Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

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Information Regarding Contract Requirements for Medicaid Managed Care Organizations

The purpose of this Medicaid Memo is to describe contract requirements that the Department of Medical Assistance ("DMAS") has with Medicaid Managed Care Organizations who provide services to Virginia Medicaid recipients. This memo does not restate each contract requirement. Instead, this memo underscores the contractual obligations for DMAS contracted Commonwealth Coordinated Care Plus ("CCC Plus") and Medallion 4.0 MCOs to ensure all federal and state regulations regarding the managed care grievance and appeal system contained in state and federal regulations codified in 12 VAC 30-120-420[1] and §§42 CFR 438.400 - 42 CFR 438.424 (https://www.govregs.com/regulations/title42_chapterIV_part438_subpartF) are followed throughout the MCO appeal processes. The MCOs are contractually obligated to ensure their appeal system is compliant with these requirements. Additionally, the MCOs are required to evaluate their appeals; at a minimum, tracking trends in appeals. Routine review of the appeal system not only ensures alignment between current practices and requirements but can also identify gaps that put member rights at risk. Examples provided are by no means exhaustive but are to clarify specific provisions where suitable. The relevant citation from federal code and both CCC Plus (CCC Plus Contract, July 1, 2020) and Medallion 4.0 (Medallion 4.0 Contract, July 1, 2020) Contracts are cited for reference. Appeals received by the DMAS Appeals Division that reflect the MCO did not abide by these requirements may result in a decision reversing the MCO's action.

I. **Timely and adequate notice of adverse benefit determination *(Subpart F of §§42 CFR 438.404 - 42 CFR 438.406, §42 CFR 438.210, and §42 CFR 438.201b)***

A. Notice *(CCC Plus Contract Section 15.1 & Medallion 4.0 Contract Section 12)*
   1. The MCO shall ensure that Members and providers are sent written notice of any adverse benefit determination or adverse action.
   2. The MCO shall ensure Members are informed of their rights to appeal through the MCO as well as their rights to access the Department's State Fair Hearing after they have exhausted their appeals with the MCO.

B. Content of the Notice *(CCC Plus Contract Section 15.1; 15.4.1; 6.2.12 & Medallion 4.0 Contract Section 12.4; 8.1.D)*
   1. The reasons for the adverse benefit determination, including the right of the Member to be provided upon request and free of charge, reasonable

access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

a. The citation to the law or policy supporting such action must be included.
b. Notices must include sufficient detail to explain the factual basis and the applicable authority that allows Members enough information about the grounds for the denial of claims or coverage so that they can adequately challenge the decision. Statutes and regulations are the highest forms of authority and must be cited where applicable. Relevant DMAS manuals can be cited in addition to statutes and regulations, or as the sole policy if there is no statute or regulation.
    1. Example: It is **not sufficient** to only state "Services Reduced. Not Medically Necessary" with no other explanation provided. The notice must specify the factual basis and applicable authority that supports the action and how it applies to the Member's circumstances.
    2. Example: It is not sufficient to use boilerplate language without any meaningful explanation of why the requested units/hours are not, or are no longer, medically necessary. The MCO must specify partial denials so that the Member is clear what is being approved and what is being denied, with the justification for each, including the clinical rationale.
    3. Example: With respect to personal care services that are reduced or denied based on a member's Level of Care, the MCO should explain why the Level of Care guidelines are a more accurate assessment of the member's individual needs than the hours requested for ADL/IADL assistance.
    4. Example: The MCO should explain how the Member's needs and/or supports have changed such that previously approved units/hours are no longer medically necessary.

2. The notice must include information on the Members' right to request an appeal of the adverse benefit determination, including information on exhausting the MCO's internal appeal process and the right to request a State Fair Hearing only after the MCO's internal appeal process has

been exhausted and the procedures for exercising these rights. The notice must include a statement that the member can file additional documents and arguments during the appeal process.

