STATE OF VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access (DVHA)

AHS Bulletin No: 10-01

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FROM: Susan Besio, Commissioner
Department of Vermont Health Access

DATE: _06/02/10_

SUBJECT: Managed Care Grievances and Appeals

CHANGES ADOPTED EFFECTIVE _09/01/10_

TYPE OF RULE CHANGE

Adopted Rule Changes

X Final Proposed Rule Change

Proposed Rule Change

RULE REFERENCE(S):

7110	**7110.2.1**	**7110.3**	**7110.5.1**	**7110.5.4**
7110.1	**7110.2.2**	**7110.4**	**7110.5.2**	**7110.5.5**
7110.2	**7110.2.**	**7110.5**	**7110.5.3**	

This bulletin proposes changes to the Managed Care Grievance and Appeal rules in order to implement the recommendations from the 2007 - 2008 external quality review, and clarify rule sections that experience has shown to be unclear.

42 CFR §438.350 and §438.358 requires that MCOs must have an external quality review, performed by an approved external quality review organization (EQRO). The EQRO includes an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that DVHA and their contractors furnish to Medicaid recipients. In summary, the EQRO measures compliance with the requirements set forth for MCOs in Part §438 - Managed Care.

One of the findings from the EQRO was that the DVHA's definition and procedure for handling "reconsiderations" did not meet the federal requirements for the appeal process. Federal rules have no provisions for "reconsiderations", so the DVHA was instructed to remove them.

Another finding from the EQRO that did not meet the federal requirements was that the DVHA's grievance filing process indicates that if a beneficiary wants a written response from the MCO they must indicate it in their grievance. This reference is being deleted to meet federal requirements.

Specific Changes to Rule Sections Since the Last Filing

Section	Description of Change
All Sections	Office of Vermont Health Access is changed to Department of Vermont Health Access and OVHA is changed to DVHA. The name change was made in the 2011 Budget Bill.
7110	"…not applicable to grievance…" was changed to "…not subject to grievance…" for grammatical clarity. A sentence was added that specified that although investment dollar services cannot be grieved or appealed, beneficiaries can still file fair hearings on actions that are taken by AHS in the provision of those services.
7110.1	Section H: the word "means" has been replaced with the "means and includes"
7110.2	Section C: "Medicaid Eligibility" was replaced with "Eligibility for Medicaid".
7110.2.3	Language was added to detail the information the Notice of Decision must have, per 42 CFR §431.210.
7110.3	The text "or if no mailing, within 90 days after the action occurred" has been removed, and "whichever comes later" was added.

Responses to Public Comments

A public hearing was held on May 17, 2010 from 2:00 - 4:00 p.m. it the Large Conference Room at the Department of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, Vermont. There were no attendees.

DVHA received written comments from the Vermont Council of Developmental and Mental Health Services, the Office of Health Care Ombudsman, and the Disability Law Project.

Their comments are summarized below along with DVHA's responses.

Comment: It was decided to insert a clarifier that a statement of dissatisfaction elevates to a grievance when a person indicates that they want a written response regarding the dissatisfaction. …the reviewer said the clarifier is not allowed. We are unclear how the reviewer came to their interpretation. 42 CFR §438.402(b)(3) simply states that "The enrollee may file a grievance either orally or in writing..."

Response: 42 CFR §438.402(b)(3) is the incorrect section to be referring to. The definition of a grievance for an MCO is found in 42 CFR §438.400, which states:

> "*Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)"

Comment: The already comprehensive but at times cumbersome review and resolution process the DA's employ now would become untenable if every utterance of dissatisfaction required that level of response.

Response: The definition of a grievance that required that the beneficiary request a written response was removed effective July 1, 2009. At that time, guidance was issued that states: "Any complaint that cannot be resolved with one response to the beneficiary (in person or by phone) must be treated as a grievance." There are 21 different departments, designated agencies and specialized service agencies that utilize the grievance and appeal system. Since the grievance process started, as a *state* we have averaged 12 grievances per quarter (4 per month). Before the definition changed, as a state we averaged 10 grievances per quarter, and since the definition changed, it has increased to 17 per quarter, due to a spike in the number of grievances filed in the last quarter of 2009. Since the grievance process started, the 16 DAs/SSAs have averaged 9 grievances per quarter. Before the definition changed, the DAs/SSAs averaged 7 grievances per quarter, and since the definition changed, it has increased to 15 per quarter, again, due to a spike in the number of grievances filed in the last quarter of 2009.

