginia 22209~~

~~Diagnostic and Statistical Manual of Mental Disorders (DSM-5®), Fifth Edition, copyright 2013, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, Virginia 22209, http:/www.psychiatry.org/dsm5~~

~~Underwriter's Laboratories Safety Standard 1635, Standard for Digital Alarm Communicator System Units, Third Edition, January 31, 1996, with revisions through August 15, 2005~~

Underwriter's Laboratories Safety Standard 1637, Standard for Home Health Care Signaling Equipment, Fourth Edition, December 29, 2006

MR/ID Waiver Slot Assignment Process, August 20, 2010, Department of Behavioral Health and Developmental Services

Virginia Medicaid Provider Manual

Chapter I: General Information (rev. 12/1/2011)

Chapter II: Provider Participation Requirements (rev. 2/8/2012)

Chapter III: Recipient Eligibility (rev. 12/1/2011)

Chapter IV: Covered Services and Limitations (rev. 7/14/2010)

Chapter V: Billing Instructions (rev. 1/26/2011)

Chapter VI: Quality Management Review (rev. 7/14/2010)

Chapter VII: Day Support Waiver (rev. 7/14/2010)

12VAC30-135-400 Definitions. (Repealed.)

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

"Action" means an action by DMAS, Cover Virginia, the service authorization contractor, or the BHSA that constitutes (i) a denial in whole or in part of payment of a covered service; or (ii) a termination or denial of eligibility or services or limited authorization of a service authorization request including (a) type or level of service; (b) reduction, suspension, or termination of a previously authorized service; (c) failure to act on a service request; (d) denial in whole or in part of coverage for a service; or (e) failure by Cover Virginia, the service authorization contractor, or the BHSA to render a decision within the required timeframes.

"Agency" means DMAS.

"Alternative home care" means mental health services more intensive than outpatient services provided (i) in the individual's home or (ii) in a therapeutic living setting that provides intensive mental health services such as residential crisis stabilization if the individual is temporarily (less than two weeks) placed in that setting.

"Appellant" means an applicant for or recipient of GAP benefits who seeks to challenge an action regarding eligibility, services, or coverage determinations.

"Behavioral health" means mental health and substance use disorder services.

"BHSA" means the same as defined in 12VAC30-50-226.

"Care coordination" means the collaboration and sharing of information among health care providers who are involved with an individual's health care to (i) improve the health and wellness of an individual with complex and special care needs and (ii) integrate services around the needs of such individual at the local level by working collaboratively with all partners, including the individual, his family, and providers.

"Care coordinator" means an individual or entity that provides care coordination services.

"Case manager" means the person or entity that provides GAP case management as defined in this section.

"CAT" means computerized axial tomography.

"Certified prescreener" means an employee of the local community services board or behavioral health authority or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DBHDS.

"Client" means an applicant for, or recipient of, GAP benefits.

"Client appeal" means an individual's request for review of an eligibility or coverage determination and is an individual's challenge to the actions regarding benefits, services, and coverage determinations provided by the department, its service authorization contractor, Cover Virginia, or the BHSA.

"Cover Virginia" or "Cover VA" means a department contractor that receives applications for the GAP Demonstration Waiver for Individuals with SMI, determines eligibility, and attends and defends its eligibility decisions at appeal hearings.

"CSB" means the local community services board or behavioral health authority agency, which is the entry point for citizens into behavioral health services as established in Chapter 5 (§ 37.2-500 et seq.) and Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"Department" or "DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia, or its designee.

"Direct services" means the provision of direct behavioral health and medical treatment, counseling, or other supportive services not included in the definition of care coordination or case management services.

"DSM-IV-TR" means the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, copyright 2000, American Psychiatric Association.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Duration of illness" means the individual (i) is expected to require treatment and supportive services for the next 12 months; (ii) has undergone psychiatric treatment more intensive than outpatient care such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization more than once in his lifetime; or (iii) has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted his normal living situation. A significant disruption of a normal living situation means the individual has been unable to maintain his housing or has had difficulty maintaining his housing due to being in a supportive residential facility or program that was not a hospital. This includes group home placement as an adolescent and assisted living facilities but does not include living situations through the Department of Social Services.

"Eight dimensions of wellness" means the same as found on the website for the Substance Abuse and Mental Health Services Administration at https://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness.

"Enrollee" means an individual who has applied for the GAP SMI program, was determined eligible, and was enrolled in the GAP SMI program.

"Ex parte renewal" means the same as set forth in 42 CFR 435.916(a)(2).

"Expedited appeal" means an appeal that must have a decision issued within a shortened timeframe when the treating provider indicates that taking the time for a standard resolution could seriously jeopardize the individual's life, physical health, mental health, or ability to attain, maintain, or regain maximum function.

"Final decision" means a written determination pertaining to client appeals by a department hearing officer that is binding on the department.

"FPL" means the federal poverty level.

"FQHC" means a federally qualified health center.

"GAP" means Governor's Access Plan.

"GAP case management" means services to assist individuals in solving problems, if any, in accessing needed medical, behavioral health, social, educational, vocational, and other supports essential to meeting basic needs, including (i) assessment and planning services, including developing an individual service plan (does not include performing medical and psychiatric assessment but does include referral for such assessment); (ii) linking the individual to services and supports specified in the individual service plan; (iii) assisting the individual

for the purpose of locating, developing, or obtaining needed services and resources; (iv) coordinating services and service planning with other agencies and providers involved with the individual; (v) enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services; (vi) making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment; (vii) follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and (viii) education and counseling that guides the individual and develops a supportive relationship that promotes the service plan.

"GAP screening entity" means the entity that conducts the SMI screening for the GAP SMI program and shall be a CSB, participating FQHC, participating free clinic, inpatient psychiatric hospital, general hospital with an inpatient psychiatric unit, local or regional jail, or the Department of Corrections and shall be conducted for the purpose of determining eligibility for participation in the GAP SMI program.

"GAP SMI program" means the program within the Governor's Access Plan Demonstration Waiver for individuals with serious mental illness.

"Good cause" means to provide sufficient cause or reason for failing to file a timely appeal or for missing a scheduled appeal hearing. The existence of good cause shall be determined by the hearing officer.

"Grievance" means an expression of dissatisfaction about any matter other than an action. A grievance shall be filed and resolved at Cover Virginia, the service authorization contractor, or the BHSA. Possible subjects for grievances include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect an enrollee's rights.