3. The notice must inform Members about their right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it.

4. The notice must inform Members about their rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which Members may be required to repay the costs of these services.

5. The MCOs shall include the notice elements identified on the DMAS templates for 1) adverse benefit determinations and 2) internal appeal decisions. DMAS shall review and approve the form and content of the MCO's templates for adverse benefit determinations and internal appeal decisions prior to implementation. As described above, the notice must be individually tailored to include the relevant facts and authority for each adverse action.

6. The notice must include the titles and qualifications, including specialties, of individuals participating in the authorization review. Per contractual and federal requirements, the individuals must have appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs.

C. Timing of notice. *(CCC Plus Contract Sections 15.4.1; 6.2.12.1 & Medallion Contract Sections 8.1.D; 12.4)*

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, such notice shall be provided at least ten (10) days in advance of the date of its action. **This ten day period is not inclusive of mailing time.** Federal

and State regulations provide for a 5-day mailing period. It is presumed the notice is received by the member 5 days after the date on the notice, unless the member shows he did not receive the notice within the 5-day period. 42 CFR 431.231(c)(2); 12VAC30-110-160.

For denial of payment, such notice shall be provided at the time of action.

For standard service authorization decisions that deny or limit services, the notice is required as expeditiously as the Member's condition requires. The MCOs must ensure its service authorization policies and procedures meet the National Committee for Quality Assurance (NCQA) service authorization timeliness standards included as stated in the CCC Plus Contract Section 6.2.10.4 and Medallion 4.0 Contract Section 8.1.D.

2. For cases in which a Member's provider indicates or the MCO determines that following the standard authorization timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and **no later** than seventy-two (72) hours after receipt of the request for service.

3. In accordance with 42 CFR § 438.404(c), the MCO shall mail the adverse benefit determination notice within the following timeframes:

   a) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR §§ 431.211, 431.213, and 431.214.

   b. For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the

timeframes expire.

c. For expedited service authorization decisions, within the timeframes specified in § 438.210(d)(2).

II. **Handling of MCO Internal Appeals *(Subpart F of § 42 CFR 438.406)*** *(CCC Plus Contract Sections 15.1; 15.4.2 & Medallion Contract 4.0 Sections 12; 12.5)*

A. The MCO shall provide reasonable assistance to Members in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

B. The MCO's internal appeals process shall include the following requirements:

1. The MCO shall ensure that neither the individual nor a subordinate of any such individual who makes decisions on appeals was involved in any previous level of review or decision-making. In any case where the reason for the appeal involves clinical issues or is related to denials of expedited resolution of an appeal, the MCO shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the Member's condition or disease.

2. Decision-makers take into account all comments, documents, records, and other information submitted by the Member or the Member's authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

3. An appeal may be submitted orally or in writing by the Member, Member's attorney, or Member's authorized representative. The MCO shall recognize oral inquiries seeking to appeal an adverse benefit determination (to establish the earliest possible filing date for the appeal). If the Member does not request an expedited appeal, the MCO shall require the Member to follow an oral appeal with a written, signed appeal.

4. A reasonable opportunity for the Member or authorized representative to present evidence and allegations of fact or law in person, as well as in writing. The MCO shall inform the Member of the limited time available for this, especially in the case of expedited resolution.

5. A process to provide the Member and his or her representative the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO or at the direction of the MCO in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for standard (thirty (30) calendar days) and expedited (seventy-two (72) hours) internal appeals.

6. The Member, authorized representative, or estate representative of a deceased Member are considered as parties to the appeal.

III. MCO Internal Appeal Resolution and Notification (Subpart F of § 42 CFR 438.408)

A. Basic Rule and Specific Timeframe *(CCC Plus Contract Sections 15.1; 15.4.2 & Medallion Contract Section 12.5)*

1. Standard Resolution
    a. The MCO shall respond in writing to standard internal appeals as expeditiously as the Member's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal.