Comment: "Services funded with Managed Care Entity investments dollars are not Medicaid covered services, and are therefore not applicable to grievance and appeal rules." Some of the "investments," however, do appear to be for what are usually thought to be Medicaid covered services and ought to trigger grievance and appeal rights.

Response: Services covered in the four approved investment categories are: services not covered by Medicaid because of the nature of the delivery model or because of the service type itself; provided to beneficiaries not covered by Medicaid; or represent public/private approaches to increasing health outcomes for all Vermonters. They represent services that would traditionally be 100% state general fund programs. Since they are not part of the Medicaid covered benefit plan, they are not covered under Medicaid grievance and appeal rules.

Comment: This proposed rule also makes it sound like denials for any of the services provided through the long list of investment programs would not trigger the right to any appeal. This section of the proposed rules seems to eliminate the right to file a fair hearing, in violation of 3 V.S.A. 3091.

Response: While we believe that stating that individuals receiving services provided through investment dollars cannot use the grievance and appeal process does not imply that fair hearing rights are lost, we have added a sentence to state that specifically:

> Services funded with Managed Care Entity investments dollars are not Medicaid covered services, and are therefore not subject to grievance and appeal rules (see annual OVHA Budget Document - http://OVHA.vermont.gov/budget-legislative). Beneficiaries retain their ability to file fair hearings with the Human Services Board for denials, limitations, reductions, suspensions or terminations of these services.

Comment: As the new language at the end of the first paragraph of Sec. 7110, and the definitions under 7110.1(H) indicate, the DAs/SSAs are each individually considered to be Managed Care Entities, as are the individual state agencies that manage Medicaid programs, as well as contracted service providers.

Response: This is a misunderstanding of the definition of the Managed Care Entity. The Managed Care Entity is comprised of each entity listed. To clarify, the word "means" has been replaced with the "means and includes".

Comment: Since many DAs often operate both under DAIL and DMH, could there be one appeal procedure for DAIL programs and another for DMH programs within the same DA? Would the same framework apply to both appeals and grievances?

Response: This has been the case up until July 1, 2010, when DAIL's new rules are effective. The new rules were taken directly from these Grievance & Appeal rules. As of July 1, 2010, the same framework will finally apply to notices of decisions, grievances, and appeals for both DAIL and DMH.

Comment: It is true that multi-disciplinary team decisions are not, in themselves, MCE actions and subject to appeal. However, the provision of specific services that may be considered by the interagency process still falls to the individual agencies, and any decision by that agency not to provide a service is still subject to notice and appeal rights that govern any Medicaid-covered service. The note should add language to clarify this obligation.

Response: The note language was added to explain that decisions (or recommendations) by the multi-agency collaborative teams are not actions and therefore not appealable. If the multi-agency team decision/recommendation is not to the liking of the individual/parents and they request a service from the relevant portion of the Managed Care Entity, then any decision that entity makes is an action and therefore appealable.

Comment: Medicaid eligibility decisions are all supposed to be referred to DCF Economic Services Division. The regulation should clarify that this refers to financial eligibility decisions, not clinical eligibility decisions. Such decisions, such as clinical eligibility for Developmental Services or Choices for Care, or a disability determination by DDS, would presumably not go to ESD, but would be handled by the entity responsible for clinical review.

Response: This section is talking about initial Medicaid eligibility and the determinations of premiums required. Medicaid eligibility is, by definition, a financial eligibility and all Medicaid eligibility decisions go to DCF - ESD. The clinical eligibility referred to in the comment is clinical eligibility for programs, not Medicaid eligibility itself. That said, we did agree to adjust the wording from "Medicaid Eligibility" to "Eligibility for Medicaid".

Comment: Third party providers and representatives may only file on behalf of a beneficiary "after a clear determination that the third party involvement is being initiated at the beneficiary's request." There are many cases where this requirement would be very difficult to meet, such as a person with a developmental disability with limited verbal abilities (not all such people have a legal guardian), or a person who, due to a sudden decline in health, is not able to engage in communication. Attempts to resolve this question could result in significant delay in moving the appeal process forward, including the possibility of missing a fair hearing deadline. We would suggest a more open rule regarding third-party standing to initiate an appeal. The MCE could then use the appeal fact-finding process itself to resolve any questions about the desires of the beneficiary regarding the appeal.

