DDSD APPEAL AND GRIEVANCE TRAINING

Presented: April 4th, 2022

ALERT!!!

The information shared in these slides are not intended to be a comprehensive outline of all of the details related to the Appeal and Grievance process that you are required to follow.

We will focus on specific pieces of these processes, more information can be found through the links located on the final slide of this presentation.

Your agency's legal counsel is also resource for any questions or concerns related to appeals and grievances.

Definitions

"Medicaid Program" means

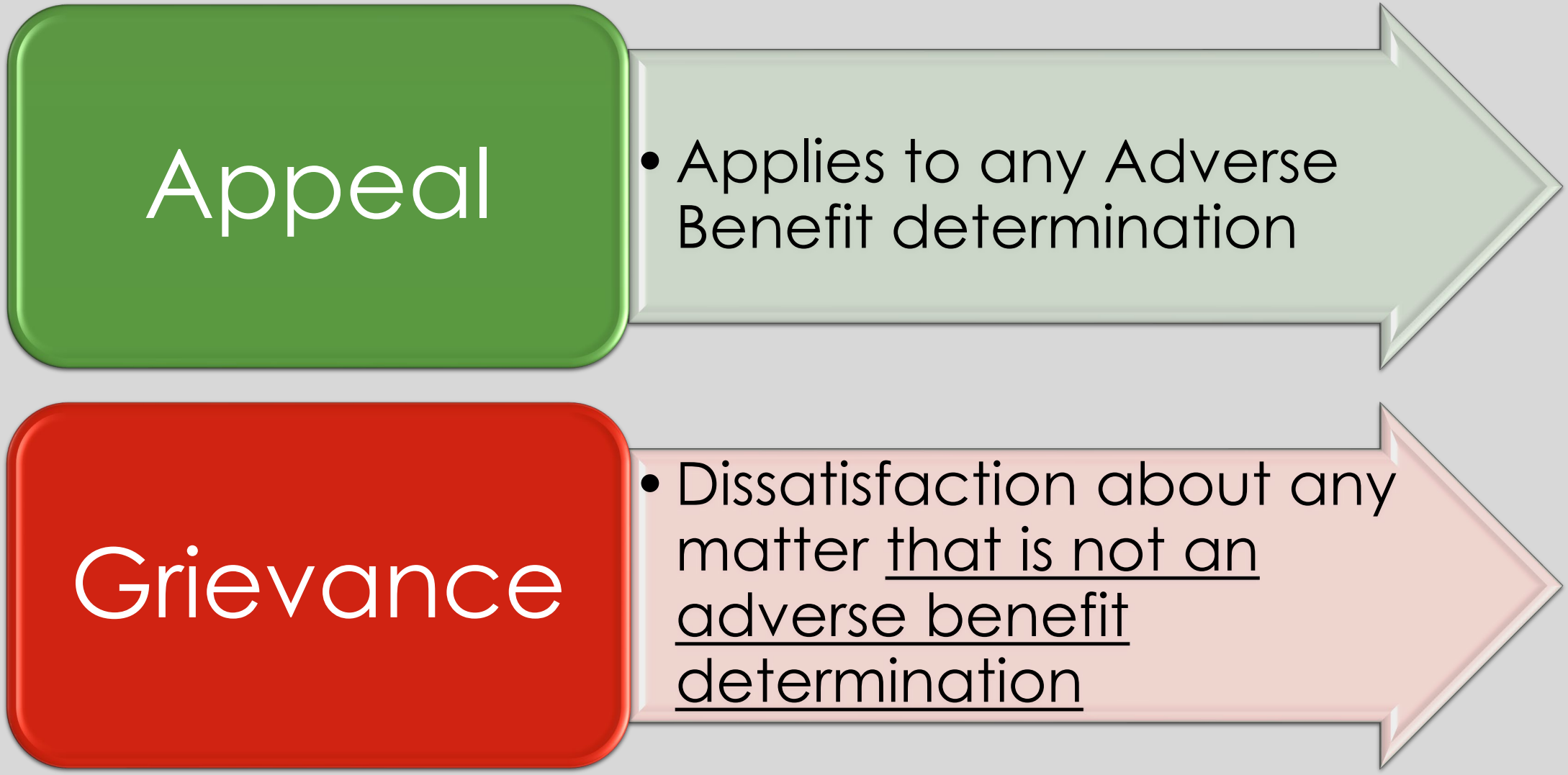
(1) **DVHA** in its managed care function of administering services, including service authorization decisions, **under the Global Commitment to Health Waiver** ("the Waiver"),

(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.