"Hearing" means an informal evidentiary proceeding conducted by a hearing officer during which an individual has the opportunity to present his concerns with or objections to an action taken by Cover Virginia, the service authorization contractor, or the BHSA.

"Hearing officer" means an impartial decision maker who conducts evidentiary hearings on behalf of the department.

"High intensity case management" means the same as GAP case management and is reimbursed for months in which a face-to-face contact with the individual takes place in a community setting outside of the GAP case management office.

"Individual" means the client, enrollee, or recipient of services described in this section, and these terms are used interchangeably.

"Individual service plan" or "ISP" means the same as defined in 12VAC30-50-226.

"Intensive outpatient services" means the same as set forth in 12VAC30-130-5090 A.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance use disorder treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency program as defined in 18VAC125-20-10 for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work" or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"MAGI" means modified adjusted gross income and is an eligibility methodology for how income is counted and how household composition and family size are determined. MAGI is based on federal tax rules for determining adjusted gross income.

"MRI" means magnetic resonance imaging.

"PSN" means a peer support navigator employed by the BHSA who has self-declared that he is living with or has lived with a behavioral health condition. PSNs assist individuals to successfully remain in or transition back into their communities from inpatient hospital stays, help them avoid future inpatient stays, and increase community tenure by providing an array of linkages to peer run services, natural supports, and other recovery oriented resources.

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in 12VAC35-105-20.

"Register" or "registration" means notifying DMAS or its designee that an individual will be receiving services that do not require service authorization.

"Regular case management" means the same as GAP case management and is reimbursed for months in which the minimum requirements are met for GAP case management.

"Remand" means the return of a case by the hearing officer to Cover Virginia, the service authorization contractor, or the BHSA for further review, evaluation, and action.

"Representative" means an attorney or other individual who has been authorized to represent an applicant or enrollee pursuant to this part.

"Reverse" means to overturn the action of Cover Virginia, the service authorization contractor, or the BHSA and direct that eligibility or requested services be fully approved for the amount, duration, and scope of requested services.

"Serious mental illness" or "SMI" means, for the purpose of this part, a diagnosis of (i) schizophrenia spectrum disorders and other psychotic disorders but not substance/medication induced psychotic disorder; (ii) major depressive disorder; (iii) bipolar and related disorders but not cyclothymic disorder; (iv) post-traumatic stress disorder; (v) obsessive-compulsive disorder; (vi) agoraphobia; (vii) panic disorder; (viii) anorexia nervosa; or (ix) bulimia nervosa.

"Service authorization" means the same as defined in 12VAC30-50-226.

"Service-specific provider intake" means the same as defined in 12VAC30-50-130.

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

"State Plan" or "the Plan" means the document required by § 1902(a) of the Act.

"Substance use disorder" or "SUD" means a disorder, as defined in the DSM-5, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, tobacco, or other drugs despite significant related problems.

"Sustain" means to uphold the action of Cover Virginia, the service authorization contractor, or the BHSA.

"Title XIX of the Social Security Act" or "the Act" means the United States Code beginning at 42 USC § 1396.

"Warm line" means a peer-support telephone line operated by the BHSA that provides peer support for adult individuals who are living with or have lived with behavioral health conditions. The peer support navigators shall have specific training to provide telephonic support, and such systems may operate regionally or statewide and beyond traditional business hours.

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

12VAC30-135-410 Administration; authority; waived provisions . (Repealed.)

A. DMAS shall cover a targeted set of services as set forth in 12VAC30-135-440 for currently uninsured individuals who have diagnoses of serious mental illnesses with incomes less than or equal to 80% of the federal poverty level (FPL) using the MAGI eligibility methodology until September 30, 2017. Beginning October 1, 2017, the income limit will increase to incomes less than or equal to 100% FPL using the MAGI eligibility methodology.

B. Consistent with § 1115 of the Social Security Act (42 USC § 1315), the department covers certain limited services specified in 12VAC30-135-440 for certain targeted individuals specified in 12VAC30-135-420.

C. The Secretary of the U.S. Department of Health and Human Resources has waived compliance for the department with the following for the purpose of the GAP SMI program:

1. Consistent with § 1902(a)(10)(B) of the Act, the amount, duration, and scope of services covered in the State Plan for Medical Assistance shall be waived. The department shall cover a specified set of benefits for the individuals who are determined to be eligible for the GAP SMI program.

2. Consistent with § 1902(a)(23)(A) of the Act, the participating individual's freedom of choice of providers of services shall be waived for GAP case management.

3. Consistent with § 1902(a)(23) of the Act, the services shall be provided by a different delivery system than otherwise used for full State Plan services for GAP case management.

4. Consistent with § 1902(a)(4) of the Act, insofar as it incorporates 42 CFR 431.53 permitting the Commonwealth to waive providing nonemergency transportation to and from participating providers for eligible, participating individuals.

5. Consistent with § 1902(a)(35) of the Act, permitting the Commonwealth to waive offering eligible, participating individuals retroactive eligibility for the GAP SMI program.

D. The GAP SMI program shall operate statewide.

E. The GAP SMI program shall operate for at least two years beginning January 2015 and continuing through January 2017 or until the Commonwealth implements an alternative plan to provide health care coverage to all individuals having incomes less than or equal to 80% of the FPL using the MAGI eligibility methodology until September 30, 2017. Beginning October 1, 2017, the income limit will increase to incomes less than or equal to 100% FPL using the MAGI eligibility methodology.

F. The GAP SMI program shall not affect or modify components of the Commonwealth's existing medical assistance or children's health insurance programs.

12VAC30-135-420 Individual eligibility; limitations; referrals; eligibility determination process . (Repealed.)

A. The GAP SMI program eligibility determination process shall have two parts: (i) a determination of whether the applicant meets the GAP nonfinancial eligibility criteria including a diagnosed SMI and (ii) a determination of whether the applicant meets the GAP SMI Program financial eligibility criteria.

1. A person may apply through Cover Virginia for GAP by phone or through a provider-assisted web portal.

2. If an applicant is found not to meet GAP eligibility criteria, either the GAP financial eligibility criteria or the GAP SMI program nonfinancial eligibility criteria, then the applicant shall be sent a letter with appeal rights. Such applicants shall be assessed and referred for eligibility through Medicaid, FAMIS MOMS, or the federal marketplace for private health insurance as appropriate.