Response: Only beneficiaries and providers, with written consent, are allowed to file a grievance or appeal as stipulated in the CFR sections below. Vermont is allowing "personal representatives" to file grievances and appeals on behalf of a beneficiary, when the beneficiary gives approval. This allowance exceeds what is required under CFR, and was determined as acceptable through the EQRO process. At this time, we are not going to "open the rule" up for anyone to file an appeal

or grievance. Appeals are for denials of services, and are not the "fact-finding process" to determine if there is in actuality an appeal. We are aware that some beneficiaries are not physically able, cognitively able, or legally able to file a grievance or appeal on their own behalf. The Managed Care Entity understands this and makes allowances in these situations. No grievances or appeals have been held up in these situations.

42 CFR §438.402(b)(1) "Authority to File" states that

(i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.

(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.

In addition, the "personal representative" does not show up until 42 CFR §438.402(b)(3) and (4) which state:

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal-

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

Comment: The person conducting an appeal must have the clinical expertise to conduct the review. We generally support this provision. However, we would note that the current practice in some cases is for appeals to be conducted as Commissioner's Reviews, where the person conducting the review is the Commissioner or Deputy Commissioner, who may not have this clinical expertise (though the person would, presumably, consult with someone with such expertise, though not necessarily a person other than the one who made the initial decision).

Response: As subsection H states: "Appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess(es) the requisite clinical expertise, as determined by the managed care entity, in treating the beneficiary's condition or disease." Commissioners and Deputy Commissioners, by nature of their position, have the expertise to make service provision decisions for their Departments. In addition it is the managed care entity's decision to designate the person responsible for hearing appeals. This was one area that was audited by the EQRO and non-compliance with this element was not found.

Comment: The new language states that the time frame of an appeal may be extended "if the extension is in the best interest of the beneficiary." It does not state, however, who makes the decision as to what is in the beneficiary's best interest. A better standard would be to allow an extension of the time frame based on informed consent of the beneficiary, or the beneficiary's legal representative (if any). At a minimum, the MCE should be required to articulate why the delay is in the beneficiary's interest, and make an attempt to obtain informed consent.

Response: The language stated as new is not. It was moved up and other language was added. The sentences "If a meeting cannot be scheduled so that the decision can be made within the 45-day time limit, the time frame may be extended up to an additional 14 days, by request of the

beneficiary or by the managed care entity if the extension is in the best interest of the beneficiary. If the extension is at the request of the managed care entity, it must give the beneficiary written notice of the reason for the delay." remain the same. The "reason for the delay" that must be part of the written notice of the delay is the articulation of why the delay is in the beneficiary's best interest. Since the grievance and appeal process began on July 1, 2007, only 12 appeals have been extended, of those only 4 were extended by the MCO/MCE.

Comment: The Beneficiary Notice section is missing criteria that is in 42 CFR §431.210.

Response: We agree. That section has been updated to reflect the language found at 42 CFR §431.210.

Comment: The rule states (in existing language) that if there is no written notice of decision, the deadline for filing a fair hearing is 90 days after the adverse action occurred. However, the MCE does not have the option of not providing written notice, which is required by due process.

Response: We agree. The language "or if no mailing, within 90 days after the action occurred" has been removed.

Comment: In the language stating that fair hearing requests must be filed within 90 days of the original notice of the MCE's decision or within 30 days of the notice of the appeal decision, the regulation should add "whichever comes later."

Response: We agree. This language was added.

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For information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Office of the Vermont Secretary of State at: http://vermont-archives.org/aparules/index.htm or call Louise Corliss at 828-2863. [General information, not specific rule content information]

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: http://www.leg.state.vt.us/schedules/schedule2.cfm or call 828-5760.

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Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

7110 Grievances and Appeals

7110.1 Definitions

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7110.2.2 Participating Provider Decisions
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7110 Grievances and Appeals

"Global Commitment" is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Department of Vermont Health Access (DVHA) is required under the Global Commitment to Health 1115(a) waiver, to implement all 42 CFR Part 438 regulations, related to Managed Care Organizations, in its operations. Under 42 C.F.R. Part 438, Subpart F, the Managed Care Entity is required to have an internal grievance and appeal process for resolving service disagreements between beneficiaries and the managed care entity, including employees, representatives, and state designated agencies, including Designated Agencies and Specialized Service Agencies.

The Managed Care Entity and any part of the entity receiving funds for the provision of services under Global Commitment shall be responsible for resolving all grievances and all appeals initiated under these rules.

Beneficiaries and providers shall not be subject to retribution or retaliation for filing a grievance or an appeal with the managed care entity.

