

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

From: Susan Besio, Ph. D., 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, 2008 – December 31, 2008
Choices for Care Appeal Report: July 1, 2008 – December 31, 2008

Date: January 30, 2009

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 third semi-annual report on the implementation of the Grievance and Appeal process.

Act 65, Sec. 111a. Global Commitment; Grievance And Appeal Rules: Beginning July 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 January 12, 2009.

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 this report period (July 1, 2008 – December 31, 2008), there were 16 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 this report period (July 1, 2008 – December 31, 2008), there were 58 appeals filed with the MCO. Twelve of these cases requested an expedited appeal and all of them were denied because they did not meet expedited criteria. They were all processed as regular appeals. Of the 58 appeals, 49 were resolved within this reporting period (84%). In 32 cases (65% of those resolved), the original decision was upheld by the hearing officer. There were eight cases reversed (16%), no cases were modified from the original decision, three were withdrawn (6%), six were approved as a result of the information received prior to or at the appeal meeting (12%), and there were no cases closed because the person filing the appeal was not authorized by the beneficiary. There was an increase in the number of MCO appeals that can be partially attributed to changes in prior authorization requirements for specific prescription medications.

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 48 appeals for a denial or limitation of authorization of a requested service or eligibility for service (89%), nine were for a reduction/suspension/termination of a previously authorized covered service or service plan (16%), and one case has not had its category entered yet (2%).

At the end of the last report period (January 1, 2008 – June 30, 2008), there were seven appeals pending. Five of them (71%) were resolved in this reporting period. In one case (20%) the original decision was upheld by the hearing officer, one case (20%) was reversed, three (60%) were modified from the original decision, and none were withdrawn.

During this report period (July 1, 2008 – December 31, 2008), there were 25 appeals filed in the Choices for Care program. There were no requests for an expedited appeal. Of those 25 appeals, nine have been resolved within this reporting period. In seven cases (78%), the original decision was upheld by the hearing officer. There were no cases reversed, none were modified from the original decision, and two were withdrawn (22%). 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 25 appeals, 13 were for a denial or limitation of authorization of a requested service or eligibility for service (52%), and 12 were for a reduction/suspension/termination of a previously authorized covered service or service plan (48%).

At the end of the last report period (January 1, 2008 – June 31, 2008), there were seven appeals left pending for CFC, and six 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%).

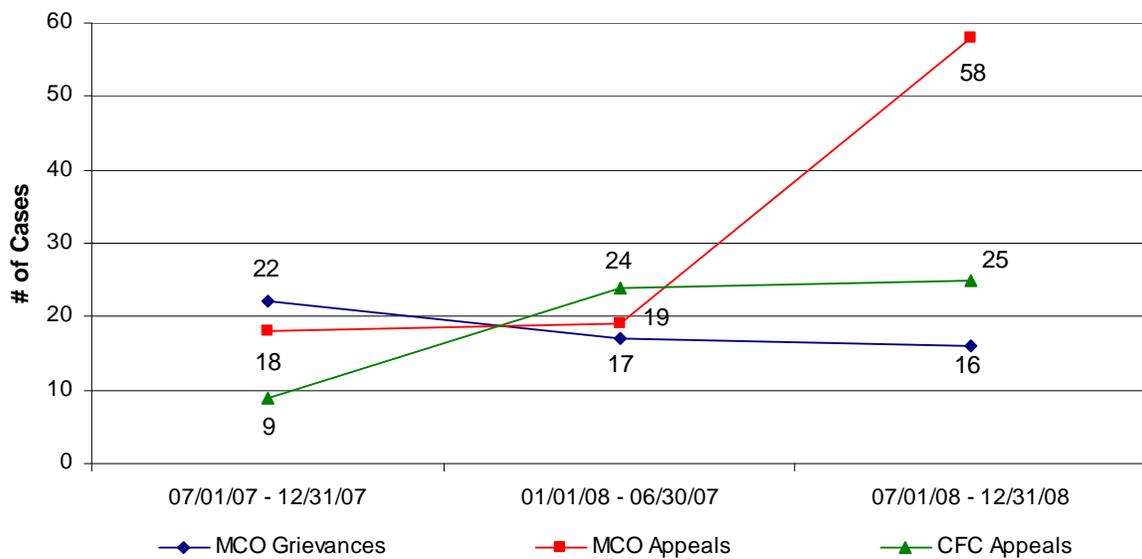
Fair Hearings

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.