B. Applicants shall have a screening conducted by a DMAS-approved GAP screening entity for the determination of SMI.

C. To be eligible for the GAP SMI program, applicants shall be assessed to determine whether their diagnosed condition is a serious mental illness. The serious mental illness shall be diagnosed according to criteria defined in the DSM-IV-TR or DSM-5. LMHPs, including LMHP-supervisees, LMHP-residents, LMHP-residents in psychology, and those exempt from licensure as described in § 54.1-3601 of the Code of Virginia, shall conduct the clinical screening required to determine the applicant's diagnosis if one has not already been made. At least one of the following diagnoses shall be documented for the applicant to be approved for GAP SMI program services:

1. Schizophrenia spectrum disorders and other psychotic disorders with the exception of substance/medication induced psychotic disorders;

2. Major depressive disorder;

3. Bipolar and related disorders with the exception of cyclothymic disorder;

4. Post-traumatic stress disorder; or

5. Obsessive compulsive disorder, panic disorder, agoraphobia, anorexia nervosa, or bulimia nervosa.

D. To be eligible for this program, applicants shall meet at least one of the following criteria to reflect the duration of illness:

1. The applicant is expected to require treatment and supportive services for the next 12 months;

2. The applicant has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization for a psychiatric condition, more than once in his lifetime; or

3. The applicant has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation. A significant disruption of a normal living situation means the applicant has been unable to maintain his housing or had difficulty maintaining his housing due to being in a supportive residential facility or program that was not a hospital. This includes group home placement as an adolescent and assisted living facilities but does not include living situations through the Department of Social Services.

E. To be eligible for this program, applicants shall demonstrate a significant level of impairment on a continuing or intermittent basis. Evidence of severe and recurrent impairment resulting from mental illness shall exist. The impairment shall result in functional limitation in major life activities. Due to the mental illness, the applicant shall meet at least two of the following:

1. The applicant is either unemployed or employed in a sheltered setting or a supportive work situation, has markedly limited or reduced employment skills, or has a poor employment history;

2. The applicant requires public and family financial assistance to remain in his community;

3. The applicant has difficulty establishing or maintaining a personal social support system;

4. The applicant requires assistance in basic living skills such as personal hygiene, food preparation, or money management; or

5. The applicant exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

F. The applicant shall require assistance to consistently access or to utilize needed medical or behavioral, or both, health services and supports due to the mental illness.

G. In addition, the applicant shall:

1. Be an adult 21 years through 64 years of age;

2. Be a United States citizen or lawfully residing immigrant;

3. Be a resident of the Commonwealth;

4. Be uninsured;

5. Be ineligible for any state or federal benefits health insurance program including Medicaid, Children's Health Insurance Program (CHIP/FAMIS), Medicare, or TriCare Federal Military benefits;

6. Have household incomes less than or equal to 80% of the federal poverty level using the MAGI eligibility methodology until September 30, 2017. Beginning October 1, 2017, the income limit will increase to incomes less than or equal to 100% FPL using the MAGI eligibility methodology. Reported income shall be verified via reliable electronic sources or if not available electronically, by pay stubs or other income documents accepted under Medicaid policy. All individuals enrolled in the GAP SMI program with incomes between 61% and 100% of the FPL using the MAGI eligibility methodology as of May 15, 2015, who continue to meet other program eligibility rules shall maintain enrollment in the GAP SMI program until their next eligibility renewal period or July 1, 2016, whichever comes first. Pursuant to federal authority under the § 1115 waiver, should expenditures for the GAP SMI program compromise the program's budget neutrality, DMAS may amend the waiver to maintain budget neutrality by reducing income eligibility levels to below 80% of the FPL until September 30, 2017, and below 100% FPL beginning October 1, 2017; and

7. Not be a current resident of a long-term care facility, mental health facility, or penal institution.

H. GAP enrollees shall have 12 months of continuous coverage regardless of household or income changes unless the individual becomes 65 years of age, becomes eligible for Medicare or full Medicaid benefits, moves out of the Commonwealth, dies, or is unable to be located.

I. Individuals who are enrolled in the GAP SMI program who require hospitalization shall not be disenrolled from the GAP SMI program during their hospitalization.

J. If a GAP enrollee secures Medicare or Medicaid/FAMIS MOMS coverage, his GAP enrollment shall be canceled to align with the effective date of the Medicare or Medicaid coverage. Enrollees who gain other sources of health insurance, other than Medicare or Medicaid/FAMIS MOMS, shall not be disenrolled from the GAP SMI program during their 12-month enrollment period; however, in such instances, the GAP SMI program shall be the payer of last resort.

K. DMAS or its designee shall verify income data via existing electronic data sources, such as Virginia Employment Commission and TALX. Citizenship and identity shall be verified through the monthly file exchange between DMAS and the Social Security Administration. The applicant's age, residency, and insurance status shall be verified through self-attestation. Applicants shall be permitted 90 days to resolve any citizenship discrepancies resulting from the Social Security Administration matching process, in any of the information provided, and in the verification process findings of DMAS or its designee.

12VAC30-135-430 Individual screening requirements; enrollment process . (Repealed.)

A. All applicants shall be screened by a GAP screening entity using the screening tool, DMAS P603, and shall meet the requirements identified in the screening tool to meet the SMI criteria. Screenings shall be provided to persons without regard to whether they have serious mental illness. Screenings may be either limited or a full screening depending on the applicant's prior history of serious mental illness.

B. Two types of screenings shall be conducted:

1. Limited screenings shall be conducted for those applicants who have had a diagnostic evaluation within the past 12 months, and this evaluation is available to the screener. These limited screenings may be conducted by an LMHP, a QMHP-A, a QMHP-E, or those exempt from licensure as described in § 54.1-3601 of the Code of Virginia.

2. Full screenings shall be conducted for those applicants who have not had a diagnostic evaluation within the past 12 months or for whom the evaluation is not available to the screener. These full screenings shall be conducted by an LMHP.

C. All SMI screenings shall be submitted to the BHSA. The diagnostic evaluation shall be signed and contemporaneously dated by the LMHP who completed it.

