12VAC30-120-360. Definitions.

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

"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~~ MCO contractor by DMAS on behalf of a client, in return for which the ~~HMO~~ MCO accepts responsibility for the services to be provided under a contract.

"Client," "clients," "recipient," or "enrollee" 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 enrollment from one Medallion II ~~HMO~~ Managed Care Organization ("MCO") plan to another MCO.

"DMAS" means the Department of Medical Assistance Services.

"Eligible person" means any person determined by DMAS as eligible to receive services and benefits under the State Plan for Medical Assistance.

"Emergency services" means those health care services that are rendered by participating or non-participating providers ~~provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care,~~ 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 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 recipient marketing and outreach.

"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~~ MCO to resolve a dispute regarding coverage or payment for services under the Medallion II Program.

"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 which offers managed care health insurance plans (MCHIP) as defined by Virginia Code § 38.2-5800. Any health maintenance organization as defined in

§ 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 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.

"Nonparticipating provider" means a facility not in the ~~HMO's~~ MCO's network or a provider not in the ~~HMO's~~ MCO's network practicing at a facility not in the ~~HMO's~~ MCO's network.

"Primary care case management (PCCM)" means a system under which a primary care case manager contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

"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.

12VAC30-120-370. 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;

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~~ MCO 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~~ MCO to which they were previously assigned. Exclusion requests may be made by the ~~HMO~~ MCO, a provider, or the recipient. 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 who live outside their area of residence for greater than 60 days except those individuals placed there for medically necessary services funded by the ~~HMO~~ MCO;

9. Individuals who enter into a Medicaid approved hospice program in accordance with DMAS criteria;

10. Individuals with any other comprehensive group or individual health insurance coverage;

11. Individuals who have been preassigned to an ~~HMO~~ MCO but have not yet been enrolled, who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, until the first day of the month following discharge;

12. Individuals who have been preassigned to an ~~HMO~~ MCO 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~~ MCO, which requires an inpatient hospital stay, until the first day of the month following discharge;

13. 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. 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~~ MCO shall be assigned to an ~~HMO~~ MCO as described in subdivision 3 of this subsection.

5. 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. 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~~ MCO 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.~~

2. ~~3.~~ 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.

3. ~~4.~~ 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 programs. 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 a 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 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 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. 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. 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~~ MCO and shall have priority over those individuals who are seeking to enroll with that ~~HMO~~ MCO.

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 current ~~HMO~~ MCO but is under contract to another ~~HMO~~ MCO available to the recipient;

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 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 12VAC30-110-10 through 12VAC30-110-380.

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

12VAC30-120-380. 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.

Non-emergency 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 school-based services and community mental health services (rehabilitative, targeted case management and waiver services). Clients may also seek emergency services and family planning services from a provider outside the ~~HMO~~ MCO. The ~~HMOs~~ MCOs shall pay for emergency services and family planning services 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.

C. ~~D.~~ 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.

D. ~~E.~~ 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.

E. ~~F.~~ 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.

F. ~~G.~~ Effective January 1, 1997, each ~~HMO~~ MCO 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.

G.~~H.~~ The ~~HMOs~~ MCOs shall promptly provide or arrange for the provision of all required services. Initial face-to-face medical evaluations shall be available within 48 hours for urgent care and within 15 business days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

H. ~~I.~~ The ~~HMOs~~ MCOs must meet standards specified by DMAS for sufficiency of provider networks. 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~~ MCOs must include, but are not necessarily limited to, providers specializing in early childhood, youth and geriatric services.

I. ~~J.~~ Preauthorization and concurrent review decisions must be supervised by qualified medical professionals and completed within two business days after receipt of all necessary information.

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

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

12VAC30-120-385. Medallion II provider responsibilities in Northern Virginia. Repealed.

~~In addition to the requirements in 12VAC30-120-380, 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.~~

12VAC30-120-390. Payment rate for Medallion II ~~HMOs~~ MCOs.

The payment rate to ~~HMOs~~ MCOs shall be based on contract negotiations.

12VAC30-120-395. Payment rate for emergency care out-of-network providers.

The ~~HMOs~~ MCOs shall pay for emergency services when ~~they are~~ provided outside the ~~HMO~~ MCO network. 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.

12VAC30-120-400. 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.. 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. 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. Misrepresents or falsifies information that it furnishes, under §1903(m) of the Social Security Act (42 USC §1396b(m)) to HCFA, 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. 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.

12VAC30-120-410. Sanctions.

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 12VAC30-120-380 F), 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,

5. Terminating the ~~HMO's~~ MCO's Medallion II contract, and

6. Developing procedures with which the HMO MCO 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 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 and 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 et seq. of the Code of Virginia). Pursuant to §§11-70 and 11-71 of the Code of Virginia, DMAS establishes an administrative appeals procedure, which the ~~HMO~~ MCO may elect to appeal decisions on disputes arising during the performance of its contract. Pursuant to §11-71 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 of the Code of Virginia.

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

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

12VAC30-120-420. 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 12VAC30-110-70 through 12VAC30-110-100, federal requirements at 42 CFR 431.211, 431.213 and 431.214, 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 12VAC30-110-160 and 12VAC30-110-170. 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 14VAC5-210-70 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 12VAC30-110-100.

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~~ MCO 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~~ MCO maintains a separate system for Medicaid clients.

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. 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.

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 12VAC30-110-10 through 12VAC30-110-380. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12VAC30-110-10 through 12VAC30-110-380 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 12VAC30-110-10 through 12VAC30-110-380 and shall not base any appealed decision on the record established by any 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.

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