

GLOBAL COMMITMENT TO HEALTH

Medicaid Program Grievance and Appeals

***Technical Assistance
Manual***



**Procedures for Grievances and Appeals
Under Vermont’s Global
Commitment to Health**

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printable forms at <http://dvha.vermont.gov/>
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Medicaid Program Grievances and Appeals

Introduction to Grievances and Appeals

The Global Commitment to Health, or “Global Commitment” is an 1115(a) Medicaid 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), which operates using a managed care delivery model, and is therefore required under 42 C.F.R. Part 438, Subpart F, to have an internal grievance and appeal process for resolving service disagreements between members and the Medicaid Program, representatives of the Medicaid Program, and state designated agencies, including Designated Agencies (DAs) and Specialized Service Agencies (SSAs) for mental health services.

The Medicaid Program and any part of the Medicaid Program receiving funds for the provision of services under Global Commitment shall be responsible for resolving grievances and appeals initiated under 42 C.F.R. Part 438, Subpart F.

The overall goal of the grievance and appeal process is to resolve disputes fairly, to enhance member and public confidence in the equity and integrity of the service system, to ensure members access to medically necessary, covered, benefits, and to allow for the independent review of Medicaid Program staff decisions concerning appealable actions. Members initiating or pursuing a grievance or appeal will be free from retaliation.

Definitions

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

The following definitions shall apply:

- A. “**Adverse benefit determination**” means any of the following:
- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements of medical necessity, appropriateness, setting, or effectiveness of a covered service,
 - Reduction, suspension, or termination of a previously authorized service,
 - Denial, in whole or in part, of payment for a service,
 - Failure to provide services in a timely manner, as defined by the Agency of Human Services,
 - Failure to act within timeframes regarding standard resolution of grievances and appeals,
 - Denial of a beneficiary's request to obtain services outside the network,
 - Denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary liabilities.

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 which include Medicaid Program and non-Medicaid Program membership 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 Medicaid Program and therefore are not eligible for an internal Medicaid Program appeal or a fair hearing.

- B. “**Internal Appeal**” means an internal review by the Medicaid Program of an adverse benefit determination.
- C. “**Designated Agency/Specialized Service Agency**” (DA/SSA) means an agency designated or deemed by the Department of Mental Health or the Department of Disabilities, Aging, and Independent Living to provide and administer services, including service authorization decisions, for beneficiaries with mental health needs and/or developmental disabilities.
- D. “**ACO**” Accountable Care Organization
- E. “**Authorized Representative**” means an individual, either appointed by a member or authorized under state or other applicable law, to act on behalf of the member 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 member in obtaining a determination or in dealing with any of the levels of the appeals process.
- F. “**Expedited Internal Appeal**” means an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- G. “**Fair Hearing**” means an external appeal that is filed with the Human Services Board, and whose procedures are specified in rules separate from the Medicaid Program grievance and appeal process.
- H. “**Grievance**” means an expression of dissatisfaction about any matter that is not an adverse benefit determination, including a member’s right to dispute an extension of time proposed by the Medicaid Program and the denial of a request for an expedited appeal. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights.

If a grievance is not acted upon within the timeframes specified in rule, the member may ask for a fair hearing 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 Medicaid Program will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services).

- I. **"Medicaid Program"** means (1) DVHA in its managed care function of administering services, including service authorization decisions, under the Global Commitment to Health Waiver (“the Waiver”), (2) a State department of AHS (i.e., Department for Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; and Department of Mental Health) with which DVHA enters into an agreement delegating its managed care functions including providing and administering services such as service authorization decisions, under the Waiver, (3) a Designated Agency or a Specialized Service Agency to the extent that it carries out managed care functions under the Waiver, including providing and administering services such as service authorization decisions, based upon an agreement with a State department of AHS, and (4) any subcontractor performing service authorization decisions on behalf of a State department of AHS.
- J. **“Network”** means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.
- K. **“Provider”** means a person, facility, institution, partnership, or corporation licensed, certified or authorized by law to provide services to a beneficiary.
- L. **“Service”** means a benefit (1) covered under the Global Commitment to Health Waiver, (2) included in the State Medicaid Plan, (3) authorized by state rule or other law, (4) required by federal law, or (5) identified in the Intergovernmental Agreement between DVHA and AHS for the administration and operation of the Global Commitment to Health Waiver.

Staff Support – Medicaid Program Grievance and Appeals Manager

DVHA will designate an individual as the Medicaid Program Grievance and Appeals Manager. This person will have responsibility for:

- Assisting the departments and agencies that are part of the Medicaid Program in the development and operation of their grievance and appeal procedures

- Maintaining data on Medicaid Program appeals and grievances
- Receiving grievances information summaries from each part of the Medicaid Program
- Analyzing appeal and grievances trends
- Identifying areas where standards are not being met
- Recommending corrective action when required standards are not being met
- Maintaining appeal and grievance procedures
- Responding to Medicaid Program staff questions concerning these procedures
- Periodically providing training to Medicaid Program staff when needed
- Medicaid Program grievance and appeal reporting to Medicaid Program entities and AHS

Each Contracted Department and DA/SSA must appoint a grievances and appeals coordinator who will be responsible for ensuring timely processing and resolution of grievances and appeals. These positions need not be full-time or dedicated only to one program.

