12 VAC 30-120-360. Definitions.

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

"Appeal" means any written communication from a client or his representative which clearly expresses that he wants to present his case to a reviewing authority.

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

"Capitation payment" means the payment issued to an HMO contractor by DMAS on behalf of a client, in return for which the HMO accepts responsibility for the services to be provided under a contract a payment the department makes periodically to a contractor for each recipient enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the recipient receives services during the period covered by the [fee. payment.]

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

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

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

"DMAS" means the Department of Medical Assistance Services.

"Eligible person" means any person determined by DMAS as eligible to receive services and benefits under eligible for Virginia Medicaid in accordance with the State Plan for Medical Assistance under Title XIX of the Social Security Act.

"Emergency services" means those health care services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, that are rendered by participating or nonparticipating providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency services provided within the MCO plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the managed care organization could reasonably be expected to cause the recipient's condition to worsen if left unattended.

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

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

"Foster care" means a child who received either foster care assistance under Title IV-E of the Social Security Act or state and local foster care assistance.

"Grievance" means any request by a client, or a provider on behalf of a client, to an HMO to resolve a dispute regarding coverage or payment for services under the Medallion II Program an oral or written communication made by or on behalf of a member expressing dissatisfaction with the resolution of a complaint. Grievances are usually handled by the MCO's Internal Grievance Committee and are related to: (i) the availability, delivery or quality of health care services including the utilization review decisions that are adverse to the member or (ii) payment or reimbursement of health care service claims.

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

"HMO" "Managed care organization" or "MCO" means a health maintenance organization, as licensed by the State Corporation Commission's Bureau of Insurance, which undertakes to provide or arrange for one or more health care plans an organization that offers managed care health insurance plans (MCHIP) as defined by § 38.2-5800 of the Code of Virginia. Any health maintenance organization as defined in § 38.2-4300 of the Code of

Virginia or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 of the Code of Virginia or preferred provider subscription contracts as defined in § 38.2-4209 of the Code of Virginia shall be deemed to be offering one or more MCHIPs.
"Network" means doctors, hospitals or other health care providers who participate or contract with an HMO MCO and, as a result, agree to accept a mutually-agreed upon sum or fee schedule as payment in full for covered services that are rendered to eligible participants.
"Nonparticipating provider" means a facility not in the HMO's network or a provider not in the HMO's network practicing at a facility not in the HMO's health care entity or health care professional not in the contractor's participating provider network.
"Primary care case management" or "PCCM" means a system under which a primary care case manager contracts with the Commonwealth to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid recipients.
"School-based services" means those therapy services, nursing services, psychiatric/psychological screenings, and well-child screenings, rendered to children who qualify for these services under the federal Individuals with Disabilities Education Act (20 USC § 1471 et seq.) by (i) employees of the school divisions or (ii) providers that subcontract with school divisions.
"Spend-down" means the process of reducing countable income by deducting incurred medical expenses for medically needy individuals, as determined in the State Plan for Medical Assistance.
"Subsidized adoption" means any child for whom an adoption assistance agreement is in effect.
12 VAC 30-120-370. Medallion II enrollees.
A. DMAS shall determine enrollment in Medallion II. Enrollment in Medallion II is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Program.
B. The following individuals shall be excluded from participating in Medallion II. Individuals not meeting the exclusion criteria must participate in the Medallion II program.
1. Individuals who are inpatients in state mental hospitals;
2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded;
3. Individuals who are placed on spend-down;
4. Individuals who are participating in federal waiver programs for home-based and community-based Medicaid coverage;
5. Individuals who are participating in foster care or subsidized adoption programs;
6. Individuals who are in the third trimester of pregnancy upon initial assignment to Medallion II and who request exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid enrolled in DMAS authorized residential treatment or treatment foster care programs;
7. Individuals who are in their ninth month of pregnancy, when they are or will be automatically assigned or reassigned, and were not in the Medicaid HMO to which they were assigned or reassigned within the last seven months, if they are seeking care from a provider (physician or hospital or both) not affiliated with the HMO to which they were previously assigned. Exclusion requests may be made by the HMO, a provider, or the recipient. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member’s obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid and do not meet any other exclusion;
8. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the HMO MCO;
9. Individuals who enter into a Medicaid approved receive hospice program services in accordance with DMAS criteria;
10. Individuals with any other comprehensive group or individual health insurance Medicare coverage;
11. Individuals who have been preassigned to an HMO but have not yet been enrolled, requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time