~~D. Once an applicant's eligibility has been determined consistent with all of the requirements set out in 12VAC30-135-420, his coverage shall become effective on the first day of the same month in which his signed application was received. No retroactive eligibility shall be permitted in the GAP SMI program. No service coverage shall begin prior to the first day of the month that the applicant's signed and dated application for the GAP SMI program is received.~~

~~E. Once an applicant is determined to be eligible for the GAP SMI program, his eligibility shall remain effective for 12 continuous months except if the individual becomes 65 years of age, becomes eligible for Medicare or Medicaid, moves out of the Commonwealth, dies, or is unable to be located.~~

~~F. The renewal of an enrollee's eligibility for this GAP SMI program shall be redetermined prior to the end of the 12-month coverage period. No additional determination of serious mental illness shall be required to complete a renewal for program eligibility.~~

~~G. GAP SMI program enrollees shall not be required to report changes in their financial circumstances during their 12-month coverage period but only at the time of their renewal application.~~

~~1. If an ex parte renewal cannot be completed for the GAP SMI program enrollee, a prefilled paper renewal application will be generated, and the enrollee shall be given 30 days to return the completed renewal with the requested verification documentation. If the enrollee fails to provide the completed renewal and documentation in the designated timeframe, his GAP enrollment shall be canceled for failure to complete his renewal process.~~

~~2. Such an individual shall be permitted a three-month grace period in which to supply the required documentation to have his GAP enrollment reinstated at the first of the month following cancellation.~~

~~H. The new application determination process shall be completed within 45 days except in cases of unusual circumstances as described in this subsection:~~

~~1. Unusual circumstances include administrative or other emergency beyond the control of DMAS or its designee. In such case, DMAS or its designee shall document in the applicant's record the reasons for delay. DMAS or its designee shall not use the time standards as a waiting period before determining eligibility or as a reason for denying eligibility because it has not determined eligibility within the time standards.~~

~~2. Incomplete new applications shall be held open for a period of 45 calendar days to enable applicants to provide outstanding information needed for an eligibility determination. Any applicant who fails to provide within 45 calendar days of the receipt of the initial application information or verifications necessary to determine eligibility shall have his application for GAP SMI program denied.~~

~~I. Cover Virginia shall mail a notice to the applicant following the eligibility determination. An approval notice shall include the applicant's identification number, enrollment periods, and a member handbook. A denial notice shall include information about appeal rights.~~

~~J. Following an approval notice, the BHSA shall mail the enrollee's GAP identification card to the address provided on the application.~~

12VAC30-135-440 ~~Covered services; limitations; restrictions.~~ (Repealed.)

~~A. GAP SMI program coverage shall be limited to certain outpatient medical, behavioral health, pharmacy, GAP case management, and care coordination services for individuals determined to meet the GAP SMI program eligibility criteria. This program intends that such services will significantly decrease the severity of the serious mental illnesses of these individuals so that they can recover, work, parent, learn, and participate more fully in their communities.~~

~~B. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities.~~

~~C. Medical services including outpatient physician and clinic services, telemedicine services, specialists services, diagnostic procedures, laboratory procedures, and pharmacy services shall be covered as follows:~~

~~1. Outpatient physician services and medical office visits, which include (i) evaluation and management, (ii) diagnostic and treatment procedures performed in the physician's office, and (iii) therapeutic or diagnostic injections. The requirements of 12VAC30-50-140 shall be met in order for these services to be reimbursed by DMAS.~~

2. Outpatient clinic services, which include (i) evaluation and management, (ii) treatment and procedures performed in the clinic's office, and (iii) medically necessary therapeutic and diagnostic injections. The requirements of 12VAC30-50-180 shall be met in order for this service to be reimbursed by DMAS.

3. Outpatient specialty care, consultation, management, and treatment, which include (i) evaluation and treatment, (ii) procedures performed in the physician's office, and (iii) medically necessary therapeutic or diagnostic injections consistent with 12VAC30-50-140.

4. Outpatient diagnostic services, which include ultrasounds, electrocardiogram, service-authorized CAT and MRI scans, and diagnostic services that can be performed in a physician's office with the exception of colonoscopy procedures and other services listed as not covered in 12VAC30-135-450. The requirements of 12VAC30-50-140 O shall be met as they pertain to GAP services for these services to be reimbursed by DMAS. CAT and MRI scans shall be covered if the service is authorized by either DMAS or the service authorization contractor.

5. Outpatient laboratory services consistent with 12VAC30-50-120.

6. Outpatient pharmacy services consistent with 12VAC30-50-210.

7. Outpatient family planning consistent with 12VAC30-50-130 D; sterilization procedures and abortions shall not be covered.

8. Outpatient telemedicine, which is covered the same as Medicaid for services that are not otherwise excluded from GAP coverage.

9. Outpatient durable medical equipment and supplies coverage shall be limited to diabetic equipment and supplies consistent with 12VAC30-50-165.

10. Outpatient hospital procedures shall be limited to (i) diagnostic ultrasound procedures; (ii) electrocardiogram (EKG/ECG) including stress tests; and (iii) radiology procedures except for positron emission tomography (PET) scans, colonoscopy, and radiation treatment procedures.

D. Behavioral health services shall be covered as follows:

1. Behavioral health services shall be subject to service authorization or registration as specified 12VAC30-50-226.

2. GAP case management as defined in 12VAC30-135-400.

a. GAP case management shall be provided by CSB case managers with consultation and support from BHSA care coordinators. This service shall be targeted to individuals who are expected to benefit from assistance with medication management and appropriate use of community resources. The CSB GAP case managers shall have the same knowledge, skills, and abilities as set out in 12VAC30-50-420 E 2 e and the CSB shall maintain all licenses required by DBHDS in 12VAC35-105. GAP case management shall not include the provision of direct treatment services and shall have two levels of service intensity: regular and high intensity case management, as defined in 12VAC30-135-400. GAP case management shall be focused on assisting individuals to access needed medical, behavioral health (psychiatric and substance use disorder services), social, education, vocational, and other support services.

b. Reimbursement shall be provided only for active case management individuals. An active individual for GAP case management purposes means an individual for whom there is a current ISP that requires regular direct or client-related contacts or activity or communication with the individuals or families, significant others, service providers, or others. Billing may be submitted only for months in which direct or individual-related contacts, activity, or communications occur. Regular case management shall be reimbursed for months in which the minimum requirements as described in 12VAC30-135-410, are met for case management. High intensity case management shall be reimbursed for months in which a face-to-face contact with the individual takes place in a community setting outside of the case management office.

c. Case management shall not be billed for enrollees while they are in institutions for mental disease.

d. The case management entity shall collaborate monthly with the BHSA for care coordination efforts.

3. Crisis intervention shall be covered consistent with the limits and requirements set out in 12VAC30-50-226 B 3 and 12VAC30-60-143.