Proceedings for addressing grievances and making decisions on appeals should be confidential unless the member elects to make grievance issues or appeals public.

Finally, the result of the process shall be clearly communicated to the member and his/her designated representative.

Reviewers

- a) Appeals and grievances and grievance reviews will be heard by the designated individual(s) from the department or designated agency responsible for the services that are the subject of the appeal or grievance.
- b) Individuals hearing appeals will be appointed by the appropriate official in each department (Commissioner or program director as determined by the respective department). One or more individuals will be appointed from each department or program entity that is part of the Medicaid Program.
- c) If necessary, reviewers will be made available for specialized cases where additional clinical expertise is required.

Administrative Responsibilities

The Medicaid Program shall use a variety of methods to familiarize members and their representatives with the grievance process. In addition to handbook distribution and an annual review of member rights to promote awareness of the process, designated departments, ACO and the DAs/SSAs shall provide a variety of methods, including an initial rights information orientation, posted notices, periodic staff training, and periodic consumer education to assure that beneficiaries and interested persons know about the grievance and appeal processes.

Department and ACO/ DA/SSA staff members should have support and training in identifying issues of concern with a member or his/her representative, various communication and listening skills, negotiation, and mediation.

The grievances and appeals coordinator is responsible for all administrative functions related to grievances and appeals. The grievances and appeals coordinator will ensure that grievances filed with the designated departments, ACO, DA or SSA are addressed by the appropriate staff person as set out in our policies.

Responsibilities include the following:

- Acknowledging grievances and appeals
 - Gathering information
 - Writing responses
 - Mailing the responses
 - Entering data into and managing the Medicaid Program Grievances and Appeals database as it applies to the designated department, ACO, DA or SSA
- Entrance to the database is located at: <http://dvha.vermont.gov/>

Documentation and Reporting

Data Documentation

Data on grievances and appeals will be documented in the Grievance and Appeals database, as will Fair Hearing requests and outcomes for those cases. The Medicaid Program Grievance and Appeals Manager at the Department of Vermont Health Access (DVHA) will maintain the database. All related correspondence and other pertinent documentation must be maintained in individual member files and be retrievable for audits and reviews by the Medicaid Program or other authorized entity.

Documentation will include:

- A general description of the reason for the appeal or grievance.
- The date received.
- The date of each review or, if applicable, review meeting.
- Resolution of the appeal or grievance.
- Date of resolution.
- Name of the member for whom the appeal or grievance was filed.

Reporting

The DVHA Medicaid Program Grievance and Appeals Manager will review the data and information submitted to identify any trends that may require further investigation and/or corrective action, and to ensure that grievances and appeals are being resolved in a timely manner.

The DVHA Medicaid Program Grievance and Appeals Manager will compile internal reports quarterly. Reports will be submitted to the DVHA Commissioner, AHS Secretary, and the Medicaid Program Quality Committee which includes a representative from each department. The data used to compile these reports will be provided to the departments as requested.

Other Documentation

All related correspondence and other pertinent documentation must be maintained in individual member files maintained by DVHA, contracted department or DA/SSA files and be retrievable for audits and reviews by the Medicaid Program or other authorized entity.

Grievance Procedures

A. Filing Grievances

A grievance may be expressed orally or in writing. A member or designated representative may file a grievance at any time. With the beneficiary's written consent, a provider may serve as the beneficiary's representative for the purpose of filing a grievance and assisting the beneficiary with the proceedings of the grievance. Staff members will assist a member if the member or his or her representative requests such assistance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability.

Members may grieve any matter that is not an adverse benefit determination including denial of a request for an expedited appeal, an extension of time by the Medicaid Program for deciding a service authorization or resolving an internal appeal, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the failure to respect a beneficiary's rights.

NOTE: A designated department or ACO/DA/SSA may not require that grievances be put in writing before considering them formal grievances. A designated department or ACO/DA/SSA is free to make forms available for this purpose, but a member is not required to complete the form. Medicaid Program staff members will assist a member if the member or his or her representative requests assistance in filing a grievance. The designated department or ACO/DA/SSA will train staff in the practices and procedures to promote prompt informal and formal resolution of disagreements. Sample forms are included in this packet. (See Attachment 3.D, Grievance or Appeal Form and Attachment 3.E, Grievance Process Flow Chart pages 22 and 23).

The Medicaid Program shall provide the member, free of charge, with all of the information in its possession or control relevant to the grievance process and the subjects of the grievance, including:

- I. The members case record, including medical records and other records and documents related to the grievance, and
- II. Other information relevant to members grievance including relevant policies and procedures.

B. Written Acknowledgement

Written acknowledgment of the grievance must be mailed within five (5) days of receipt by the Medicaid Program. The acknowledgement must be made by the part of the Medicaid Program responsible for the service that is the subject of the grievance. If the Medicaid Program 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. (See Attachment 3.G, Sample Grievance Acknowledgment Letter, page 25). The grievance and appeal coordinator is responsible for seeing that a copy of the letter of acknowledgment is uploaded to the database.