Services funded with Managed Care Entity investments dollars are not Medicaid covered services, and are therefore not subject to grievance and appeal rules (see annual DVHA Budget Document - http://DVHA.vermont.gov/budget-legislative). Beneficiaries retain their ability to file fair hearings with the Human Services Board for denials, limitations, reductions, suspensions or terminations of these services.

NOTE: Unless otherwise stated, all timeframes are stated in calendar days.

7110.1 Definitions

The following definitions shall apply for use in 7110 through 7110.5.2:

A. "Action" means an occurrence of one or more of the following by the managed care entity for which an internal appeal may be requested:
   1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
   2. reduction, suspension or termination of a previously authorized covered service or an approved (by the managed care entity) service plan;
   3. denial, in whole or in part, of payment for a covered service;
   4. failure to provide a clinically indicated, covered service, when the DA/SSA is acting as the managed care entity;
   5. failure to act in a timely manner when required by state rule;
   6. denial of a beneficiary's request to obtain covered services outside the network.

   NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

   NOTE: Collaborative decisions of any type made by multi-disciplinary groups that include managed care entity and non-entity members, such as Local Interagency Teams (LIT), the State Interagency Team (SIT), the State or Local Team for Functionally Impaired, and the Case Review Committee (CRC), are not actions of the managed care entity, see Medicaid Rule 7110.1(H), and therefore are not governed by Medicaid Rule 7110 et seq.

7110.1 Definitions (Continued)

B. "Appeal" means a request for an internal review of an action by the managed care entity.

C. "Designated Agency/Specialized Service Agency" (DA/SSA) means an agency designated by the Department of Mental Health (DMH) or Department of Disabilities, Aging and Independent Living (DAIL) to provide services and/or service authorizations for eligible individuals with mental health or developmental disabilities.

D. "Designated Representative" means an individual, either appointed by a beneficiary or authorized under State or other applicable law, to act on behalf of the beneficiary in obtaining a determination or in dealing with any of the levels of the appeal or grievance process. Unless otherwise stated in this rule, the designated representative has all of the rights and responsibilities of a beneficiary in obtaining a determination or in dealing with any of the levels of the appeals process.

E. "Expedited Appeal" means an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

F. "Fair Hearing" means an external appeal that is filed with the Human Services Board, and whose procedures are specified in rules separate from the managed care entity grievance and appeal process.

G. "Grievance" means an expression of dissatisfaction about any matter that is not an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights.

If a grievance is not acted upon within the timeframes specified in rule, the beneficiary may ask for an appeal under the definition above of an action as being "failure to act in a timely manner when required by state rule."

If a grievance is composed of a clear report of alleged physical harm or potential harm, the managed care entity will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services).

H. "Managed Care Entity" means and includes:
1. the Department of Vermont Health Access (DVHA);
2. any State department with which DVHA has an Intergovernmental Agreement under Global Commitment, excluding the Department of Education, that results in that department administering or providing services under Global Commitment (i.e. Department for Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; Department of Mental Health);
3. a DA/SSA; and
4. any contractor performing service authorizations or prior authorizations on behalf of the managed care entity.

7110.1 Definitions (Continued)

I. "Network" means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.

J. "Provider" means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individual's medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that self-manages services is not a provider for purposes of this rule.

K. "Service" means a benefit 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the Intergovernmental Agreement between the Department of Vermont Health Access and Agency of Human Services Departments for the administration and operation of the Global Commitment to Health waiver.

7110.2 Beneficiary Appeals

A. Right to Appeal

Beneficiaries may request an internal appeal of a managed care entity's action, and a fair hearing before the Human Services Board. A beneficiary may utilize the internal appeal process while a fair hearing is pending or before a fair hearing is requested (see 7110.3), except when a benefit is denied, reduced, or eliminated as mandated by federal or state law or rule, in which case the beneficiary cannot use the appeal process and would challenge the decision only by requesting a fair hearing.

B. Request for Non-Covered Services

An appeal under this rule may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to DVHA under the provisions of the Medicaid rules at 7104. A subsequent DVHA denial under 7104 to cover such service cannot be appealed using the appeal process set forth in this rule, but may be appealed through the fair hearing process.

C. Eligibility for Medicaid and Premium Determinations

If a beneficiary files an appeal regarding eligibility for Medicaid or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families (DCF), Economic Services Division. They will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the appeal process and will be considered a request for fair hearing as of the date the managed care entity received it.

D. Filing of Appeals

Beneficiaries may file appeals orally or in writing for any managed care action. Providers and representatives of the beneficiary may initiate appeals only after a clear determination that the third-party involvement is being initiated at the beneficiary's request. Appeals of actions must be filed with the managed care entity within 90 days of the date of the notice of action. The date of the appeal, if mailed, is the postmark date.

