

Memo to: House Committee on Human Services
House Committee on Health Care
Senate Committee on Health and Welfare

From: Joshua Slen, Director, Office of Vermont Health Access
Joan Senecal, Commissioner, Department of Disabilities, Aging and Independent Living

Re: Medicaid MCO Legislative Grievance and Appeal Report: July 1, 2007 – December 31, 2007
Choices For Care Grievance and Appeal Report: July 1, 2007 – December 31, 2007

Date: January 15, 2008

The Office of Vermont Health Access became the first state-wide publically run Managed Care Organization (MCO) under the Global Commitment to Health waiver. The Grievance and Appeal process is a federal requirement under MCO regulations [42 C.F.R. 438.408]. In addition, the Choices for Care (CFC) program, operated within DAIL, utilizes the MCO Grievance and Appeals database to track grievances and appeals, bringing all public health care programs into alignment with one standard process. Following the direction of Act 65 of the 2007 legislative session, AHS is pleased to present to you our first semi-annual report on the implementation of the Grievance and Appeal process.

Act 65, Sec. 111a. Global Commitment; Grievance And Appeal Rules: Beginning January 1, 2008 and every six months thereafter, the secretary of the agency of human services or designee shall report on the implementation of the grievance and appeal rules for Global Commitment for health and for Choices for Care, including the number and types of grievances, internal appeals, and appeals to the human services board, and the number of internal appeals that were reversed by the independent decision-maker.

The MCO is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Office of Vermont Health Access (OVHA), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCO are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity has at least one assigned grievance and appeal coordinator who enters data into the MCO database. This report is based on data compiled from the centralized database.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the MCO. It includes a request for a written response.

During the first report period (July 1, 2007 – December 31, 2007), there were 22 grievances filed with the MCO. The grievance and appeal coordinator analyzes the content of each grievance and categorizes each grievance into one or more topic areas. Approximately half of these grievances related to quality of service. The breakdown of topic areas is in the attached data summary.

During the first report period (July 1, 2007 – December 31, 2007), there were no grievances filed for the DAIL Choices for Care program.

- Appeals: Medicaid rule M180.1 defines actions that an MCO entity makes that are subject to an internal appeal. These actions are:
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 a 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 MCO provider is a DA/SSA;
 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.

During the first report period (July 1, 2007 – December 31, 2007), there were 17 appeals filed with the MCO. Of the 17 appeals, 12 were resolved within the first reporting period (71%). In nine cases (75% of those resolved), the original decision was upheld by the hearing officer. There were no cases reversed or modified from the original decision, two were withdrawn (17%) and one was approved as a result of the information received at the appeal meeting (8%).

As each appeal was received the grievance and appeal coordinator assigned it to an action category that related to the content of the appeal. There were 13 appeals for a denial or limitation of authorization of a requested service or eligibility for service (76%), one was for a reduction/suspension/termination of a previously authorized covered service or service plan (6%), two were for a denial, in whole or in part, of payment for a covered service (12%), and one case has not had its category entered yet (6%).

During the first report period (July 1, 2007 – December 31, 2007), there were seven appeals filed in the Choices for Care program. There were no requests for an expedited appeal. Of those seven appeals, none have been resolved within this first reporting period. The Choices for Care program also assigns one of the MCO action categories to each appeal, bringing all public health care programs into alignment with one standard process. Of the seven appeals, five were for a denial or limitation of authorization of a requested service or eligibility for service (71%), and two were for a reduction/suspension/termination of a previously authorized covered service or service plan (29%).

Individuals can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. Although there have been nine appeals that have not been decided in the individual's favor for the MCO, none of these have gone to a fair hearing yet. Of the two cases that have gone to fair hearing, one was filed simultaneously with the appeal and the other was filed after the appeal was withdrawn. For the Choices for Care program, during this period there were no fair hearings filed with the appeals.

