

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: January 1, 2008 – June 30, 2008  
Choices for Care Appeal Report: January 1, 2008 – June 30, 2008

Date: July 30, 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 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 second 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 as of July 16, 2008.

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 second report period (January 1, 2008 – June 30, 2008), there were 17 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. Again, approximately half of these grievances related to quality of service. The breakdown of topic areas is in the attached data summary.

The DAIL Choices for Care program does not have a grievance component.

- 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 second report period (January 1, 2008 – June 30, 2008), there were 34 appeals filed with the MCO, with only one of them receiving an expedited appeal. Of the 34 appeals, 24 were resolved within this reporting period (71%). In twelve cases (50% of those resolved), the original decision was upheld by the hearing officer. There was one case reversed (4%), no cases were modified from the original decision, seven were withdrawn (29%), three were approved as a result of the information received prior to or at the appeal meeting (13%), and one case was closed because the person filing the appeal was not authorized by the beneficiary (4%).

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 25 appeals for a denial or limitation of authorization of a requested service or eligibility for service (74%), seven were for a reduction/suspension/termination of a previously authorized covered service or service plan (20%), and two cases have not had their category entered yet (6%).

During the first report period (July 1, 2007 – December 31, 2007), there were five appeals left pending that were resolved within this reporting period. In four cases (80%), the original decision was upheld by the hearing officer. There were no cases reversed or modified from the original decision, and one was withdrawn (20%).

During the second report period (January 1, 2008 – June 30, 2008), there were 24 appeals filed in the Choices for Care program. There were no requests for an expedited appeal. Of those 24 appeals, none have been resolved within this 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 24 appeals, 13 were for a denial or limitation of authorization of a requested service or eligibility for service (54%), and 11 were for a reduction/suspension/termination of a previously authorized covered service or service plan (46%).

During the first report period (July 1, 2007 – December 31, 2007), there were six appeals left pending for CFC that were resolved within this reporting period. In four cases (66%), the original decision was upheld by the hearing officer. There was one case reversed (17%), none were modified from the original decision, and one was withdrawn (17%).

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.

During the second report period (January 1, 2008 – June 30, 2008), there were four fair hearings filed for MCO appeal decisions. None of them were resolved this period. There were two fair hearings pending from the last period and both of them were withdrawn. There are still four fair hearings pending at the end of this quarter.

During the second report period (January 1, 2008 – June 30, 2008), there were ten fair hearings filed for the Choices for Care program. One was withdrawn, leaving nine pending. There was one fair hearing pending from the last period that has not been resolved yet. There are still ten total fair hearings pending at the end of this quarter.

Medicaid MCO Legislative Grievance and Appeal Report  
 Data Summary  
 January 1, 2008 – June 30, 2008

 Number of Grievances filed: 17

## Number by Category:

Staff/Contractor:	<u>9</u>
Program Concern:	<u>2</u>
Management:	<u>3</u>
Policy or Rule Issue:	<u>4</u>
Quality of Service:	<u>5</u>
Service Accessibility:	<u>4</u>
Timeliness of Service Response:	<u>2</u>
Service Not Offered/Available:	<u>5</u>
Other:	<u>2</u>

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

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

 Number of Appeals Filed: 34

Regular Appeals:	<u>34</u>
Expedited (met criteria) Appeals:	<u>0</u>

 Number Resolved: 24

Number Upheld:	<u>12</u>
Number Reversed:	<u>1</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>7</u>
Number Approved by Dept/DA/SSA:	<u>3</u>
"Representative not authorized"	<u>1</u>

## From Last Period:

Number Pending: <u>5</u>	
Number Upheld:	<u>4</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>1</u>
Number Approved by Dept/DA/SSA:	<u>0</u>

## Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	<u>25</u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u>7</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>
Did not answer:	<u>2</u>

 Number of Fair Hearings Filed with an Appeal this period: 4

 From last period: 2

 Number of Resolved Fair Hearings with an Appeal: 0

 From Last Period: 2

Number Upheld:	<u>0</u>	Number Upheld:	<u>0</u>
Number Reversed:	<u>0</u>	Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>	Number Modified:	<u>0</u>
Number Withdrawn:	<u>0</u>	Number Withdrawn:	<u>2</u>

Total Number of Pending Fair Hearings (all report periods): 4

Choices for Care Legislative Appeal Report  
Data Summary  
January 1, 2008 – June 30, 2008

Number of Appeals Filed: 24Regular Appeals: 24Expedited (met criteria) Appeals: 0Number Resolved: 0Number Upheld: 0Number Reversed: 0Number Modified: 0Number Withdrawn: 0Number Approved by Dept/DA/SSA: 0

From Last Period:

Number Pending: 6Number Upheld: 4Number Reversed: 1Number Modified: 0Number Withdrawn: 1Number Approved by Dept/DA/SSA: 0

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service: 13Reduction/suspension/termination of a previously authorized covered service or service plan: 11Denial, in whole or in part, of payment for a covered service: 0Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA: 0Denial of a beneficiary request to obtain covered services outside the network: 0Failure to act in a timely manner when required by state rule: 0Number of Fair Hearings Filed with an Appeal this period: 10From last period: 1Number of Resolved Fair Hearings with an Appeal: 1From Last Period: 0Number Upheld: 0Number Upheld: 0Number Reversed: 0Number Reversed: 0Number Modified: 0Number Modified: 0Number Withdrawn: 1Number Withdrawn: 0Total Number of Pending Fair Hearings (all report periods): 10