The DVHA, designated departments, ACO, or DA/SSA grievances and appeals coordinator has responsibility for acknowledging all grievances. Copies will be sent to the member (and his or her designated representative, if applicable).

C. Withdrawal of Grievances

Members 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 Medicaid Program in writing within five (5) days. (See Attachment 3.H, Sample Letter Acknowledging Oral Withdrawal of Grievance, page 26).

D. Disposition

All grievances shall be addressed as expeditiously as the beneficiary's health requires but not more than 90 days of receipt. The decision-maker must provide the member with written notice of the disposition. The written notice shall include the basis or rationale for the decision in sufficient detail for the member to understand the decision. A summary of the grievance. The telephone number of the Health Care Advocate at Vermont Legal Aid. The notice must also inform the member of his or her right to initiate a grievance review with the Medicaid Program as well as information on how to initiate such review (See Attachment 3.I, Sample Grievance Response, page 27).

Grievance Not Timely Resolved: If the Medicaid Program does not act upon the grievance within the time for resolution, the beneficiary may request an internal appeal pursuant to the definition of adverse benefit determination

Grievance Reviews

1. Filing a Grievance Review - If the member is dissatisfied with the grievance response the member may request a grievance review by the department responsible within 10 calendar days of the decision.
2. Written Acknowledgment - The Department responsible will acknowledge grievance review requests within 5 calendar days of receipt.
 - (A) Grievance Reviewer - The grievance review shall be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of such individual.
 - (B) Disposition –

The grievance review shall assess the merits of the grievance issue, the process employed in reviewing the issue, 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 member will be notified in writing of the findings of the grievance review within ninety (90) days. The grievance review determination is considered final.

Department Involvement in the ACO/DA/SSA Grievance Process

Receipt of Unresolved Grievances by Medicaid Program

An unresolved grievance is one that has not gone through the ACO/ DA/SSA grievance process at the ACO/DA/SSA level. The departments encourage members to use the grievance and appeal process at the ACO/ DA/SSA. The ACO/DA/SSA and the member and/or representative are expected to complete the grievance process, and the ACO/DA/SSA is expected to address the grievance within the grievance time lines specified. Unresolved grievances received by department will be acknowledged in writing to both the member and the DA/SSA within five calendar days of receipt. This notification shall cause the ACO/DA/SSA grievance process to begin. The department will see that the information is entered into the Medicaid Program Grievance and Appeal database and assign the case to the ACO/DA/SSA grievance and appeal coordinator.

Appeal Procedures

Internal Appeal System: The Medicaid Program shall maintain an internal appeal system, including an expedited appeal process, for a beneficiary to appeal an adverse benefit determination. The system shall not have more than one level of internal appeal.

A. Right to Appeal

- (1) A member may file an internal appeal of an adverse benefit determination with the Medicaid Program.
 - (2) There is no right to an internal appeal when the sole issue is a federal or state law requiring an automatic change adversely affecting some or all members.
- (b) Provider Decisions: Network provider decisions that do not require a service authorization are not adverse benefit determinations of the Medicaid Program and are not subject to the internal appeal process.
- (c) Exhaustion Requirement; Deemed Exhaustion
- (1) Exhaustion Requirement: A member may only request a State fair hearing after receiving notice of resolution of an internal appeal **under 8.100.3(c)** that the Medicaid Program upheld an adverse benefit determination, except that the member shall be deemed to have exhausted the internal appeal process pursuant to paragraph (d)(2) below.
 - (2) Deemed exhaustion: If the Medicaid Program fails to comply with the requirements regarding notice content and timing at **8.100.3(c) and 8.100.4(n), (o) and (p)**, exhaustion of the internal appeal process shall be deemed, and a member may immediately request a State fair hearing.

B. Request for Non-Covered Services

An Internal 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. Medicaid Eligibility and Premium Determinations

If a member files an internal appeal regarding only a Medicaid eligibility or premium determination, the entity that receives the appeal will forward it to the Department of Health Access (DVHA), Health Care Appeals Team (HCAT). The entity that received the appeal originally will then notify the member in writing that the issue has been forwarded to and will be resolved by the DVHA. These appeals will not be addressed through the internal appeal process and will be considered a request for fair hearing as of the date the Medicaid Program received it (See Attachment 3.J, Sample Letter Informing Member That Appeal Has Been Forwarded to Another Department for Resolution, page 28).

D. Filing of Appeals

Members may file appeals orally or in writing for any Medicaid Program adverse benefit determination. Providers and representatives of the member may initiate appeals only after a clear determination that the third-party involvement is being initiated at the member's request, except that providers may not request that services be continued pending appeal. Appeals of adverse benefit determinations must be filed with the Medicaid Program within sixty (60) days of the date of the Medicaid Program notice of adverse benefit determination. The date of the appeal, if mailed, is the postmark date (See Attachment 3.D, Grievance or Appeal form, page 22). If a member waits longer than sixty (60) days to file an appeal, the Medicaid Program does not have to proceed (See Attachment 3.N, Sample Letter in Response to an Appeal Filed After 60 Days, page 34).