of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge;
12. Individuals who have been preassigned to an HMO but have not yet been enrolled, who are scheduled for surgery which is scheduled to be within 30 days of initial enrollment into the HMO, which requires an inpatient hospital stay, until the first day of the month following discharge;
13. 12. Individuals who have been preassigned to an HMO MCO but have not yet been enrolled, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less, if they request exclusion. The client's physician must certify the life expectancy; and
14. 13. Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment.
C. Medallion II managed care plans shall be offered to recipients, and recipients shall be enrolled in those plans, exclusively through an independent enrollment broker under contract to DMAS.
D. Clients shall be enrolled as follows:
1. All eligible persons, except those meeting one of the exclusions of subsection B of this section, shall be enrolled in Medallion II.
2. Clients shall receive a Medicaid card from DMAS during the interim period, and shall be provided authorized medical care in accordance with DMAS' procedures, after eligibility has been determined to exist.
3. Once individuals are enrolled in Medicaid, they will receive a letter indicating that they may select one of the contracted HMOs MCOs. These letters shall indicate a preassigned HMO MCO, determined as provided in subsection E of this section, in which the client will be enrolled if he does not make a selection within a period specified by DMAS of not less than 45 30 days.
4. The effective date of coverage in the Medallion II program for newly eligible individuals under the Virginia Medical Assistance Program (except for those specified under subdivision 6 of this subsection) and individuals who move from the area of their Medallion II HMO shall be assigned to an HMO as described in subdivision 3 of this subsection.
5. 4. A child born to a woman enrolled with an HMO MCO will be enrolled with the HMO MCO from birth until the last day of the third month including the month of birth, unless otherwise specified by the Enrollment Broker. For instance, a child born during the month of February will be automatically enrolled until April 30. By the end of that third month, the child will be disenrolled unless the Enrollment Broker specifies continued enrollment. If the child remains an inpatient in a hospital at the end of that third month, the child shall automatically remain enrolled until the last day of the month of discharge, unless this child's parent requests disenrollment.
6. 5. Individuals who lose then regain eligibility for Medallion II within 60 days will be reenrolled into their previous HMO MCO without going through preassignment and selection.
E. Clients who do not select an HMO MCO as described in subdivision D 3 of this section shall be assigned to an HMO MCO as follows:
1. MEDALLION primary care physicians will be asked to select the HMO in which their MEDALLION clients will be enrolled.
2. Clients currently enrolled in "Options" shall be assigned to the HMO in which they participated under "Options" if that HMO contracts with DMAS for Medallion II.
1. Clients are assigned through system algorithm based upon the client's history with a contracted MCO.
3. 2. Clients not assigned pursuant to subdivision 1 or 2 of this subsection shall be assigned to the HMO MCO of another family member, if applicable.
4. 3. All other clients shall be assigned to an HMO MCO on a basis of approximately equal number by HMO MCO in each locality.
4. In areas where there is only one contracted MCO, recipients have a choice of enrolling with the contracted MCO or the PCCM program. All eligible recipients in areas where one contracted MCO exists, however, are automatically assigned to the contracted MCO. Individuals are allowed 90 days after the effective date of new or initial enrollment to change from either the contracted MCO to the PCCM program or vice versa.