2. Expedited Resolution
    a. The internal appeals process shall include provisions for expedited appeals for Members within seventy-two (72) hours from receipt of the appeal request.

B. Extension of Timeframes *(CCC Plus Contract Sections 15.4.2; 15.4.3.2 & Medallion Contract Sections 12;12.5)*

1. Member Request or MCO Determination:
    a. The MCO may extend this timeframe by up to an additional fourteen (14) calendar days if the Member requests the extension or if the MCO provides evidence satisfactory to DMAS that there is a need for additional information and that a delay in rendering the decision is in the Member's interest.

2. Requirements Following the Extension:
    a. If the MCO extends the timeframe for an appeal not at the Member's request, reasonable efforts shall be made to give the Member prompt oral notice of the delay.
    b. The MCO shall make reasonable efforts to provide oral notice and shall within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision.
    c. The MCO shall resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

3. Deemed Exhaustion of Appeals Process:
    a. If the MCO internal appeal resolution notice does not meet the timing requirements, the process may be deemed exhausted which allows the Member to file an appeal with the DMAS Appeals Division, or as applicable, its contractor for FAMIS Medallion 4.0 members.

4. Format and Content of Internal Appeal Decision Notice:
    a. Written materials for Members shall use easily understood

language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs or those who are not English language proficient. Members shall be informed that information is available in alternate formats and how to access those formats.

b. The MCO shall provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited internal appeal within seventy-two (72) hours from the initial receipt of the appeal.
c. All MCO internal appeal decisions shall be in writing and shall include, at a minimum, the following information:
    1. The decision reached by the MCO, including a specific discussion of the reason for any adverse benefit determination, including citations to the statutes, regulations, policies and/or other authority that supports the decision.
        a. Notices must include sufficient detail to explain the factual basis and the applicable authority that allows Members enough information about the grounds for the denial of claims or coverage so that they can adequately challenge the decision. Further, the Notice must address any additional comments, documents, records, and other information submitted by the Member or his/her representative during the internal appeals process, and explain how it was considered when determining medical necessity.
            i. Example: It is not sufficient to repeat language from the original denial or utilize boilerplate language without any meaningful explanation of why units/hours were no longer medically necessary.
            ii. Example: It is not sufficient to simply state the units/hours requested are more than required to perform the task. The MCO must explain why a reduction/termination is warranted and why the units/hours requested are more than required to perform the service. The explanation must be specific to the Member's conditions and circumstances.
            iii. Example: The MCO must explain how needs or supports have changed such that previously approved units/hours are no longer medically

necessary.

2. The date the Member's appeal request was received.
3. The date of the decision.
4. For appeals not resolved wholly in favor of the Member:
    a. The right to request an appeal of the MCO's final denial through the DMAS State Fair Hearing process and how to do so. The final denial letter shall clearly identify that the MCO's internal appeal process has been exhausted, and include the timeframe for filing an appeal to DMAS, the submission methods and related address and phone numbers to file an appeal, and list pertinent statutes/regulations governing the appeal process.
    b. The right to request to receive benefits while the State Fair Hearing is pending and how to make the request, explaining that the Member may be held liable for the cost of those services if the State Fair Hearing decision upholds the MCO to the extent that services were furnished (continued) solely because of the requirements of this section.
    c. A list of titles and qualifications, including specialties, of individuals participating in the appeal review. As required in both the CCC+ and Medallion 4.0 contracts and federal regulation, an MCO's process for handling appeals of adverse benefit determinations must ensure that the individuals who make decisions on appeals are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease.
    d. The right to be represented by an attorney or other individual.
    e. If applicable, information on how to contact the Office of the State Long-Term Care Ombudsman, Department for Aging and Rehabilitative Services.