4. Crisis stabilization shall be covered consistent with the limits and requirements set out in 12VAC30-50-226 B and 12VAC30-60-143 except that service authorization shall be required in place of registration.

5. Psychosocial rehabilitation service-specific provider intake and services shall be covered consistent with the limits and requirements set out in 12VAC30-50-226 B 4.

6. Peer support services for GAP members shall be covered consistent with the limits and requirements set out in 12VAC30-50-226.

E. Outpatient psychotherapy services shall be covered consistent with 12VAC30-50-140 D 1 through D 4.

F. Effective October 1, 2017, substance use disorder services shall be covered as described in 12VAC30-130-5030. Peer support services for GAP members with SUD shall be covered consistent with the limits and requirements set out in 12VAC30-130-5160 through 12VAC30-130-5210.

G. Care coordination, crisis phone line, and peer support navigation services shall be administered through the BHSA as follows:

1. Care coordination shall be provided by the BHSA care coordinators. BHSA-LMHP care coordinators shall work closely with behavioral health providers including local CSB staff to provide information to the enrollee in accessing covered services, provider selection, and how to access all services including noncovered services.

2. The BHSA shall provide crisis phone lines 24 hours per day and seven days per week including access to a licensed care coordinator during a crisis.

3. Before July 1, 2017, peer support navigation services shall only be provided by peer support navigators through the BHSA. On and after July 1, 2017, peer support services will be a state plan service and, therefore, shall be provided by peer recovery specialists employed by or contracted with licensed and enrolled providers consistent with the limits and requirements set out in 12VAC30-50-226 for adults with mental illness and in 12VAC30-130-5160 through 12VAC30-130-5210 for adults with substance use disorders. However, the BHSA or its designee may continue to provide peer support navigation services to GAP enrollees during a transition period described in subdivision 4 of this subsection.

4. The BHSA or its designee shall provide peer support navigation services seven days per week. A telephonic support shall be staffed by peer support navigators who have been trained specifically in telephonic support operations and resources. The telephonic support associated with the peer support services shall offer extended hours, toll-free access, and dedicated data collection capabilities. The BHSA shall provide trained peer navigators as part of its care coordination team or may contract with other entities to do so. The BHSA shall utilize community-based peer navigators to work in provider settings, community settings, and peer-run organizations. The scope of peer support navigation services shall include:

a. Visiting enrollees in inpatient settings to develop the peer relationship.

b. Describing and developing a plan for engaging in peer and natural community support resources as part of the recovery process.

c. Initiating rapport, teaching, and modeling positive communication skills with enrollees to help them self-advocate for an individualized services plan and assisting the enrollee with the coordination of services to promote successful community integration strategies.

d. Assisting in developing strategies to decrease or avoid the need for future hospitalizations by offering social and emotional support and an array of individualized services.

e. Providing social, emotional, and other supports framed around the eight dimensions of wellness as defined in 12VAC30-135-400.

f. Assisting with the transition from BHSA-provided peer support navigation if a GAP enrollee elects to receive peer support services as defined in 12VAC30-50-226 B 7 or 12VAC30-130-5170 B. The transition period may last up to 30 consecutive calendar days and address discharging from recovery navigator services and engagement in peer support services.

12VAC30-135-450 ~~Noncovered medical and behavioral health services .~~ (Repealed.)

~~A. Noncovered medical services shall include:~~

~~1. Inpatient hospital treatment including psychiatric facilities and psychiatric facility partial hospitalization programs;~~

~~2. Emergency room treatment;~~

~~3. Ambulatory surgical centers;~~

~~4. Military treatment facilities;~~

~~5. Outpatient hospital procedures other than diagnostic procedures;~~

~~6. Positron emission tomography (PET) scans;~~

~~7. Home health;~~

~~8. Skilled and intermediate nursing facilities;~~

~~9. Long-term care including home and community-based care waiver services, custodial care facilities, and intermediate care facilities for individuals with intellectual disabilities;~~

~~10. Psychiatric residential treatment centers;~~

~~11. Comprehensive inpatient/outpatient rehabilitation facilities;~~

~~12. End-stage renal disease treatment facilities;~~

~~13. Hospice;~~

~~14. Ambulance (including land, air, and water);~~

~~15. Early and periodic screening diagnosis and treatment (EPSDT) services;~~

~~16. Dental services;~~

~~17. Nonemergency transportation;~~

~~18. Physical therapy (PT), occupational therapy (OT), and speech therapies;~~

~~19. Obstetrics/maternity care including birthing centers (gynecology services are covered);~~

~~20. Routine eye exams;~~

~~21. Abortions, sterilization (vasectomy or tubal ligation);~~

~~22. Chemotherapy, radiation therapy;~~

~~23. Colonoscopy;~~

~~24. Dialysis;~~

~~25. Durable medical equipment (DME) and supply items (other than those required to treat diabetes); orthotics; prosthetics; home IV therapy; nutritional supplements;~~

~~26. Cosmetic procedures;~~

~~27. Eyeglasses, contact lenses, hearing aids;~~

~~28. Private duty nursing;~~

~~29. Assisted living;~~

~~30. Other unspecified facilities;~~

~~31. Services specifically excluded under Virginia Medicaid;~~

~~32. Services not deemed medically necessary;~~

~~33. Services that are considered experimental or investigational;~~

~~34. Services from non-Medicaid-enrolled providers; and~~

~~35. Any medical services not otherwise defined as covered.~~

~~B. Noncovered traditional mental health services shall include:~~

~~1. Inpatient hospital or partial hospital services, hospital observation services, emergency room services;~~

~~2. Electroconvulsive therapy and related services (e.g., anesthesia and hospital charges);~~

~~3. Residential treatment services;~~

~~4. Psychological and neuropsychological testing;~~

~~5. Smoking and tobacco cessation and counseling;~~

~~6. Transportation;~~

~~7. Services specifically excluded under Virginia Medicaid;~~

~~8. Services not deemed medically necessary;~~

~~9. Services that are considered experimental or investigational;~~

~~10. Services from non-Medicaid-enrolled providers; and~~

~~11. Any mental health services not otherwise defined as covered.~~

~~C. Noncovered nontraditional mental health services shall include:~~

~~1. Day treatment partial hospitalization, mental health skill building services, and intensive community treatment;~~

~~2. Treatment foster care case management;~~

~~3. Mental health family support partners;~~

~~4. Transportation;~~

~~5. Services specifically excluded under Virginia Medicaid;~~

~~6. Services not deemed medically necessary;~~

~~7. Services that are considered experimental or investigational;~~

~~8. Services from non-Medicaid-enrolled providers; and~~

~~9. Any mental health services not otherwise defined as covered.~~

~~D. Noncovered substance use disorder services are as described in 12VAC3-130-5030. ARTS family support partners is a noncovered service.~~

12VAC30-135-460 ~~[Reserved] .~~ (Repealed.)