F. Following their initial enrollment into an HMO MCO or PCCM program, recipients shall be restricted to that HMO the MCO or PCCM program until the next open enrollment period, unless appropriately disenrolled or excluded by the department.
1. During the first 90 calendar days of enrollment in a new or initial HMO MCO, a client may disenroll from that HMO MCO to enroll into another HMO MCO or into PCCM, if applicable, for any reason. Such disenrollment shall be effective no later than the first day of the second month after the month in which the client requests disenrollment.
2. During the remainder of the enrollment period, the client may only disenroll from one HMO MCO into another MCO or PCCM, if applicable, upon determination by DMAS that good cause exists as determined under subsection H of this section.
G. The department shall conduct an annual open enrollment for all Medallion II participants, including in areas where there is only one contracted MCO. The open enrollment period shall be the 60 calendar days before the end of the enrollment period. Prior to the open enrollment period, DMAS will inform the recipient of the opportunity to remain with the current HMO MCO or change to another HMO MCO, without cause, for the following year. In areas with only one contracted MCO, recipients will be given the opportunity to select either the MCO or the PCCM program. Enrollment selections will be effective on the first of the next month following the open enrollment period. Recipients who do not make a choice during the open enrollment period will remain with their current HMO and shall have priority over those individuals who are seeking to enroll with that HMO MCO selection.
H. Disenrollment for good cause may be requested at any time.
1. After the first 90 days of enrollment in an HMO MCO, clients must request disenrollment from DMAS based on good cause. The request must be made in writing to DMAS and cite the reasons why the client wishes to disenroll. Good cause for disenrollment shall include the following:
a. A recipient's desire to seek services from a federally qualified health center which is not under contract with the recipient's current HMO but is under contract to another HMO available to the recipient MCO, and the recipient (i) requests a change to another MCO that subcontracts with the desired federally qualified health center or (ii) requests a change to the PCCM, if the federally qualified health center is contracting directly with DMAS as a PCCM;
b. Performance or nonperformance of service to the recipient by an HMO MCO or one or more of its providers which is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care;
c. Lack of access to necessary specialty services covered under the State Plan;
d. A client has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted HMO MCO or PCCM program, if applicable, or provider; or
e. Other reasons as determined by DMAS through written policy directives.
2. DMAS shall determine whether good cause exists for disenrollment.
3. Good cause for disenrollment shall be deemed to exist and the disenrollment shall be granted if DMAS fails to take final action on a valid request prior to the first day of the second month after the request.
4. The DMAS determination concerning good cause for disenrollment may be appealed by the client in accordance with the department's client appeals process at 12 VAC 30-110-10 through 12 VAC 30-110-380.
5. The current HMO MCO shall provide, within two working days of a request from DMAS, information necessary to determine good cause.
12 VAC 30-120-380. Medallion II provider MCO responsibilities.
A. The HMO MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part.
Nonemergency services provided by hospital emergency departments shall be covered by HMOs MCOs in accordance with rates negotiated between the HMOs MCOs and the emergency departments.
B. Services that shall be provided outside the HMO MCO network, and reimbursed by DMAS, are shall include, but are not limited to, those services defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include school-based services and community mental health services (rehabilitative, targeted case management and waiver substance abuse services). Clients may also seek emergency services and family planning services from a provider outside the HMO. The HMOs MCOs shall pay for emergency services and family planning services and supplies whether they are provided inside or outside the HMO MCO network.

The HMOs shall pay for services furnished in:
1. Facilities or by practitioners outside the HMOs' networks if services are needed because of a medical emergency;
2. Areas outside the HMOs' service areas if medical services are needed and the recipient's health would be endangered if he were required to travel to his place of residence;
3. Another state if it is general practice for recipients in that area to receive medical services in another state; and
4. Facilities or by practitioners outside the HMOs' networks if the needed medical services or necessary supplementary resources are not available in the HMOs' networks.

C. Immunizations shall not be included in the fee that DMAS pays the HMOs. The HMO may choose to offer immunizations under the regular Medicaid immunization reimbursement methodology or may refer the patient to a local health department.

D. C. The HMOs MCOs shall report encounter data to DMAS under the contract requirements, which may include data reports based on the Health Plan Employer Data and Information Set (HEDIS), report cards for clients, and ad hoc quality studies performed by the MCO or third parties.

E. D. The HMO MCO shall maintain such records as may be required by federal and state law and regulation and by DMAS policy. The HMO MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

F. E. The HMO MCO shall ensure that the health care provided to its clients meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

G. Effective January 1, 1997, each HMO shall test the readability of its program information documents by use of the Flesch Readability Formula, as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1962), and no program information document shall be used unless it achieves a Flesch total readability score of 40 or better. This requirement shall not apply to language that is mandated by federal or state laws, regulations or agencies.