"Person" means the individual requesting or receiving services,


Appeal
• Applies to any Adverse Benefit determination
Grievance
• Dissatisfaction about any matter that is not an adverse benefit determination

What is an Adverse Benefit Determination?

- 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

*Found on page 4 of Medicaid Program Grievance and Appeal Manual

What is an Adverse Benefit Determination? (continued)

- Failure to act within timeframes regarding standard resolution of grievances and appeals
- Denial of a person's request to obtain services outside the network
- Denial of a person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other liabilities of person

*Found on page 4 of Medicaid Program Grievance and Appeal Manual

Adverse Benefit Determinations (ABD) Requirements

- Clear explanation of ABD and reasons why decision was made
- Cite specific rule that supports ABD
- The right to appeal, appeal timeframe and how to request
- At least a 11-day notice to reduce, terminate or suspend services
- Instructions to request continued services during appeal
- Right for legal counsel with VT Legal Aid contact information
- How to Request an Expedited Appeal and criteria for this action
- The right to request, free of charge, access to all documents related to ABD

Important Appeal Timeframes

- Person has **60 days** to file an appeal, verbally or in writing
- Person has **11 days** to request continued services
- Medicaid Program has **5 days** to acknowledge in writing
- Medicaid Program has **30 days** to decide on appeal, can extend for **14 days** if in **person's** best interest
- Medicaid Program has **72 hours** to decide on an expedited appeal, can extend for **14 days** if in **person's** best interest)

Expedited Appeal

If taking the time for a standard resolution **could seriously jeopardize the person's life or health or ability to attain, maintain, or regain maximum function.**

Medicaid Program has 2 days to orally notify person if criteria is not met, written notice is also sent.

Right to Participate (Part 1)

- The person, their authorized representative, or their provider, if involvement is requested by the person, **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. 8.1002(g) med Pro definitions

- 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.

- The person, their designated representative, or treating provider **may submit additional information**

*Found on page 13-14 of Medicaid Program Grievance and Appeal Manual

Right to Participate (Part 2)

- Upon request, the Medicaid Program shall timely provide the person, 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.**

  These records shall include:

  - The person'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

  - Other information relevant to the person'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.

Right to Participate (Part 3)

- The Medicaid Program shall timely **notify the person 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, the Medicaid Program shall make a decision that resolves the appeal without a meeting with the person, his/her authorized representative, or provider.
- The person, 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.

*Found on page 13-14 of Medicaid Program Grievance and Appeal Manual

Appeal Decision Notice Requirements

- A clear and understandable summary of decision
- Why ABD was upheld or revised
- A summary of documents or evidence used to make decision, for example the specific policy or regulation
- The effective date of decision
- How to Request a Fair Hearing and timeframes (including expedited process and right to continued benefits)
- Right for legal counsel with VT Legal Aid contact information

Fair Hearings

- Fair Hearing is conducted by Human Services Board
- Must be requested within **120 days** from appeal decision
- All documents regarding decision will be requested by DDSD Specialist and provided to the DAIL Legal Team

DDSD Specialist role is to support your decision:

- We rely on you following ABD and appeal process
- We rely on you to make decisions based on Needs Assessments
- We rely on you to submit funding proposals that meet funding priorities

Fair Hearing decisions can be based on these actions and not based on the DDSD System of Care or other policies

Human Services Board | Agency of Human Services (vermont.gov)