12VAC30-135-470 ~~Provider qualifications; requirements .~~ (Repealed.)

~~The provider qualifications and requirements for GAP-covered services shall be the same as those set forth for each service in 12VAC30-50 and 12VAC30-130.~~

12VAC30-135-475 ~~Individual service plan requirements .~~ (Repealed.)

~~A. Individual service plans shall contain all of the elements as set out in 12VAC30-50-226. ISPs that do not contain the specified elements shall be considered by DMAS to be incomplete and not adequate to support service reimbursement.~~

~~B. Prior to the development of an ISP:~~

~~1. A service-specific provider intake shall be completed for the following services: (i) psychosocial rehabilitation, (ii) crisis intervention, and (iii) crisis stabilization.~~

~~2. An evaluation consistent with 12VAC30-60-181 shall be completed for substance use disorder intensive outpatient and opioid treatment services.~~

~~3. DBHDS licensure requirements for assessment and planning as defined in 12VAC35-105-650 shall be completed for GAP case management.~~

12VAC30-135-480 ~~Utilization review .~~ (Repealed.)

~~A. The utilization requirements of this section shall apply to all GAP covered services unless otherwise specified.~~

~~B. DMAS, or its designee, shall perform reviews of the utilization of all GAP-covered services in accordance with 42 CFR 440.260 and 42 CFR Part 456.~~

~~C. DMAS shall recover expenditures made for covered services when provider documentation does not comport with standards specified in state and federal Medicaid requirements.~~

~~D. The utilization review requirements for GAP-covered services shall be the same as those set forth for each service in 12VAC30-60.~~

12VAC30-135-485 ~~Reimbursement .~~ (Repealed.)

~~A. All services covered in the GAP SMI program shall be billed and reimbursed through the existing Medicaid/CHIP fee-for-service methodology and claims process.~~

~~B. Reimbursement for substance use disorder services shall be consistent with 12VAC30-80-32 A 1 through A 6.~~

~~C. Service authorization shall not guarantee payment for the service.~~

12VAC30-135-487 ~~Client appeals .~~ (Repealed.)

~~A. Notwithstanding the provisions of 12VAC30-110-10 through 12VAC30-110-370, the regulations for client appeals described in this section through 12VAC30-135-495 govern state fair hearings for GAP SMI program applicants and enrolled individuals. Appeal procedures for GAP SMI providers are set out in 12VAC30-135-496.~~

~~B. GAP SMI program applicants and enrollees shall have the right to a hearing pursuant to 42 CFR 431.220.~~

~~C. Applicants shall be notified in writing of the appeals process at the time of the request for enrollment by Cover Virginia. Enrollees shall be notified in writing of the appeals process upon receipt of an adverse decision in a notice of action from the BHSA or the service authorization contractor.~~

~~D. An appellant shall have the right to representation by an attorney or other individual of his choice at all stages of an appeal at the administrative agency level.~~

~~1. For those appellants who wish to have a representative, a representative shall be designated in a written statement that is signed by the appellant whose GAP SMI program benefits were adversely affected. If the appellant is physically unable to sign a written statement, the DMAS Appeals Division shall allow a family member or other person acting on the appellant's behalf to be the representative. If the appellant is mentally unable to sign a written statement, the DMAS Appeals Division shall require written documentation that a family member or other person has been appointed or designated as his legal representative.~~

~~2. If the representative is an attorney or a paralegal working under the supervision of an attorney, a signed statement by such attorney or paralegal that he is authorized to represent the appellant, prepared on the attorney's letterhead, shall be accepted as a designation of representation.~~

3. A member of the same law firm as the designated representative shall have the same rights as the designated representative.

4. An appellant may revoke representation by another person at any time. The revocation is effective when the DMAS Appeals Division receives written notice from the appellant.

E. Any written communication from an applicant or enrollee or his representative that clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request.

1. The written communication should explain the basis for the appeal of the action taken by Cover Virginia, the BHSA, or the service authorization contractor.

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

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

G. Cover Virginia, the BHSA, or the service authorization contractor shall attend and defend its decisions at all appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS Appeals Division.

H. Requests for expedited appeals referenced in subsection K of this section may be filed by telephone or by any of the methods set forth in subsection F in this section.

I. The agency shall continue benefits while the appeal is pending when all of the following criteria are met:

1. The enrollee or his representative files the appeal within 10 calendar days, plus five mail days, of the date the notice of action was sent by the agency;

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

3. In the case of services, the services were ordered by an authorized provider, and the original period covered by the initial authorization has not expired; and

4. The enrollee or his representative requests continuation of benefits.

J. After the final resolution and if the final resolution of the appeal is adverse to the enrollee (e.g., the agency's action is upheld), the department may recover the costs of services furnished to the enrollee while the appeal was pending to the extent they were furnished solely because of the pending appeal.

K. The department shall maintain an expedited process for appeals when the treating provider of an appellant certifies in writing that taking the time for a standard resolution could seriously jeopardize the appellant's life, physical health, mental health, or ability to attain, maintain, or regain maximum function. DMAS will make every effort to facilitate an expedited hearing and appeal decision process to accommodate the serious health condition of the appellant.

1. For eligibility matters, the hearing officer shall render appeal decisions within a reasonable amount of time. In setting timeframes, the hearing officer shall consider the need for expedited appeals that meet criteria described in this subsection.

2. For health services matters, the hearing officer shall ensure that appeals that meet the criteria for expedited resolution are completed no later than 72 hours after the agency receives a fair hearing request. The hearing officer may extend the timeframes for resolution of an expedited appeal by up to 14 calendar days if the appellant or the appellant's representative requests the extension, or if the hearing officer:

a. Shows that there is a need for additional information and how the delay is in the appellant's best interest;

b. Promptly notifies the appellant of the reason for an extension and provides the date the extension expires; and

~~c. Resolves the appeal as expeditiously as the appellant's health condition requires and no later than the date the extension expires.~~

12VAC30-135-489 ~~Appeal timeframes .~~ (Repealed.)