All program information documents within the scope of this section, and all amendments thereto, shall be filed with DMAS in advance of their use and distribution, accompanied by certificates setting forth the Flesch scores and certifying compliance with the requirements of this section. Any program information document to which this does not apply shall be accompanied by a documentation of the federal or state laws, regulation or agency mandate that authorizes the exemption. The term "program information documents" means all forms, brochures, handbooks or other documentation (i) provided to recipients covered under Medicaid managed care programs and (ii) describing the programs' medical care coverages and the rights and responsibilities of recipients covered. The term "recipient" shall include potential recipients and recipients.

H. F. The HMOs MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the state and the contractor. Initial face-to-face Medical evaluations shall be available within 48 hours for urgent care and within 15 business 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

I. G. The HMOs MCOs must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor. The HMOs shall include in their network a sufficient number of providers of each type of covered service (i.e., speech, occupational, or physical therapy) to ensure adequate access. For example, HMOs must include, but are not necessarily limited to, providers specializing in early childhood, youth and geriatric services.

J. H. Preauthorization and concurrent review decisions must be supervised by qualified medical professionals and completed within two business days after receipt of all necessary information as defined by the contract between DMAS and the MCO.

K. When the need is identified, the HMOs shall designate a single case manager, who shall function as an exceptional needs care coordinator within the HMO, for all persons with complex health care needs.

L. I. The HMOs MCOs shall not charge copayments to any categorically needy enrollees.

12 VAC 30-120-385. Medallion II provider responsibilities in Northern Virginia. (Repealed.)

In addition to the requirements in 12 VAC 30-120-380, HMOs providing services in the Northern Virginia region shall comply with the requirements of this section. Inpatient and outpatient mental health services provided by physicians, practitioners, and clinics shall be provided outside the HMO network and shall be reimbursed directly by DMAS.

12 VAC 30-120-390. Payment rate for Medallion II HMOs MCOs.
The payment rate to HMOs MCOs shall be based on contract negotiations set by negotiated contracts.
12 VAC 30-120-395. Payment rate for preauthorized or emergency care provided by out-of-network providers.
The HMOs MCOs shall pay for preauthorized or emergency services when they are provided outside the HMO MCO network. Preauthorized or emergency care provided to a Medallion II client by a provider or facility not participating in the client's MCO's network will be reimbursed according to the current Medicaid fee schedule. This reimbursement shall be considered payment in full to the provider or facility of emergency care.
12 VAC 30-120-400. Quality control and utilization review.
A. DMAS shall rigorously monitor the quality of care provided by the HMOs MCOs. DMAS may contract with one or more external quality review organizations to perform focused studies on the quality of care provided by the HMOs MCOs. The external organizations may utilize data or other tools to ensure contract compliance and quality improvement activities. Specifically, DMAS shall monitor to determine if the HMO MCO:
1. Fails substantially to provide the medically necessary items and services required under law or under the contract to be provided to an enrolled recipient and the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual. This shall be monitored through the review of encounter data on a routine basis and other methods determined by DMAS.
2. Imposes on clients premium amounts in excess of premiums permitted. This shall be monitored through surveying a sample of clients at least annually and other methods determined by DMAS.
3. 2. Engages in any practice that discriminates among individuals on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, or any practice that could reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by § 1903(m) of the Social Security Act (42 USC § 1396b(m))) by eligible individuals whose medical conditions or histories indicate a need for substantial future medical services. This shall be monitored through surveying a sample of clients at least annually and other methods determined by DMAS.
4. 3. Misrepresents or falsifies information that it furnishes, under § 1903(m) of the Social Security Act (42 USC § 1396b(m)) to HCFA CMS, DMAS, an individual, or any other entity. This shall be monitored through surveying a sample of clients at least annually and other methods determined by DMAS.
5. 4. Fails to comply with the requirements of 42 CFR 417.479(d) through (g) relating to physician incentive plans, or fails to submit to DMAS its physician incentive plans as required or requested in 42 CFR 434.70. This provision shall be monitored through review of the information listed in 42 CFR 417.479(h)(1) as submitted by the HMOs in accordance with the requirements of 42 CFR 434.70.
B. DMAS shall ensure that data on performance and patient results is collected. Specifically, DMAS shall review, which may include on-site reviews, encounter data submitted by the HMOs as defined in the contracts. This review shall include, but not be limited to:
1. Whether services were properly authorized or excluded,
2. The adequacy and appropriateness of services provided or denied, and
3. Analysis of possible trends in increases or reductions of services.
C. DMAS shall ensure that quality outcomes information is provided to HMOs MCOs. DMAS shall ensure that changes which are determined to be needed as a result of quality control or utilization review are made.
12 VAC 30-120-410. Sanctions.
A. If DMAS determines that an HMO MCO is not in compliance with state or federal laws, regulations (including but not limited to the requirements of or pursuant to 12 VAC 30-120-380 F E), or their Medallion II contract, DMAS may impose sanctions on the HMO MCO. The sanctions may include but are not limited to:
1. Limiting enrollments in the HMO MCO by freezing voluntary recipient enrollments,
2. Freezing DMAS assignment of recipients to the HMO MCO,
3. Limiting HMO MCO enrollment to specific areas,
4. Denying, withholding, or retracting payments to the HMO MCO, and
5. Terminating the HMO's MCO's Medallion II contract, and.
6. Developing procedures with which the HMO must comply to eliminate specific sanctions.
B. In the case of an HMO MCO that has repeatedly failed to meet the requirements of §§ 1903(m) and 1932 of the Social Security Act, DMAS shall, regardless of what other sanctions are imposed, impose the following sanctions.
1. Appoint a temporary manager to:

a. Oversee the operation of the Medicaid managed care organization upon a finding by DMAS that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or
b. Assure the health of the organization's enrollees if there is a need for temporary management while (i) there is an orderly termination or reorganization of the organizations organization or (ii) improvements are made to remedy the violations found under subsection A of this section. Temporary management under this subdivision may not be terminated until DMAS has determined that the HMO MCO has the capability to ensure that the violations shall not recur.
2. Permit individuals enrolled with the HMO MCO to disenroll without cause. If this sanction is imposed, DMAS shall be responsible for notifying such individuals of the right to disenroll.
C. Prior to terminating a contract as permitted under subdivision A 5 of this section, DMAS shall provide the HMO MCO with a hearing. DMAS may not provide an HMO MCO with a pretermination hearing before the appointment of a temporary manager under subdivision B 1 of this section.
D. Prior to imposing any sanction other than termination of the HMO's MCO's contract, DMAS shall provide the HMO MCO with notice, develop procedures with which the MCO must comply to eliminate specific sanctions, and provide such other due process protections as the state may provide.
E. In accordance with the terms of the contract, HMOs MCOs shall have the right to appeal any adverse action taken by DMAS. For appeal procedures not addressed by the contract, the HMO MCO shall proceed in accordance with the appeals provisions of the Virginia Public Procurement Act (§ 11-35 2.2-4300 et seq. of the Code of Virginia). Pursuant to §§ 11-70 2.2-4364 and 11-71 2.2-4365 of the Code of Virginia, DMAS establishes shall establish an administrative appeals procedure, through which the HMO MCO may elect to appeal decisions on disputes arising during the performance of its contract. Pursuant to § 11-71 2.2-4365 of the Code of Virginia, such appeal shall be heard by a hearing officer; however, in no event shall the hearing officer be an employee of DMAS. In conducting the administrative appeal, the hearing officer shall follow the hearing procedure used in § 9-6.14:12 2.2-4020 of the Code of Virginia.
F. When DMAS determines that an HMO MCO committed one of the violations specified in 12 VAC 30-120-400 A, DMAS shall implement the provisions of 42 CFR 434.67.
1. Any sanction imposed pursuant to this subsection shall be binding upon the HMO MCO.
2. The HMO MCO shall have the appeals rights for any sanction imposed pursuant to this subsection as specified in 42 CFR 434.67.
12 VAC 30-120-420. Client grievances.
A. The HMOs MCOs shall, whenever a client's request for covered services is reduced, denied or terminated, or payment for services is denied, provide a written notice in accordance with the notice provisions specified in 12 VAC 30-110-70 through 12 VAC 30-110-100,; federal requirements at 42 CFR 431.211, 431.213 and 431.214, 42 CFR Part 431, Subpart E, Fair Hearings for Applicants and Recipients; and any other statutory or regulatory requirements.
B. Disputes between the HMO MCO and the client concerning any aspect of service delivery, including medical necessity and specialist referral, shall be resolved through a verbal (informal) or written (formal) grievance process operated by the HMO MCO or through the DMAS appeals process. A provider may act on behalf of a client in the HMO's MCO's internal informal or formal grievance procedures.
1. A written request for a grievance or appeal shall be filed within 30 days of the client's receipt of the notice of adverse action, in accordance with the time limit for requests for appeal specified in 12 VAC 30-110-160 and 12 VAC 30-110-170. Any written communication from a client or his representative (including a provider acting on behalf of the client) which clearly expresses that he wants to present his case to a reviewing authority shall constitute an appeal request.
2. In compliance with 14 VAC 5-210-70 H 4, pending resolution of a written grievance filed by a client or his representative (including a provider acting on behalf of the client), coverage shall not be terminated for the client for any reason which is the subject of the written complaint. In addition, the HMO MCO shall not terminate or reduce services as specified in 12 VAC 30-110-100.
C. The HMO MCO shall develop written materials describing the informal and formal grievance system and its procedures and operation.
D. The HMO MCO shall designate a person or persons to be responsible for the receipt and timely processing of client grievances. The HMO must maintain a grievance log summarizing each grievance. The grievance log shall capture the dates of receipt and decision and the nature of the decision. The log shall distinguish between Medicaid clients and commercial clients unless the HMO maintains a separate system for Medicaid clients