The parties to an internal appeal are the beneficiary or his/her authorized representative, or the legal representative of a deceased beneficiary's estate.

The Medicaid Program will give members reasonable assistance in completing forms and taking other steps to initiate and participate in the internal appeals process. Assistance includes auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that include adequate TTY/TTD. Members may also call the Office of the Health Care Advocate at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

E. Written Acknowledgment

Written acknowledgement of the appeal shall be mailed within five (5) days of receipt by the part of the Medicaid Program that receives the appeal (See Attachment 3.K, Sample Appeal Letter Acknowledging Appeal, page 30, and Attachment 3.F, Appeal Process Flow Chart, page 23). Include the What you need to know about internal appeals document available on the DVHA website with the notice templates.

If a member files an appeal with the wrong entity, that entity will notify the member 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 Medicaid Program, 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 (See Attachment 3.J, Sample Letter Informing Member That Appeal Has Been Forwarded to Another Department for Resolution, page 28).

F. Withdrawal of Appeals

Members 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 Medicaid Program in writing within five (5) days (See Attachment 3.Q, Acknowledgment of Oral Withdrawal of an Appeal Request, page 39).

G. Member Participation in Appeals

The beneficiary, his/her authorized representative, or his/her provider, if requested by the beneficiary, has the right to participate in person, by phone, or in writing in the meeting in which the Medicaid Program is considering the issue that is the subject of the appeal. Participation includes the right to present evidence and testimony and make factual and legal arguments. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Members, their designated representative, or treating provider may submit additional information that was already submitted.

Upon request, Prior to the appeal meeting, the Medicaid Program shall timely provide the beneficiary, his/her authorized representative, or his/her provider with an opportunity to examine, and, if requested, get copies of all the information in its possession or control relevant to the appeal process and the subject of the appeal. The Medicaid Program shall not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal. These records shall include:

The beneficiary's case record, including medical records, other records and documents, and any new or additional evidence considered, relied on, or generated by the Medicaid Program, or at its direction, that is related to the appeal, and

Other information relevant to the beneficiary's adverse benefit determination, including relevant policies or procedures which shall include medical necessity criteria and any processes, strategies, or evidentiary standards used in setting service limits.

The Medicaid Program shall timely notify the beneficiary when the appeal meeting is scheduled. If necessary, the appeal meeting will be rescheduled to accommodate individuals wishing to participate.

If an appeal meeting cannot be scheduled within the timeframe for resolving the appeal, including if the timeframe is extended pursuant to paragraph (o) below, the Medicaid Program shall make a decision that resolves the appeal without a meeting with the beneficiary, his/her authorized representative, or provider. The beneficiary, his/her authorized representative, or provider shall have an opportunity to submit evidence and argument by other means to the appeals reviewer for consideration in making a decision.

H. Medicaid Program Appeals Reviewer

The individual who hears the appeal shall not have been involved in any previous level of review or decision making, nor be a subordinate of any such individual. Shall have appropriate clinical expertise in treating the members condition or disease when deciding an appeal of a denial of medical necessity. Shall consider all comments, documents, records and other information submitted by the member or their representative or provider without regard to whether this information was submitted or considered in the

initial benefit determination made the decision subject to appeal and shall not be a subordinate of the individual who made the original decision.

I. Resolution

The Medicaid Program shall act promptly and in good faith to obtain any necessary information to resolve the appeal. For purposes of this paragraph, “necessary information” may include the results of any face-to-face clinical evaluation or second opinion that may be required.

Appeals shall be decided, and written notice sent to the member within thirty (30) days of receipt of the appeal. The member 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 30-day time limit, the time frame may be extended up to an additional fourteen (14) days, by request of the member or by the Medicaid Program if the extension is in the best interest of the member. If the extension is at the request of the Medicaid Program, it must give the member written notice of the reason for the extension. The maximum total time period for the resolution of an appeal, including any extension requested either by the member or the Medicaid Program, is 44 days. If a meeting cannot be scheduled within these time frames, a decision will be rendered by the Medicaid Program without a meeting with the member, the designated representative, or treating provider (See Attachment 3.L, Sample Letter Informing Client of Favorable Internal Review of Appeal, page 30, and Attachment 3.M, Sample Letter Informing Client of Adverse Internal Review of Appeal, page 32).

For appeals not resolved wholly in favor of the members notices must include:

- I. The right to request a State fair hearing, how to request a fair hearing, and the timeframe for doing so (120 days),
- II. The circumstances in which a State fair hearing will be expedited and how to request it,
- III. The right to have services continue pending resolution of the State fair hearing including how to request continuing services and the timeframe for doing so,
- IV. The timeframes, whether standard or expedited, in which AHS, which may include the Human Services Board, must take final administrative action, and
- V. That the beneficiary may, consistent with State policy, be held liable for the cost of continued services if the State fair hearing process results in a final administrative decision that upholds the Medicaid Program’s adverse benefit determination.

Include the Internal Appeal Resolution Denied Form available with the denial notices on the DVHA website with the denial notice.