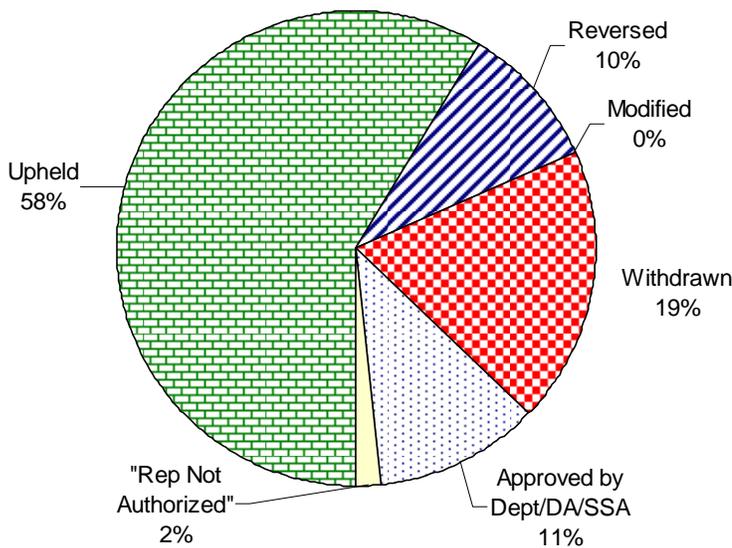
During this report period (July 1, 2008 – December 31, 2008), there were six fair hearings filed for MCO appeal decisions. One of them was withdrawn this period. There were five fair hearings pending from all previous periods and two of them were resolved. One case was upheld, while the other was reversed. There are now eight fair hearings pending at the end of this report period.

During this report period (July 1, 2008 – December 31, 2008), there were eight fair hearings filed for the Choices for Care program. None of them were resolved. There were ten fair hearings pending from all previous periods, and one of them was withdrawn this period. There are now seventeen total fair hearings pending at the end of this report period.

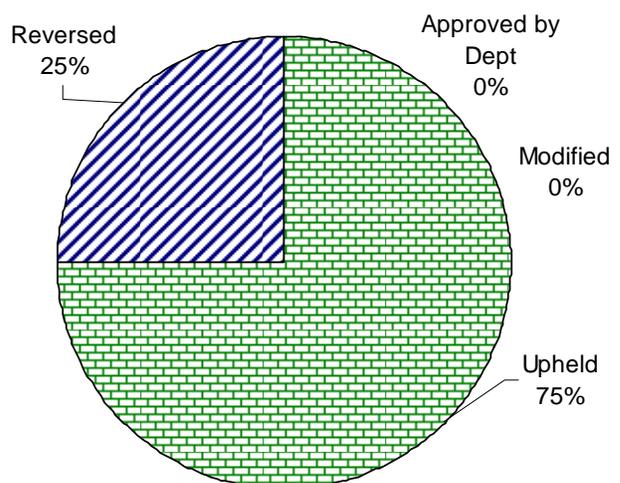
Grievances and Appeals



MCO Appeal Resolutions



CFC Appeal Resolutions



Medicaid MCO Legislative Grievance and Appeal Report
 Data Summary
 July 1, 2008 – December 31, 2008

 Number of Grievances filed: 16

Number by Category:

Staff/Contractor:	<u>6</u>
Program Concern:	<u>1</u>
Management:	<u>0</u>
Policy or Rule Issue:	<u>3</u>
Quality of Service:	<u>4</u>
Service Accessibility:	<u>4</u>
Timeliness of Service Response:	<u>4</u>
Service Not Offered/Available:	<u>3</u>
Other:	<u>3</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: 58

Regular Appeals:	<u>58</u>
Expedited (met criteria) Appeals:	<u>0</u>

 From Last Period - Pending: 7

 Number Resolved: 5

Number Upheld:	<u>32</u>
Number Reversed:	<u>8</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>3</u>
Number Approved by Dept/DA/SSA:	<u>6</u>
"Representative not authorized"	<u>0</u>

Number Upheld:	<u>1</u>
Number Reversed:	<u>1</u>
Number Modified:	<u>3</u>
Number Withdrawn:	<u>0</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>48</u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u>9</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>1</u>

 Number of Fair Hearings Filed with an Appeal this period: 6

 Pending from last period: 5

 Number of Resolved Fair Hearings with an Appeal: 1

 Resolved from last period: 2

Number Upheld:	<u>0</u>
Number Reversed:	<u>0</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>1</u>

Number Upheld:	<u>1</u>
Number Reversed:	<u>1</u>
Number Modified:	<u>0</u>
Number Withdrawn:	<u>0</u>

Total Number of Pending Fair Hearings (all report periods): 8

Choices for Care Legislative Appeal Report
Data Summary
July 1, 2008 – December 31, 2008

Number of Appeals Filed: 25

Regular Appeals: 25

Expedited (met criteria) Appeals: 0

From Last Period - Pending: 7

Number Resolved: 6

Number Resolved: 9

Number Upheld: 7

Number Upheld: 4

Number Reversed: 0

Number Reversed: 1

Number Modified: 0

Number Modified: 0

Number Withdrawn: 2

Number Withdrawn: 1

Number Approved by Dept/DA/SSA: 0

Number Approved by Dept/DA/SSA: 0

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service: 13

Reduction/suspension/termination of a previously authorized covered service or service plan: 12

Denial, in whole or in part, of payment for a covered service: 0

Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA: 0

Denial of a beneficiary request to obtain covered services outside the network: 0

Failure to act in a timely manner when required by state rule: 0

Number of Fair Hearings Filed with an Appeal this period: 8

Pending from last period: 10

Number of Resolved Fair Hearings with an Appeal: 0

Resolved from last Period: 1

Number Upheld: 0

Number Upheld: 0

Number Reversed: 0

Number Reversed: 0

Number Modified: 0

Number Modified: 0

Number Withdrawn: 0

Number Withdrawn: 1

Total Number of Pending Fair Hearings (all report periods): 17