The appeal process will include assistance by staff members of the managed care entity, as needed, for the beneficiary to initiate and participate in the appeal.

E. Written Acknowledgement

Written acknowledgement of the appeal shall be mailed within 5 days of receipt by the part of the managed care entity that receives the appeal.

If a beneficiary files an appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct part of the managed care entity, identify the part to which it has been forwarded, and explain that the appeal will be addressed by that part. This does not extend the deadline by which appeals must be determined.

7110.2 Beneficiary Appeals (Continued)

F. Withdrawal of Appeals

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the managed care entity in writing within 5 days.

G. Beneficiary Participation in Appeals

The beneficiary, their designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which the managed care entity is considering the final decision regarding their appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

Upon request, the managed care entity shall provide the beneficiary or their designated representative with all the information in its possession or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The entity will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

H. Appeals Reviewer

The individual who hears the appeal shall not have made the decision subject to appeal and shall not be a subordinate of the individual that made the original decision. Appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess(es) the requisite clinical expertise, as determined by the managed care entity, in treating the beneficiary's condition or disease.

I. Resolution

Appeals shall be decided and written notice sent to the beneficiary within 45 days of receipt of the appeal. The beneficiary shall be notified as soon as the appeal meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a meeting cannot be scheduled so that the decision can be made within the 45-day time limit, the time frame may be extended up to an additional 14 days, by request of the beneficiary or by the managed care entity if the extension is in the best interest of the beneficiary. If the extension is at the request of the managed care entity, it must give the beneficiary written notice of the reason for the delay. The maximum total time period for the resolution of an appeal, including any extension requested either by the beneficiary or the managed care entity, is 59 days. If a meeting cannot be scheduled within these timeframes, a decision will be rendered by the managed care entity without a meeting with the beneficiary, their designated representative, or treating provider.

7110.2 Beneficiary Appeals (Continued)

7110.2.1 Expedited Appeal Requests

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the managed care entity for any actions subject to appeal. The managed care entity will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

If the request for an expedited appeal is denied because it does not meet the criteria, the managed care entity will inform the beneficiary that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45-day time frame. An oral notice of the denial of the request for an expedited appeal must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice.

If the expedited appeal request meets the criteria for such appeals, it must be resolved within 3 working days. If an expedited appeal cannot be resolved within 3 working days, the time frame may be extended up to an additional 14 days by request of the beneficiary, or by the managed care entity if the extension is in the best interest of the beneficiary. If the extension is at the request of the managed care entity, it must give the beneficiary written notice of the reason for the delay. An oral notice of the expedited appeal decision must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice. The written notice for any expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the beneficiary’s right to request a fair hearing if not already requested.

7110.2.2 Participating Provider Decisions

Provider decisions shall not be considered managed care entity actions and are not subject to appeal using this process.

A state agency shall be considered a provider if it provides a service that is:

1. Claimed at the Medicaid service matching rate;
2. Based on medical or clinical necessity; and
3. Not prior authorized.

Designated Agencies/Specialized Service Agencies (DA/SSA) are providers when their decisions do not affect beneficiary eligibility or services.

7110.2 Beneficiary Appeals (Continued)

7110.2.3 Notices, Continued Services, and Beneficiary Liability

A. Beneficiary Notice

The part of the managed care entity issuing a services decision that meets the definition of an action must provide the beneficiary with written notice of its decision. In cases involving a termination or reduction of service(s), such notice of decision must be mailed at least 11 days before the change will take effect. Where the decision is adverse to the beneficiary, the notice must inform the beneficiary:

a. what action is being taken;
b. the reason for the action;
c. the specific rule that supports the action; and
d. explain when and how to file an appeal or fair hearing, and that he or she may request that covered services be continued without change as well as the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any appeal or fair hearing.

B. Continuation of Services

1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered service termination, suspension, or reduction under the following circumstances:
   a. The managed care entity appeal was filed in a timely manner, meaning before the effective date of the proposed action;
   b. The beneficiary has paid any required premiums in full;
   c. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan; and
   d. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.

2. Where properly requested, a service must be continued until any one of the following occurs:
   a. The beneficiary withdraws the appeal;
   b. Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;
   c. The managed care entity issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame;
   d. A fair hearing is conducted and the Human Services Board issues a decision adverse to the beneficiary; or
   e. The time period or service limits of a previously authorized service has been met.