Exceptions to Appeal Process

1. Clinical Eligibility decisions for DDSD Services go directly to the Fair Hearing stage

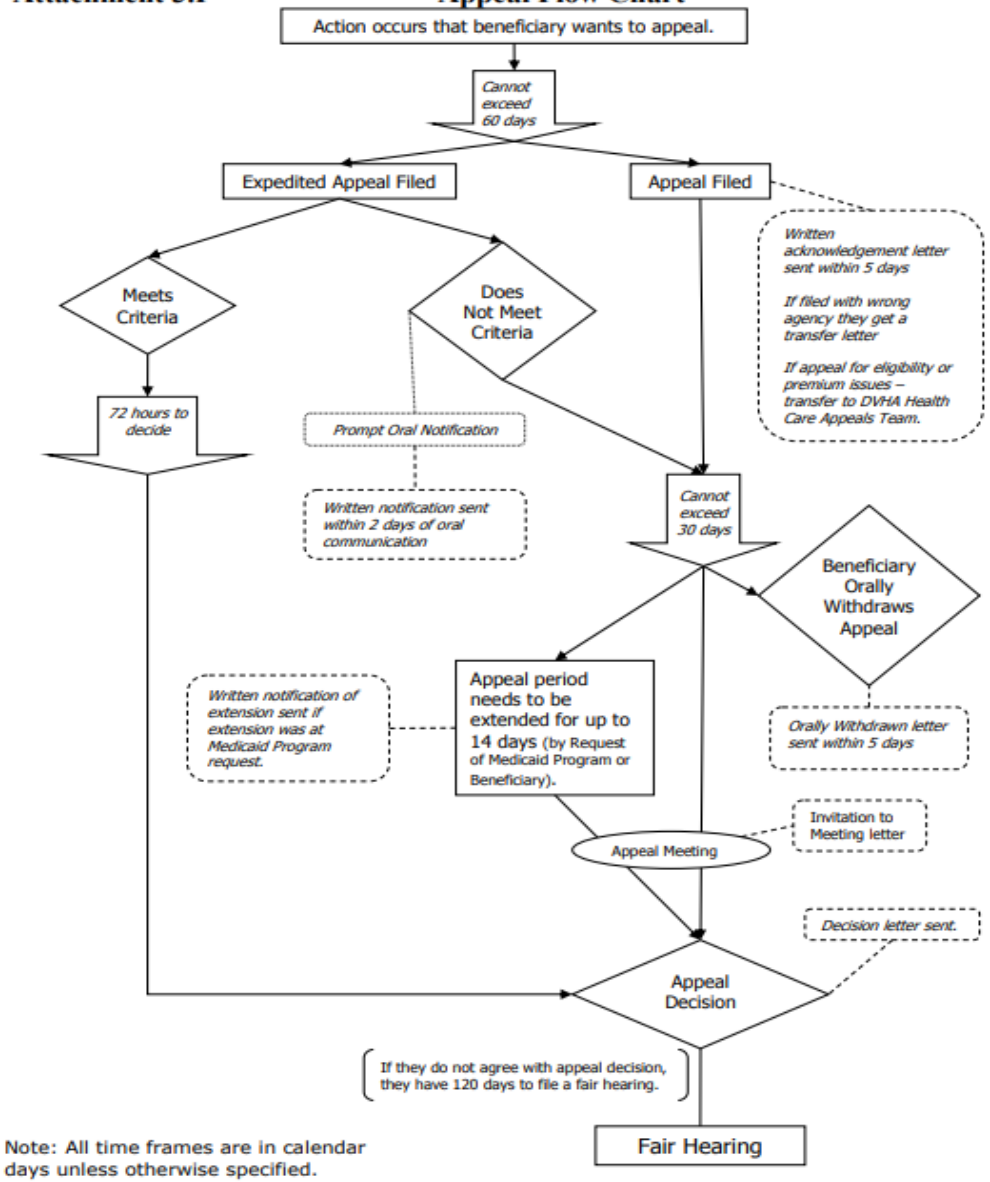
Clinical eligibility decisions are based on the person being found to have an intellectual disability defined by DDSD OR being assessed to meet criteria for autism spectrum disorder AND the person being assessed to make significant adaptive skill deficits.
(Health Benefits Eligibility and Enrollment (HBEE) Rule)

2. Appeals related to Transition II decisions are reviewed and decided the DAIL Commissioner

*Found on page 24 of Medicaid Program Grievance and Appeal Manual

Attachment 3.F

Appeal Flow Chart



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

“Grievance” means an expression of dissatisfaction about any matter that is not an adverse benefit determination, including a person’s right to dispute an extension of time proposed by the Medicaid Program and the denial of a request for an expedited appeal.

A grievance can submitted verbally or in writing

There is no time limit for a person to file grievance from the day of the incident

Grievances

- Person may grieve any matter that is not an adverse benefit determination, this includes:
  - A 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,
  - The quality of care or services provided
  - Aspects of interpersonal relationships such as rudeness of a provider or employee,
  - The failure to respect a person's rights.