~~A. Appeals to the Medicaid state fair hearing process shall be filed with the DMAS Appeals Division within 30 days of the date the notice of action was sent by the agency, unless the time period is extended by DMAS upon a finding of good cause in accordance with subsection G of this section.~~

~~B. It is presumed that applicants or enrollees will receive the notice of action five days after the agency or its designee mails it, unless the applicant or enrollee shows that he did not receive the notice within the five-day period. For purposes of calculating the five-day period, it is presumed that the notice was mailed by the agency on the date that is indicated on the notice.~~

~~C. A request for appeal on the grounds that the agency or its designee has not acted with reasonable promptness in response to an eligibility or service request may be filed at any time until the agency or its designee has acted.~~

~~D. The date of filing shall be (i) the date the request is postmarked if by U.S. mail or (ii) the date the request is received by the department if delivered other than by U.S. mail.~~

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

~~F. In computing any time period under 12VAC30-135-487 through 12VAC30-135-495, the day of the act or event from which the designated period of time begins to run shall be excluded and the last day included. If a time limit would expire on a Saturday, Sunday, or state or federal holiday, it shall be extended until the next regular business day.~~

~~G. An extension of the 30-day period for filing a request for appeal may be granted for good cause shown. Examples of good cause include the following situations:~~

~~1. The appellant was seriously ill and was prevented by illness from contacting the department;~~

~~2. The notice of action completed by the agency was not sent to the appellant. The agency may rebut this claim by evidence that the decision was mailed to the appellant's last known address or that the notice was received by the appellant;~~

~~3. The appellant sent the request for appeal to another government agency in good faith within the time limit; or~~

~~4. Unusual or unavoidable circumstances prevented a timely filing of the appeal request.~~

~~H. Appeals shall be heard and decisions issued within 90 days of (i) the postmark date if delivered by U.S. mail or (ii) the receipt date if delivered by any method other than U.S. mail.~~

~~I. Exceptions to standard appeal resolution timeframes. Decisions may be issued beyond the standard timeframe when the appellant or his representative requests or causes a delay. Decisions may also be issued beyond the standard appeal resolution timeframe when any of the following circumstances exist:~~

~~1. The appellant or representative requests to reschedule or continue the hearing;~~

~~2. The appellant or representative provides good cause for failing to keep a scheduled hearing appointment and the DMAS Appeals Division reschedules the hearing;~~

~~3. Inclement weather, unanticipated system outage, or the department's closure that prevents the hearing officer's ability to work;~~

~~4. Following a hearing, the hearing officer orders an independent medical assessment as described in 12VAC30-110-200;~~

~~5. The hearing officer leaves the hearing record open after the hearing to receive additional evidence or argument from the appellant or representative;~~

~~6. The hearing officer receives additional evidence from a person other than the appellant or his representative, and the appellant or representative requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence; or~~

~~7. The hearing officer determines that a need for additional information exists and documents how the delay is in the appellant's interest.~~

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

~~1. If an appellant or representative requests or causes a delay within 30 days of the request for a hearing, the 90-day time limit will be extended by the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.~~

~~2. If an appellant or representative requests or causes a delay within 31 to 60 days of the request for a hearing, the 90-day time limit will be extended by 1.5 times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.~~

~~3. If an appellant or representative requests or causes a delay within 61 to 90 days of the request for a hearing, the 90-day time limit will be extended by two times the number of days from the date when the first hearing was scheduled until the date to which the hearing is rescheduled.~~

~~K. Post-hearing delays requested or caused by an appellant or representative (e.g., requests for the record to be left open) will result in a day-to-day delay for the decision date. The hearing officer shall provide the appellant and representative with written notice of the reason for the decision delay and the delayed decision date, if applicable.~~

12VAC30-135-491 ~~Prehearing decisions .~~ (Repealed.)

~~A. If the DMAS Appeals Division determines that any of the conditions as described in this subsection exist, a hearing will not be held and the client appeal process shall be terminated.~~

~~1. A request for appeal may be invalidated if:~~

~~a. The request was not filed within the time limit imposed by 12VAC30-135-489 A or extended pursuant to 12VAC30-135-489 G, and the hearing officer sends a letter to the appellant for an explanation as to why the appeal request was not filed timely, and:~~

~~(1) The appellant or his representative did not reply to the request within 10 calendar days for an explanation of why good cause criteria were met for the untimely filing; or~~

~~(2) The appellant or his representative replied within 10 calendar days of the request and the DMAS Appeals Division had sufficient facts to determine that the reply did not meet good cause criteria pursuant to 12VAC30-135-489 G.~~

~~b. The individual who filed the appeal ("filer") is not the appellant or parent of a minor appellant and the DMAS Appeals Division sends a letter to the filer requesting proof of his authority to appeal on behalf of the appellant, and:~~

~~(1) The filer did not reply to the request for authorization to represent the appellant within 10 calendar days; or~~

~~(2) The filer replied within 10 calendar days of the request and the hearing officer determined that the authorization submitted was insufficient to allow the filer to represent the appellant under the provisions of 12VAC30-135-487 D.~~

~~2. A request for appeal may be administratively dismissed if:~~

~~a. The action being appealed was not taken by Cover Virginia, BHSA, or the service authorization contractor; or~~

~~b. The sole issue is a federal or state law requiring an automatic change adversely affecting some or all GAP SMI program applicants or enrollees.~~

~~3. An appeal case may be closed if:~~

~~a. The hearing officer schedules a hearing and sends a written schedule letter notifying the appellant or his representative of the date, time, and location of the hearing, the appellant or his representative failed to appear at the scheduled hearing, and the hearing officer sends a letter to the appellant for an explanation as to why he failed to appear, and:~~

~~(1) The appellant or his representative did not reply to the request within 10 calendar days with an explanation that met good cause criteria; or~~

~~(2) The appellant or his representative replied within 10 calendar days of the request and the DMAS Appeals Division determined that the reply did not meet good cause criteria.~~

~~b. The hearing officer sends a written schedule letter requesting that the appellant or his representative provide a telephone number at which he can be reached for a telephonic hearing and the appellant or his representative failed to respond within 10 calendar days to the request for a telephone number at which he could be reached for a telephonic hearing.~~

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

~~d. Cover Virginia, the BHSA, or the service authorization contractor approves the full amount, duration, and scope of services requested.~~

~~e. Evidence in the record shows that the decision made by Cover Virginia, the BHSA, or the service authorization contractor was clearly in error and that the case should be fully resolved in the appellant's favor.~~

~~B. Remand to Cover Virginia, the BHSA, or the service authorization contractor. If the hearing officer determines from the record, without conducting a hearing, that the case might be resolved in the appellant's favor if Cover Virginia, the BHSA, or the service authorization contractor obtains and develops additional information, documentation, or verification, the hearing officer may remand the case to Cover Virginia, the BHSA, or the service authorization contractor for action consistent with the hearing officer's written instructions pursuant to 12VAC30-135-494.~~

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

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

12VAC30-135-494 ~~Evidentiary hearings and final decisions .~~ (Repealed.)