Beneficiaries may waive their right to receive continued benefits pending appeal.

C. Change in Law

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law or rule affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at 4150).

7110.2 Beneficiary Appeals (Continued)

7110.2.3 Notices, Continued Services, and Beneficiary Liability (Continued)

D. Beneficiary Liability for Cost of Services

A beneficiary may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

The managed care entity may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant managed care entity or fair hearing decision is made, or following a final disposition of the matter in favor of the managed care entity. Beneficiary liability will occur only if an appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the managed care entity also determines that the beneficiary should be held liable for service costs.

If the provider notifies the beneficiary that a service may not be covered by Medicaid, the beneficiary can agree to assume financial responsibility for the service. If the provider fails to inform the beneficiary that a service may not be covered by Medicaid, the beneficiary is not liable for payment. Benefits will be paid retroactively for beneficiaries who assume financial responsibility for a service and who are successful on such service coverage appeal.

E. Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the managed care entity is not required to initiate service delivery.

The managed care entity is not required to provide a new service or any service that is not a Medicaid-covered service while a fair hearing determination is pending.

7110.3 Fair Hearing

A beneficiary may utilize the managed care entity appeal process and be entitled to a fair hearing before the Human Services Board. Fair hearings or managed care entity appeals must be filed within 90 days of the date the notice of action was mailed by the managed care entity. A request for a fair hearing challenging a managed care entity appeal decision must be made within 90 days of the date the original notice of the managed care entity's decision being appealed was made, or within 30 days of the date the notice of the decision being appealed was mailed, whichever comes later. If the beneficiary's original request for an appeal was filed before the effective date of the adverse action and the beneficiary has paid in full any required premiums, the beneficiary's services will continue consistent with 7110.2.3 B.

Individuals have the right to file requests for fair hearings related to eligibility for Medicaid and premium determinations. DCF shall retain responsibility for representing the State in any fair hearings pertaining to such eligibility and premium determinations.

7110.4 School-Based Health Services

The State uses the School-Based Health Services Program to obtain Medicaid reimbursement for medical services provided by schools to eligible students. To be eligible, the students must be enrolled in Medicaid, receiving special education services, and receiving Medicaid-billable services. School districts can claim reimbursement under the Program only for those students on an individualized education program (IEP) and not for students on 504 plans. A release of protected health information for each eligible student is required before any claims can be processed. The parent or guardian has the right to refuse to give consent to such a release. In such case, the school district cannot claim Medicaid reimbursement for any services provided to that student. Additionally, a physician or a nurse practitioner must sign a physician authorization form, establishing that the IEP services are medically necessary.

The federal Individuals with Disabilities Education and Improvement Act of 2004 (IDEIA) Part B has statutes and regulations that govern the process for assessing needs and developing the IEP. Separate Department of Education (DOE) due process and appeals procedures apply when there is a disagreement concerning the services included in the IEP. Parents of a child receiving special education services who disagree with decisions made by the school regarding a child's identification, eligibility, evaluation, IEP or placement have three options available under the DOE procedures for resolving disputes with the school: mediation, a due process hearing and/or an administrative complaint. The Department of Education due process and appeals procedures also apply to Global Commitment services authorized under Part B of IDEIA.

IDEIA Part C is an Early Intervention program for infants and toddlers that provides a broad array of services to children with special needs, birth through three years of age, and their families. Services are authorized through the DCF - Child Development Division. Global Commitment services authorized under Part C of IDEIA are subject to the managed care grievance and appeal procedures.

7110.5 Beneficiary Grievances

A. Filing Grievances

A grievance may be expressed orally or in writing. A beneficiary or his or her designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance.

B. Written Acknowledgement

Written acknowledgement of the grievance must be mailed within 5 days of receipt by the managed care entity. The acknowledgement must be made by the part of the managed care entity responsible for the service area that is the subject of the grievance. If the entity decides the issue within the five day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases.

C. Withdrawal of Grievances

Beneficiaries or their designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the managed care entity in writing within five calendar days.

D. Disposition

All grievances shall be addressed within 90 days of receipt. The decision maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review with the managed care entity as well as information on how to initiate such review.

E. Grievance Reviews

1. Filing a Grievance Review - If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the managed care entity within 10days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

2. Written Acknowledgement - The managed care entity will acknowledge grievance review requests within 5 days of receipt.

7110.5 Beneficiary Grievances (Continued)

E. Grievance Reviews (Continued)

3. Disposition - The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review within 90 days.

   Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the beneficiary may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V.S.A. §3091 (a).