NOTE: Appeals on Community and Rehabilitation Treatment (CRT) Program Actions.
A DA will notify the Department of Mental Health (DMH) of any appeal of a CRT

Program action and provide all correspondence, either electronically or via fax transmittal, and any information considered in the initial action and internal review related to an adverse appeal resolution. This information will be necessary if there is a request for a Fair Hearing. At any point in the appeal process, a DA may consult with DMH or DAIL regarding a program action or request DMH or DAIL involvement in determining a resolution decision.

NOTE: Appeals on Children’s Enhanced Family Treatment Services, Children’s e-bed extensions, and Children’s Residential Assessment & Treatment (PNMI) Actions. The Child, Adolescent, and Family Unit (CAFU) within DMH retains Medicaid Program authorization for child Enhanced Family Treatment (EFT) services, e-bed extensions and residential assessment and treatment. Following a request for these services and adverse decision by CAFU, a request for appeal to the Medicaid Program is the responsibility of DMH. CAFU as the Medicaid Program will follow member notice and appeals procedures outlined in this Provider Manual Addendum for these service appeals. Further elaboration of the procedures can be found in the Enhanced Family Treatment Services Manual or the Case Review Committee Guidelines and Procedures (for residential).

J. Expedited Appeal Requests

The Medicaid Program must expedite an appeal request when it determines that the standard for an expedited appeal is met, when the request is by the enrollee, of a provider indicates the standard is met, when a provider requests an expedited appeal.

The standard for expedited resolution of an internal appeal is that taking the time for a standard resolution could seriously jeopardize the member'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 Medicaid Program for any adverse benefit determination subject to appeal. The Medicaid Program will not take any punitive action against a provider who requests an expedited resolution or supports a member's appeal.

If the request for an expedited appeal is denied because it does not meet the criteria, the Medicaid Program will inform the member that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard thirty (30) day time frame. An oral notice of the denial of the request for an expedited appeal must be promptly communicated to the member and followed up within two (2) days of the oral notification with a written notice (See Attachments 3.O and 3.P for Sample Letters Approving/Denying a Request for an Expedited Appeal, pages 35 and 37). Notice will be provided to the beneficiary that they have the right to file a grievance of the denial of the request for an expedited appeal.

If the expedited appeal request meets the criteria for such appeals, it must be resolved, and the Medicaid Program must notify the member, within seventy-two (72) hours. If an expedited appeal cannot be resolved within 72 hours, the time frame may be extended up to an additional fourteen (14) (for a total of 17 days) days by request of the member, or by the Medicaid Program if the Medicaid Program shows that there is a need for additional information and how the delay is in the best interest of the member. If the extension is at the request of the Medicaid Program, it must give the member written notice of the reason for the extension. An oral notice of the expedited appeal decision must be promptly communicated to the member and followed up within two (2) days of the oral notification with a written notice of the reason for its decision to extend the timeframe and an explanation of the members right to file a grievance if they disagree with the extension of time. The written notice for expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the member’s right to request an expedited State fair hearing.

A member may request an expedited State fair hearing when the Medicaid Program approved the request for expedited resolution of an internal appeal:

- But the decision is wholly or partially adverse to the member, or
- The expedited internal appeal is not timely resolved by the Medicaid Program.

Participating Provider Decisions

Provider decisions shall not be considered Medicaid Program decisions and are not subject to appeal using this process.

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

1. is claimed at the Medicaid service matching rate;
2. is based on medical or clinical necessity; and
3. does not have prior authorization.

Designated Agencies(DA)/Specialized Service Agencies(SSA)/Hospitals are providers when their decisions do not affect member eligibility or services. In the case of Adult and Children’s Outpatient services and Emergency Services, a DA/SSA/Hospital action does not affect a member’s eligibility to receive these services by another Medicaid provider. The only actions that may be appealed are those that effectively deny or limit eligibility, payment or access to a service that must be authorized by the Medicaid Program.

Medicaid Program or Provider Status

If Provider “adverse benefit determinations” are in:

Developmental Disabilities Services	DA is a Medicaid program for decisions made by the DA
CRT Program	DA is included in Medicaid Program

CRT Hospitalization	Hospitals are Providers (See Participating Provider Decisions)
Adult Outpatient Program	DA is Provider (See Participating Provider Decisions)
Emergency Services Program	DA is Provider (See Participating Provider Decisions)
Child, Youth and Family Community Services	DA/SSA is Provider (See Participating Provider Decisions) (note: excludes children’s Enhanced Family Treatment)
<ul style="list-style-type: none"> • Children’s Enhanced Family Treatment (EFT) Services • Children’s E-bed extensions • Children’s residential assessment and treatment (PNMI) 	DMH is Medicaid Program and performs Grievance and Appeal Reviews

DAs and SSAs must establish and maintain their own internal procedures for internal review of appeals consistent with the requirements outlined in this Manual. The appeal procedures must be available to all interested persons. An “interested person” includes the client and/or the client’s authorized representative and any person the client appoints (verification of the appointment of an “interested person” is the responsibility of the Medicaid Program entity—DA, SSA, DAIL or DMH—receiving the appeal). This may include the client’s family members and referring service providers acting on the client’s behalf.