IV. **Expedited resolution of appeals (Subpart F of § 42 CFR 438.410)** *(CCC Plus Contract Section 15.4.2 & Medallion Contract Section 12.5)*

A. The MCO shall establish and maintain an expedited review process for internal

appeals when the MCO determines (on a request from the Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that the time expended in a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

B. The MCO shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

C. In instances where the Member's request for an expedited internal appeal is denied, the internal appeal shall be transferred according to the timeframe for standard resolution of internal appeals, and the Member shall be given prompt oral notice of the denial. Within two (2) calendar days of the oral notice of denial, written notice shall be sent stating the reason the decision for an expedited appeal was denied and informing of the right to file a grievance if the Member disagrees with that decision.

D. For any extension not requested by the Member, the MCO shall make reasonable efforts to give the Member prompt oral notice of the delay; written notice within two (2) calendar days to the Member of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. The MCO must resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

V. **Information to Subcontractors and Providers (Subpart F of § 42 CFR 438.414)** *(CCC Plus Contract Section 15.1 & Medallion Contract Section 12)*

A. The MCO shall notify providers and Members of their rights to grievances and appeals with the MCO. The MCO shall ensure that all network providers are informed, at the time they enter into a contract, about all Member grievance, appeal, and fair hearing procedures, timeframes, and associated Member rights as specified in 42 CFR 438.400 through 42 CFR 438.424.

VI. **Record Keeping (Subpart F of § 42 CFR 438.416)** *(CCC Plus Contract Section 15.8.1 & Medallion Contract Section 12.10.A)*

A. The MCO shall maintain records of grievances and appeals and must review the information as part of its ongoing quality improvement strategy, which is reported to DMAS.

B. The MCO shall maintain an accurate record in a manner accessible to DMAS which shall be made available upon request to Centers for Medicare and Medicaid Services. The record of each grievance or appeal must contain, at a minimum, all of the following information:
   1. A general description of the reason for the appeal or grievance;
   2. The date received;
   3. The date of each review or, if applicable, review meeting;
   4. Resolution at each level of the appeal or grievance, if applicable;
   5. Date of resolution at each level, if applicable; and
   6. Name of the covered Member.

VII. **Continuation of benefits while the MCO appeal is pending (Subpart F of § 42 CFR 438.420)** *(CCC Plus Contract Section 15.4 & Medallion 4.0 Contract Section 12.3)*

A. Timely File means files for continuation of benefits on or before the later of the following:
   1. Within 10 calendar days of the MCO sending the notice of adverse benefit determination.
   2. The intended effective date of the MCO's proposed adverse benefit determination.

   Note: The ten day period is not inclusive of mailing time**.** Federal and State regulations provide for a 5-day mailing period. It is presumed the notice is received by the member 5 days after the date on the notice, unless the member shows he did not receive the notice within the 5-day period. 42 CFR § 431.231(c)(2); 12VAC30-110-160.

B. Continuation of benefits must continue the enrollee's benefits if all of the

following occur:

1. The enrollee files the request for an appeal timely in accordance with 42 CFR § 438.402(c)(1)(ii) and (c)(2)(ii).
2. The appeal involves the termination, suspension, or reduction of previously authorized services.
3. The services were ordered by an authorized provider.
4. The period covered by the original authorization has not expired.
5. The enrollee timely files for continuation of benefits.

C. Duration of continuation or reinstated benefits

1. If, at the enrollee's request, the MCO continues or reinstates the enrollee's benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of following occurs:
    a. The enrollee withdraws the appeal or request for State Fair Hearing.
    b. The enrollee fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under 42 CFR § 438.408(d)(2). This ten day period is not inclusive of mailing time. Federal and State regulations provide for a 5-day mailing period. It is presumed the notice is received by the member 5 days after the date on the notice, unless the member shows he did not receive the notice within the 5-day period. 42 CFR § 431.231(c)(2); 12VAC30-110-160.
    c. A State Fair Hearing office issues a hearing decision adverse to the enrollee.

