VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Grievances, Appeals, Expedited Appeals and Fair Hearings of Medicaid Services

DVHA Unit: Appeals

Issuance Date: May 7, 2024

(Must be reviewed annually)

Vermont's Agency of Human Services (AHS) requires the Department of Vermont Health Access (DVHA) to adhere to policies that are established in AHS' Health Care Administrative Rules (HCAR), Federal statute or regulation, and/or State statute, and/or, with regards to policies that are solely in the interest of beneficiaries or providers, as relevant, but that have not yet been incorporated into HCAR, that have been announced in the Global Commitment Registry. The policies that DVHA follows for the topic of Grievances, Appeals, Expedited Appeals and Fair Hearings of Medicaid Services can be found below.

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

- 42 CFR 431.200-250 https://www.ecfr.gov/current/title-42/chapter-
- 42 CFR 438.400 -424 Managed Care Grievance and Appeal System

Vermont statute or rule:

- 3 V.S.A. § 3090: https://legislature.vermont.gov/statutes/section/03/053/03090
- Human Services Board Rules: https://humanservices.vermont.gov/sites/ahsnew/files/fair-hearing-rules-1.pdf

AHS policy:

- AHS Health Care Administrative Rule (HCAR) 8.100 Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services: https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/hcar-8.100-ga-adopted-rule-7.6.18.pdf

Purpose:

To document compliance with the above requirements concerning the processes for appeals, expedited appeals, fair hearings, and grievances.

Procedure:

The purpose of this procedure is to outline the process by which requests for internal appeals, internal expedited appeals, fair hearings, and grievances are handled.

Internal Appeal, Internal Expedited Appeal, Grievance, and Fair Hearing Requests

1. Internal Appeal
    - A member may file an appeal orally or in writing. This appeal must be filed within 60 days of the notice of adverse benefits determination.
        - A member may request continuation of benefits.
        - To be considered a valid appeal, if filed by someone other than an authorized representative or provider, the Grievance and Appeal (GA) Coordinator sends a request for written consent to the member (make note of sent date in the database).
        - Once written consent is received, upload it to database.
        - The case will not be treated as a valid appeal until consent is received.
    - The GA Coordinator:
        - Sends an acknowledgement notice within five days of receipt of a valid appeal.
        - Schedules an appeal meeting with beneficiary and appeal reviewer.
        - Sends the notice of appeal meeting to the member with a copy of the case file if requested.
    - At the appeal meeting, the decision maker meets with the member to allow them to provide additional information and discuss their reason for appeal.
        - After the appeal meeting, the GA Coordinator sends the appeals resolution notice which includes the Right to a State Fair Hearing to the member within thirty days of the receipt of a valid appeal. If it is in the best interest of the member, a 14-day extension may be granted.
            - If an extension is granted, a notice of extension must be sent to the member explaining why it was extended.
    - The GA Coordinator enters the appeal decision into the Grievance and Appeal Database within ten days of the resolution.

Expedited Internal Appeal

- A member may file an expedited internal appeal orally or in writing.
  - A member may request continuation of benefits.
  - If filed by someone other than an authorized representative or provider the GA Coordinator will send a request for written consent to the member.
  - Once written consent is received, upload it to database.
  - The case will not be reviewed until consent is received.
- If expedited criteria are met, the GA Coordinator schedules an appeal meeting as soon as possible with a decision being rendered within 72 hours.
  - A 14-day extension may be granted if additional information is needed for the review of the appeal.
  - If an extension is granted, the GA Coordinator orally notifies the member and follows up with a written notice of extension within two days.
- When the GA Coordinator outreaches the member to schedule the expedited appeal meeting, they also give the member a reasonable opportunity to provide evidence and/or testimony and to make legal and/or factual arguments, in person or in writing in advance of the resolution timeframe.
- At the expedited internal appeal meeting, the decision maker meets with the member to discuss their reason for expedited appeal.
- The GA Coordinator outreaches the member to relay the decision orally and follows up with a written notice within two days of the oral notice.
- The GA Coordinator enters the expedited appeal decision into the Grievance and Appeal Database.
- If an appeal comes in as an expedited appeal, but doesn't meet expedited criteria, the GA Coordinator notifies the member, and the appeal is processed in the standard 30-day timeframe.

2. Grievance
   - A member may file a grievance orally or in writing.
     - If filed by someone other than an authorized representative or provider the GA Coordinator will send a request for written consent to the member.
     - Once written consent is received, upload it to database.
     - The case will not be reviewed until consent is received.
   - The GA Coordinator acknowledges receipt of the grievance by sending an acknowledgement notice within five days of receipt of the valid grievance.
   - If the member orally withdraws a grievance, the GA Coordinator sends a letter acknowledging oral withdrawal of grievance within

five days.
- The appropriate Medicaid program representative reviews the grievance and provides the member with a written notice of disposition within 90 days of receipt of the grievance.
- The GA Coordinator enters the grievance disposition into the Grievance and Appeal Database.

3. Medicaid Provider Role in Grievance and Appeal Processes
    - Medicaid providers and relevant subcontractors will be informed of these processes as well as their role in supporting members with these processes.

4. Fair Hearing
    - A request for a State Fair Hearing must be made within 120 days of the notice of resolution to be considered timely.
    - The GA Coordinator reviews request to determine if internal appeal has been exhausted.
        - If the internal appeal has not been exhausted, the member is notified and the process for internal appeal is followed.
        - If the internal appeal has been exhausted, the case file is sent to the Assistant Attorney General (AAG) who will represent the department at a fair hearing.
    - The Human Services Board (HSB) schedules a hearing with appellant.
    - The Hearing Officer for the HSB listens to the evidence submitted by both sides and submits a recommendation to the HSB.
    - The HSB issues an order either affirming or overturning the original decision.
        - If the appeal request meets expedited criteria, the HSB should render a decision no later than 72 hours after receipt from DVHA.
        - If the appeal is a non-expedited appeal, the HSB should issue an order within 90 days of receipt from DVHA.
    - The AAG relays the order to the correct department/agency for implementation.
    - The GA Coordinator implements the HSB order.

Oversight and Monitoring

The HCAT Director performs a quarterly quality assurance review on all appeals, expedited appeals, and grievances to ensure compliance with the regulations as outlined above. The Director identifies any area of needed correction and/or enhanced training. The Director uses the attached Appeal and Grievance Case File Checklist in the performance of this review to document that all actions were taken timely.

The HCAT Director completes the appropriate section of the Appeal and Grievance

Case File Checklist and electronically saves the checklist for each case. This overview and specific directions for the checklist are included in the "Instructions" tab in the electronic checklist. When this SOP is selected for internal control testing, a sample of these cases will be selected for review.

Training

The HCAT Director conducts ongoing training at least annually as well as individualized training for newly appointed GA Coordinators.

- The HCAT Director documents training dates and attendance of each training.
    - If gaps in training are identified, the HCAT Director outreaches the appropriate Department.

Escalation Path

- Should the results of the quality assurance reviews trigger the need for additional training, the HCAT Director establishes a corrective action plan with the appropriate GA Coordinator.
- If needed, the HCAT Director escalates the issue to applicable department program management until adequately resolved.

Revision History:

Date	Summary of Revisions
5/7/2024	Summary of edits for HSAG recommendation

Table 1 Revision History