Notices, Continued Services, and Member Liability

A. Member Notice

The part of the Medicaid Program issuing a service decision that meets the definition of an adverse benefit determination must provide the member with written notice of its decision. The notice of adverse benefit determination shall contain clear statements of the following: The adverse benefit determination the Medicaid Program has taken or intends to take, the reason for the adverse benefit determination, the specific rule that supports the adverse benefit determination, the right to appeal, including how to request an internal appeal and the timeframe. An explanation of when there is a right to request a State fair hearing, including the exhaustion requirement and when exhaustion is deemed. The circumstances under which an appeal will be expedited and how to request it. The right to have services continue pending resolution of the appeal, including how to request continuing services, the timeframe for requesting continuing services, and under what circumstances the beneficiary may be required to pay the costs of services that are provided pending resolution of the appeal. The methods for requesting an appeal and procedures for exercising other rights.

B. Continuation of Services

1. If requested by the member, services must be continued during an appeal regarding a Medicaid-covered service termination, suspension, or reduction under the following circumstances:
 - a. the appeal was filed in a timely manner, meaning before the effective date of the proposed action or within 11 days of the Medicaid Program sending the notice of adverse benefit determination, or whichever is later;
 - b. the member 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. If properly requested, a service must be continued until any one of the following occurs:
 - a. the member withdraws the appeal or fair hearing request;
 - b. the Medicaid Program issues an appeal decision adverse to the member, and the member does not request a fair hearing within the applicable time frame;
 - c. a fair hearing is conducted, and the Human Services Board issues a decision adverse to the member.

Members 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.

D. Member Liability for Cost of Services

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

If the provider notifies the member that a service may not be covered by Medicaid, the member can agree to assume financial responsibility for the service. If the provider fails to inform the member that a service may not be covered by Medicaid, the member is not

liable for payment. Benefits will be paid retroactively for members who assume financial responsibility for a service and who are successful on their appeal.

E. Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the Medicaid Program is not required to initiate service delivery.

The Medicaid Program is not required to provide a new service or any service that is not a Medicaid-covered service while an internal appeal or fair hearing determination is pending.

F. Providing or Paying for Services Following Resolution of an Internal Appeal or a State Fair Hearing

1. **Services Not Furnished While Appeal Pending:** If the Medicaid Program or AHS, including the Human Services Board, reverses a decision to deny, limit, or delay services that were not furnished while the internal appeal or State fair hearing was pending, or if AHS decides in the member's favor before the hearing, the Medicaid Program shall authorize or provide the disputed services as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date the Medicaid Program receives notice reversing the determination.
2. **Services Furnished While Appeal Pending:** If the Medicaid Program or AHS, including the Human Services Board, reverses a decision to deny, limit, or delay services that were furnished while the appeal was pending, the Medicaid Program shall pay for those services in accordance with State policy.

Fair Hearing

- (a) **State Fair Hearing Request** means a clear expression, either orally or in writing, by a member to have a decision by the Medicaid Program reviewed by the Human Services Board. With written consent of the beneficiary, a provider or an authorized representative may request a State fair hearing on behalf of the beneficiary. The beneficiary, his or her representative, or the representative of a deceased beneficiary's estate shall be parties to a State fair hearing.
- (b) **Exhaustion Requirement; Deemed Exhaustion**
 - (1) **Exhaustion Requirement:** A member may only request a State fair hearing after receiving notice of resolution of an internal appeal under 8.100.3(c) that the Medicaid Program upheld an adverse benefit determination, except that the member shall be deemed to have exhausted the internal appeal process pursuant to paragraph (b)(2) below.
 - (2) **Deemed exhaustion:** If the Medicaid Program fails to comply with the requirements regarding notice content and timing at 8.100.3(c) and 8.100.4(n), (o)

and (p), exhaustion of the internal appeal process shall be deemed, and a member may immediately request a State fair hearing.

Members receiving services from DAs and SSAs also have the right to file requests for Fair Hearings related to program eligibility determinations and reductions or denials of services if:

- ◆ they are enrolled in Medicaid and
- ◆ they have exhausted the internal appeal process and
- ◆ actions pertain to the CRT Program or to Developmental Disabilities Services OR
- ◆ actions pertain to children's Enhanced Family Treatment services, Children's e-bed extensions, and Children's Residential Assessment & Treatment (PNMI)

The DA/SSA must cooperate with DAIL/DMH and the DAIL/DMH Legal Unit in preparation of necessary documentation for Fair Hearing. The DA/SSA will prepare and submit any medical/clinical records and other documentation pertinent to the proceedings of a Fair Hearing before the Human Services Board. The DMH Legal staff shall represent the State in any Fair Hearings pertaining to determinations of eligibility for CRT program or services and Children's Services for youth experiencing a severe emotional disturbance and their families. The DA/SSA should arrange for its own legal representation. The DAIL Legal Staff shall represent the State in any Fair Hearings pertaining to determinations of eligibility for Developmental Disabilities Services.