D. If the final resolution of the appeal upholds the MCO’s action and services to the Member were continued while the internal appeal and State Fair Hearing was pending, the MCO may recover the cost of the continuation of services from the Member.

VIII. **Effectuation of Reversed Appeal Decisions (Subpart F of § 42 CFR 438.424)**
(CCC Plus Contract Section 15.4.3.3 & Medallion Contract Section 12.6.C)

A. If the appeal decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the MCO shall authorize the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than **seventy-two (72) hours** from the date the MCO receives the notice reversing the decision. If the appeal decision reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the MCO must pay for those services.

IX. MCO Role in State Fair Hearing Process *(CCC Plus Contract Section 15.3, 15.4.3.3 & Medallion Contract Section 12.2, 12.6.C)*

A. Submission of MCO internal appeal decision to the DMAS Appeals Division
   1. Within twenty-four (24) hours of a request by DMAS, the MCO must either:
      a. Fax (or email if requested by email) a copy of the Member's internal appeal decision to the DMAS Appeals Division at 804-452-5454; or
      b. If there has been no internal appeal decision, notify the Appeals Division in writing that the Member has not exhausted the MCO's appeal process.

B. Parties to the State Fair Hearing
   1. The MCO shall attend and defend the MCO's decisions at all DMAS appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS Appeals Division.

C. Appeal Summary
   1. Upon receipt of notification by DMAS of an appeal, the MCO shall prepare and submit an appeal summary describing the basis of the adverse benefit determination to the DMAS Appeals Division and the Member involved in the appeal in accordance with required time frames noted below.
      a. For CCC Plus Members, a complete copy of the appeal summary must also be emailed to DMAS at CCCPlusAppeals@dmas.virginia.gov.
         1. The appeal summary must be sent to the appellant and DMAS on same day as it was transmitted to the DMAS

Appeals Division.

2. The appeal summary must be in accordance with 12 VAC 30-110-70.
    a. The appeal summary shall include the justification for the appealed action.
        1. Including but not limited to the facts, policy, and applicable statutes and/or regulations (not a summary thereof) upon which the MCO's decision is based. In cases of a change in a previously approved authorization, part of the explanation must include a discussion of the factual changes that warrant the reduction or termination. The MCO **must** evaluate the information contained in the appeal request, including any additional documentation received after the initial adverse benefit determination, and if it is not sufficient for an approval, state how that information and documentation does not meet the criteria for authorization at the requested level.
3. For standard appeals, the MCO must submit the appeal summary to DMAS within twenty-one (21) calendar days of the date on which the Appeals Division initially notifies the MCO of the appeal.
    a. For all standard appeals, the summary shall be received by DMAS at least ten (10) calendar days prior to the scheduled hearing date and mailed to the Member on the date submitted to the DMAS Appeals Division.
    b. For expedited appeals, the appeal summary shall be faxed to DMAS and faxed or overnight mailed to the Member, as expeditiously as the Member's health condition requires, but no later than four (4) hours after DMAS informs the MCO of the expedited appeal.
    c. Failure to submit appeal summaries within the required timeframe or with the required content shall result in performance penalties described in the Contracts.

For more information about the Medallion managed care program, please visit http://www.dmas.virginia.gov/#/med4 and for more information about the CCC Plus managed care program, please visit http://www.dmas.virginia.gov/#/cccplus

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PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or Call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	www.aetnabetterhealth.com/Virginia 1-800-279-1878
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid 1-800-901-0020
Magellan Complete Care of Virginia	www.MCCofVA.com 1-800-424-4518 (TTY 711) or 1-800-643-2273
Optima Family Care	1-800-881-2166
United Healthcare	www.Uhccommunityplan.com/VA and www.myuhc.com/communityplan 1-844-752-9434, TTY 711
Virginia Premier	1-800-727-7536 (TTY: 711)

[1] The Virginia Administrative Code can be found at https://law.lis.virginia.gov/admincode/