Medicaid MCO Legislative Grievance and Appeal Report
 Data Summary
 July 1, 2007 – December 31, 2007

 Number of Grievances filed: 22

Number by Category:

Staff/Contractor:	<u>7</u>
Program Concern:	<u>3</u>
Management:	<u>1</u>
Policy or Rule Issue:	<u>2</u>
Quality of Service:	<u>11</u>
Service Accessibility:	<u>6</u>
Timeliness of Service Response:	<u>6</u>
Service Not Offered/Available:	<u>4</u>
Other:	<u>4</u>

Since more than one category can be chosen for each grievance or appeal, total number by category may exceed total number filed.

 Number of Appeals Filed: 17

Regular Appeals:	<u>17</u>
Expedited (met criteria) Appeals:	<u>0</u>

The number of resolved appeals may not add up to the number filed, since an appeal may span two report periods.

 Number Resolved: 12

Number Upheld:	<u>9</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>2</u>
Number Approved by Dept/DA/SSA:	<u>1</u>

"Approved by Dept/DA/SSA" is when additional information received allowed the department/DA/SSA that made the original decision to reverse itself without a decision from the person hearing the internal appeal.

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	<u>13</u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u>1</u>
Denial, in whole or in part, of payment for a covered service:	<u>2</u>
Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	<u>0</u>
Denial of a beneficiary request to obtain covered services outside the network:	<u>0</u>
Failure to act in a timely manner when required by state rule:	<u>0</u>

 Number of Fair Hearings Filed with an Appeal: 2

(these are fair hearings filed during this reporting period that have also had an appeal filed for the same action)

 Number of Pending Fair Hearings with an Appeal: 2

The number of pending and resolved fair hearings may not add up to the number filed, since a fair hearing may span two report periods.

 Number of Resolved Fair Hearings with an Appeal: 0

Number Upheld:	<u>0</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>0</u>

Choices for Care Legislative Grievance and Appeal Report
 Data Summary
 July 1, 2007 – December 31, 2007

 Number of Grievances filed: 0

Number by Category:

Staff/Contractor:	<u> 0 </u>
Program Concern:	<u> 0 </u>
Management:	<u> 0 </u>
Policy or Rule Issue:	<u> 0 </u>
Quality of Service:	<u> 0 </u>
Service Accessibility:	<u> 0 </u>
Timeliness of Service Response:	<u> 0 </u>
Service Not Offered/Available:	<u> 0 </u>
Other:	<u> 0 </u>

Since more than one category can be chosen for each grievance or appeal, total number by category may exceed total number filed.

 Number of Appeals Filed: 7

Regular Appeals:	<u> 7 </u>
Expedited (met criteria) Appeals:	<u> 0 </u>

The number of resolved appeals may not add up to the number filed, since an appeal may span two report periods.

 Number Resolved: 0

Number Upheld:	<u> 0 </u>
Number Reversed:	<u> 0 </u>
Number Modified:	<u> 0 </u>
Number Withdrawn:	<u> 0 </u>
Number Approved by Dept/DA/SSA:	<u> 0 </u>

"Approved by Dept/DA/SSA" is when additional information received allowed the department/DA/SSA that made the original decision to reverse itself without a decision from the person hearing the internal appeal.

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	<u> 5 </u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u> 2 </u>
Denial, in whole or in part, of payment for a covered service:	<u> 0 </u>
Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	<u> 0 </u>
Denial of a beneficiary request to obtain covered services outside the network:	<u> 0 </u>
Failure to act in a timely manner when required by state rule:	<u> 0 </u>

 Number of Fair Hearings Filed with an Appeal: 0

(these are fair hearings filed during this reporting period that have also had an appeal filed for the same action)

 Number of Pending Fair Hearings with an Appeal: 0

The number of pending and resolved fair hearings may not add up to the number filed, since a fair hearing may span two report periods.

 Number of Resolved Fair Hearings with an Appeal: 0

Number Upheld:	<u> 0 </u>
Number Reversed:	<u> 0 </u>
Number Modified:	<u> 0 </u>
Number Withdrawn:	<u> 0 </u>