ATTACHMENT 3.D

DA/SSA GRIEVANCE OR APPEAL FORM

If you are dissatisfied with your agency, a member of its staff, or decisions about services that you receive, you may complete this form and give it to the agency's grievances & appeals coordinator so that issues can be resolved reasonably quickly. This form is made available for your convenience, but you may write your concerns down in any way you choose. Or, if you prefer, you may talk to the grievances & appeals coordinator about your concerns.

- ***We encourage you to express your dissatisfaction openly.***
- ***Your concerns are considered confidential.***
- ***Your services will not be affected if you file a grievance or appeal an action.***
- ***No staff member will treat you poorly if you express your concerns.***
- ***You are entitled to an agency decision regarding your concerns and reasons for the agency's decision.***

Name: _____ (required in order to provide a response)

Address: _____ or e-mail _____

Telephone #: _____ (if preferred) Date: _____

(X) What best describes your concerns? If your concerns are about a denial, reduction, or stoppage of service, please give as much detail as possible. If your concerns are about the agency or staff, please describe the issues.

The following categories may help, but you are not limited to this list:

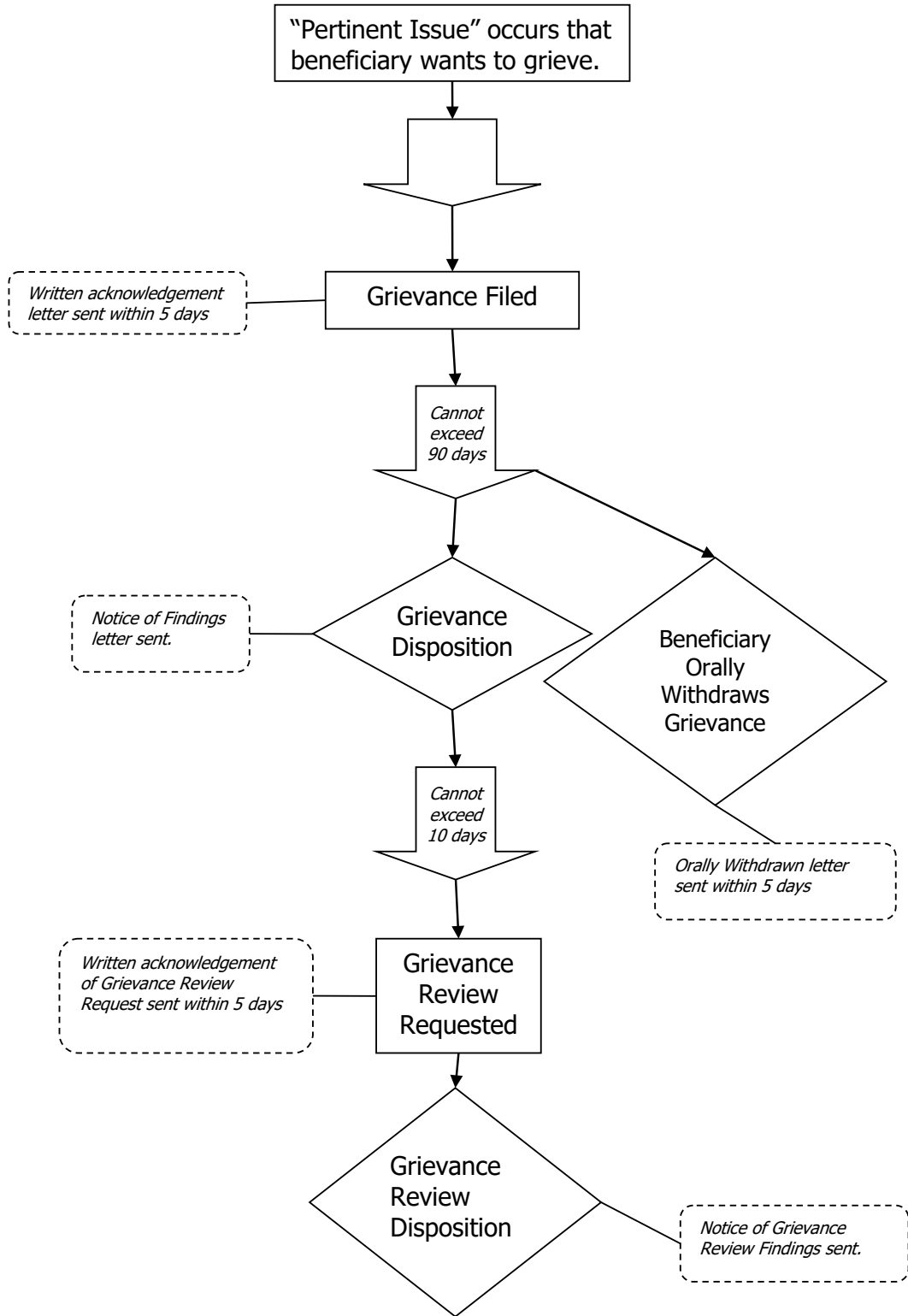
<u>Examples of Grievance Issues:</u>	<u>Examples of Appeal Issues:</u>
<ol style="list-style-type: none">1. <input type="checkbox"/> Dissatisfaction with a staff/contractor2. <input type="checkbox"/> Dissatisfaction with management3. <input type="checkbox"/> Dissatisfaction with program decision4. <input type="checkbox"/> Dissatisfaction with policy decision5. <input type="checkbox"/> Dissatisfaction with quality of services6. <input type="checkbox"/> Dissatisfaction with accessibility of services7. <input type="checkbox"/> Dissatisfaction with timeliness of response8. <input type="checkbox"/> Dissatisfaction with services not offered or not available	<ol style="list-style-type: none">1. <input type="checkbox"/> Denial or limited authorization of a requested covered service.2. <input type="checkbox"/> Reduction, suspension, or termination of an authorized service or service plan3. <input type="checkbox"/> Denial, in whole or in part, of payment for a service4. <input type="checkbox"/> Failure to provide services in a timely manner5. <input type="checkbox"/> Failure to provide clinically indicated covered services6. <input type="checkbox"/> Denial of request for covered services outside Medicaid network