*Found on page 5 of Medicaid Program Grievance and Appeal Manual

Grievances Timeframes

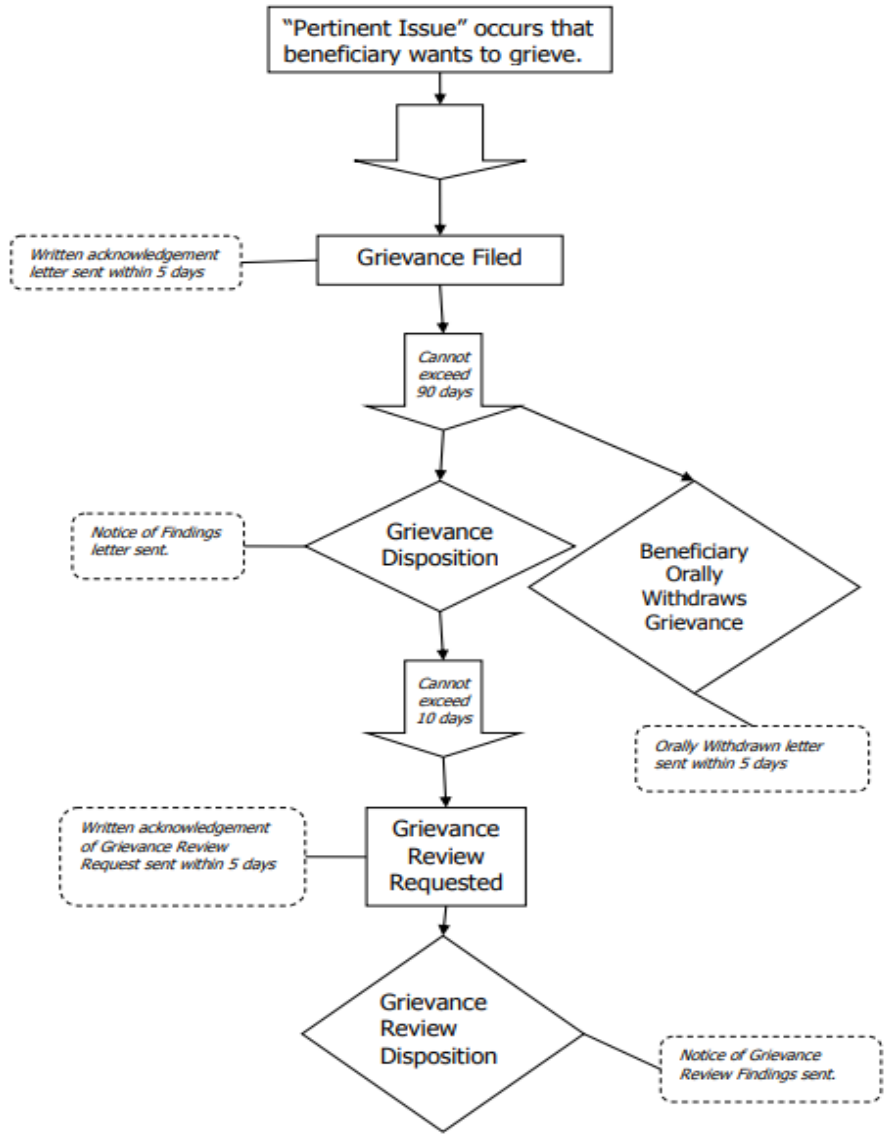
- Medicaid Program has **5 days** to acknowledge grievance in writing
- Medicaid Program has **90 days** to address grievance
- The person has **10 days** from day grievance was addressed to request a Grievance Review
- Medicaid Program has **5 days** to acknowledge grievance review request in writing
- Medicaid Program has **90 days** to complete grievance review and present findings

DAIL can be contacted by person if Grievances are not addressed within these timeframes

*Found on page 11 of Medicaid Program Grievance and Appeal Manual

*Found on page 23 of [Medicaid Program Grievance and Appeal Manual]

Attachment 3. E **Grievance Flow Chart**



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

Health Care Administrative Rules (HCAR) adopted by AHS, governs adverse benefit determinations (ABD) and grievances
https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules

HCAR Definitions 11.101-hcar-definitions-adopted-rule.pdf (vermont.gov)

HCAR Section 8.100 (Grievances and Appeals)
http://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/hcar-8.100-ga-adopted-rule-7.6.18.pdf

Health Benefits Eligibility and Enrollment (HBEE) Rule, which applies to DDSD eligibility decision

Section 68.00 (Notice of decision and appeal rights)
https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/HBEE/20-004-Part-Seven-adopted-scrubbed.pdf

Sections 80.00 through 82.00 (Fair hearings and expedited eligibility appeals)
https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/HBEE/20-005-Part-Eight-adopted-scrubbed.pdf

An additional resource:
Global Commitment to Health Medicaid Program Grievance and Appeals Technical Assistance Manual
http://dvha.vermont.gov/sites/dvha/files/documents/Members/global-commitment-manual-2017-.pdf