maintain a recordkeeping and tracking system for complaints, grievances, and appeals that includes a copy of the original written complaint, grievance, or appeal; the decision; and the nature of the decision. This system shall distinguish Medicaid from commercial enrollees, if the MCO does not have a separate system for Medicaid enrollees.

E. At the time of enrollment and at the time of any adverse actions, the HMO MCO shall notify the client, in writing, that:

1. Medical necessity, specialist referral or other service delivery issues may be resolved through a system of informal and formal grievances, within the HMO MCO or through the DMAS client appeals process,
2. Clients have the right to appeal directly to DMAS, and
3. The HMO MCO shall promptly provide grievance forms and written procedures to clients who wish to register written grievances.

F. The HMO MCO shall, within two days of receipt of any written request for a grievance, provide DMAS with a copy of the request.

G. The HMO MCO shall issue informal grievance decisions within seven days from the date of initial receipt of the grievance as defined by the contract between DMAS and the MCO. The informal decision is not required to be in writing.

H. The HMO MCO shall issue formal grievance decisions within 14 days from the date of initial receipt of the formal grievance. The formal decision shall be required to be in writing and shall include but is not limited to:

1. The decision reached by the HMO MCO,
2. The reasons for the decision,
3. The policies or procedures which provide the basis for the decision, and
4. A clear explanation of further appeal rights and a timeframe for filing an appeal.

I. The HMO MCO shall provide DMAS with a copy of its formal grievance decision concurrently with the provision of the decision to the client.

J. An expedited grievance decision shall be issued within 48 hours in case of medical emergencies, in which delay could result in death or serious injury to a client. Written confirmation of the decision shall promptly follow the verbal notice of the expedited decision.

K. Any grievance decision by the HMO MCO may be appealed by the client to DMAS in accordance with the department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-380. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-380 and shall not base any appealed decision on the record established by any grievance decision of the HMO MCO. The HMO MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the HMO MCO.

L. A client may appeal directly to DMAS in accordance with the department's client appeal process. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-380 and shall not base any appealed decision on the record established by any decision of the HMO. The HMO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the HMO.

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

CERTIFIED:

_____9/10/2002_____
Date

/s/ Patrick W. Finnerty____
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services