Describe your concerns and what steps you have taken to resolve the problem so far. _____

How would you like to see the problem resolved? _____

Attachment 3. E

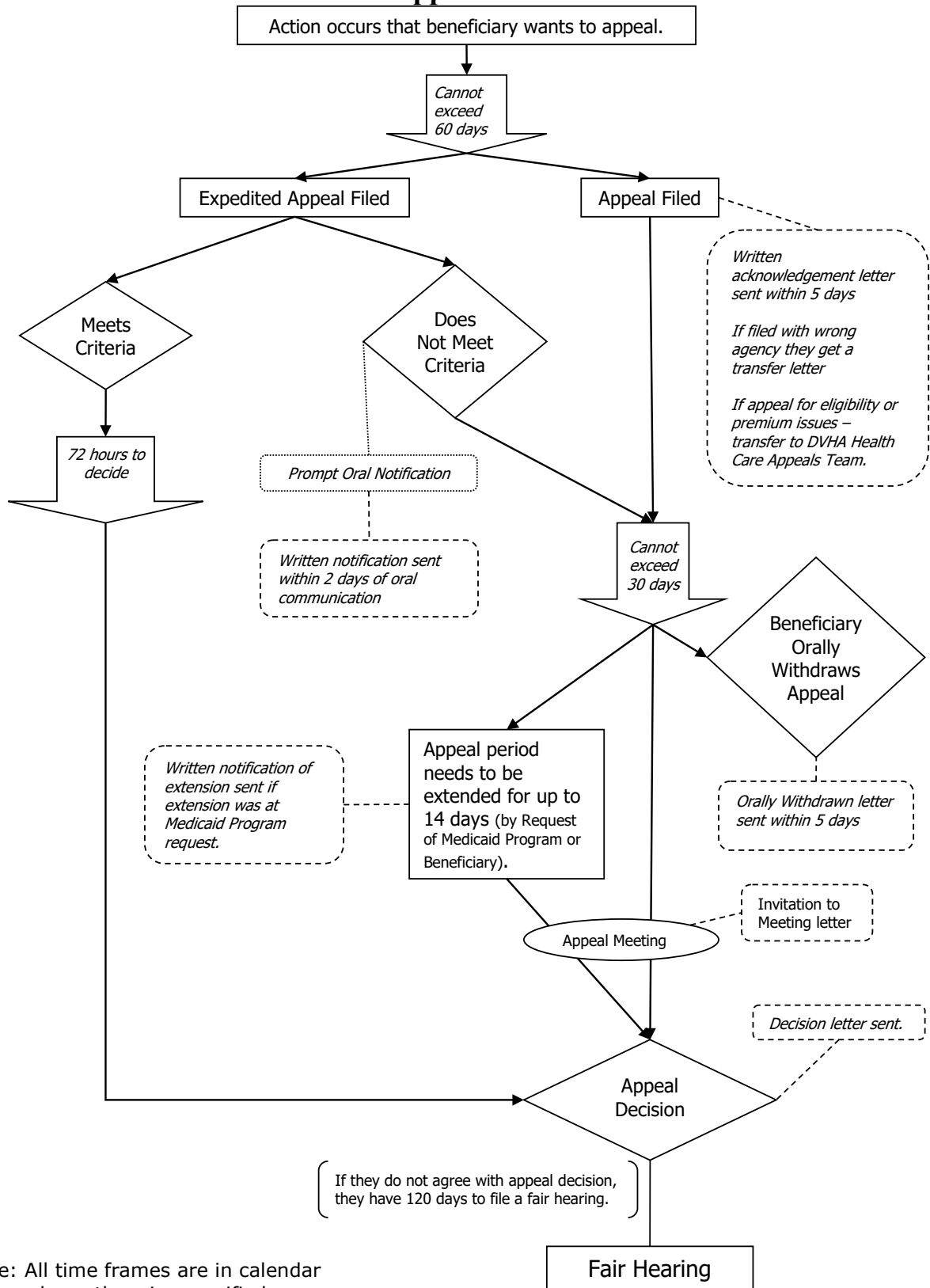
Grievance Flow Chart



Note: All time frames are in calendar days unless otherwise specified.

Attachment 3.F

Appeal Flow Chart



Note: All time frames are in calendar days unless otherwise specified.