~~A. All hearings shall be scheduled at a reasonable time, date, and place, and the appellant and his representative shall be notified in writing at least 15 days before the hearing.~~

~~1. The hearing location shall be determined by the DMAS Appeals Division.~~

~~2. A hearing shall be rescheduled at the appellant's request no more than twice unless compelling reasons exist.~~

~~3. Rescheduling the hearing at the appellant's or his representative's request will result in automatic waiver of the 90-day deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-135-489 J.~~

~~B. The hearing shall be conducted by a department hearing officer. The hearing officer shall review the complete record for all Cover Virginia, BHSA, or service authorization contractor actions that are properly appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; research the issues; and render a written final decision.~~

~~C. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeal record shall be made accessible to the appellant and his representative at a convenient place and time at least five working days before the date of the hearing and during the hearing. The appellant and his representative may examine the content of the appellant's case file and all documents and records the department will rely on at the hearing except those records excluded by law.~~

D. Appellants or their representatives who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the hearing may request in writing the issuance of a subpoena. The request must be received by the hearing officer at least 10 working days before the scheduled hearing. Such request shall include (i) the witness or respondent's name, home and work addresses, and county or city of work and residence if the subpoena is for witnesses, (ii) a description of the specific records requested if the subpoena is for records, and (iii) the name and address of the sheriff's office that will serve the subpoena.

E. The hearing officer shall conduct the hearing; decide on questions of evidence, procedure, and law; question witnesses; and assure that the hearing remains relevant to the issue or issues being appealed. The hearing officer shall control the conduct of the hearing and decide who may participate in the hearing.

F. Hearings shall be conducted in an informal, nonadversarial manner. The appellant or his representative shall have the right to bring witnesses, establish all pertinent facts and circumstances, present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine agency representatives.

G. The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

H. The hearing officer may leave the hearing record open for a specified period of time after the hearing to receive additional evidence or argument from the appellant or his representative.

1. The hearing officer may order an independent medical assessment when the appeal involves medical issues such as a diagnosis, an examining physician's report, or a medical review team's decision, and the hearing officer determines that it is necessary to have an assessment by someone other than the person or team who made the original decision (e.g., to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence). A medical assessment ordered pursuant to this subsection shall be at the department's expense and shall become part of the record.

2. The hearing officer may receive evidence that was not presented by either party if the record indicates that such evidence exists, and the appellant or his representative requests to submit it or requests that the hearing officer secure it.

3. If the hearing officer receives additional evidence from an entity other than the appellant or his representative, the hearing officer shall (i) send a copy of such evidence to the appellant and his representative and to Cover Virginia, the BHSA, or the service authorization contractor and (ii) provide each party the opportunity to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence.

4. Any additional evidence received will become a part of the hearing record, but the hearing officer must determine whether it will be used in making the decision.

I. After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision that either (i) sustains or reverses, in whole or in part, the action of Cover Virginia, the BHSA, or the service authorization contractor or (ii) remands the case for further evaluation consistent with the hearing officer's written instructions. Some decisions may be a combination of these dispositions. The hearing officer's final decision shall be considered as the department's final administrative action pursuant to 42 CFR 431.244(f). The final decision shall include:

1. Identification of the issue or issues;

2. Relevant facts, to include a description of the procedural development of the case;

3. Conclusions of law, regulations, and policy that relate to the issue or issues;

4. Discussions, analysis of the accuracy of the agency's action, conclusions, and the hearing officer's decision;

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

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

~~7. A cover letter informing the appellant and representative of the hearing officer's decision. The letter must indicate that the hearing officer's decision is final and that the final decision may be appealed directly to circuit court.~~

~~J. A copy of the hearing record shall be forwarded to the appellant and his representative with the final decision.~~

~~K. An appellant who disagrees with the hearing officer's final decision as defined in this section may seek judicial review pursuant to Article 5 (§ 2.2-4025 et seq.) of the Administrative Process Act and Rules of the Supreme Court of Virginia, Part Two A. Written instructions for requesting judicial review must be provided to the appellant or representative with the hearing officer's decision, and upon request by the appellant or representative.~~

12VAC30-135-495 ~~Department of Medical Assistance Services Appeals Division appeal records .~~ (Repealed.)

~~A. No person shall take from the DMAS Appeals Division's custody any original record, paper, document, or exhibit that has been certified to the division except as the division's director or his designee authorizes, or as may be necessary to furnish or transmit copies for other official purposes.~~

~~B. Information in the appellant's record can be released only to the appellant or the appellant's authorized representative; Cover Virginia, the BHSA, or the service authorization contractor; and other persons named in a release of information authorization signed by an appellant or his representative.~~

~~C. The fees to be charged and collected for any copies of DMAS Appeals Division records will be in accordance with Virginia's Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia) or other controlling law.~~

~~D. When copies are requested from records in the division's custody, the required fee shall be waived if the copies are requested in connection with an appellant's own appeal.~~

12VAC30-135-496 ~~Provider appeals .~~ (Repealed.)

~~A. GAP SMI program provider appeals shall be conducted in accordance with the department's provider appeal regulations in Part XII (12VAC30-20-500 et seq.) of 12VAC30-20, § 32.1-325 et seq. of the Code of Virginia, and the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).~~

~~B. The department's appeal decision shall be binding on and shall not be subject to further appeal by Cover Virginia, the BHSA, and the service authorization contractor.~~

12VAC30-135-498 ~~Individual rights .~~ (Repealed.)

~~A. Individuals who have been found eligible for and have been enrolled in the GAP SMI program shall have the right to be treated with respect and dignity by health care provider staff and to have their personal health information kept in confidence per the Health Insurance Portability and Accountability Act.~~

~~B. No premiums, copayments, coinsurance, or deductibles shall be charged to individuals who have been found to be eligible for and are enrolled in the GAP SMI program.~~