Proposed
Beneficiary Grievance and Appeal Procedures

January 25, 2006

PART I
GRIEVANCE AND APPEAL PROCEDURES

I. Introduction

The State Medicaid Program, as a Managed Care Organization (MCO) under the Global Commitment 1115 waiver, must have an internal grievance and appeal process for resolving service disagreements between beneficiaries and MCO employees, representatives of the MCO, and designated agencies. Beneficiaries (or duly appointed representatives) may file grievances or appeals orally or in writing. The overall goal of the grievance and appeal process is to resolve disputes fairly, to enhance beneficiary and public confidence in the equity and integrity of the service system, to ensure beneficiary access to clinically justified covered benefits, and to allow for the independent review of MCO staff decisions concerning appealable actions.

Under the Global Commitment, OVHA is a Managed Care Organization, and must meet rules for Medicaid managed care organizations. OVHA will have interagency agreements with AHS departments that will make them part of the MCO within the framework of the Global Commitment. Consequently, services provided by those departments pursuant to the terms of the agreements are MCO services and beneficiaries of those programs will have access to the MCO internal grievance and appeal process.

Grievance and appeal procedures must be:

- clearly communicated and consistently applied by all MCO components, programs, designated agencies and representatives;
- easily accessible, with assistance available as needed;
- confidential;
- free of retribution;
- adequately documented; and
- resolved within specified timeframes.

The procedures include a level of review by those not involved in the decision grieved or appealed. Resolutions of appeals will be clearly communicated to the beneficiary and his/her representative.

There are specified time frames for resolving grievances and appeals at the MCO level. In addition, MCO beneficiaries are entitled under federal regulation to certain protections with respect to grievances and appeals. However, the availability of these safeguards should not be construed to preclude reconsideration of a decision by a MCO staff member who made the original decision. A request for reconsideration may be made by a provider, the beneficiary or the representative of the beneficiary. A request must be accompanied by the additional information that supplements or clarifies material that was previously submitted and is likely to materially affect the decision. A request for reconsideration can be made up to 60 days after the notice of the effective date of an MCO action subject to appeal.

The procedures described in this section apply only to Medicaid, its Pharmacy programs, VHAP Uninsured beneficiaries covered by the MCO, and children covered by the State Child Health Insurance Program (SCHIP), although SCHIP beneficiaries are not part of the Global Commitment waiver.

The MCO will designate a Grievance and Appeals Coordinator who will be responsible for monitoring the timely processing and resolution of all grievances and appeals.

II. Definitions

The terms “action”, “appeal”, “DA”, “expedited appeal,” “Fair Hearing,” “grievance,” “MCO”, “Medicaid”, “network”, “OVHA”, and “service” are used as follows in describing the MCO grievance and appeals system:

An **’Action’** occurs when the MCO:

1. denies or provides limited authorization of a requested covered service, including the type, scope or level of service;
2. reduces, suspends or terminates a previously authorized covered service or a service plan;
3. denies, in whole or in part, payment for a covered service;
4. fails to provide a clinically indicated, covered service;
5. fails to act in a timely manner;
6. denies a beneficiary's request to obtain covered services outside the network, including:

    a. From any other provider (in terms of training, experience, and specialization) not available within the network;

    b. From a provider not part of the network that is the main source of a service to the beneficiary - provided that the provider is given the same opportunity to become a participating provider as other similar providers. (If the provider does not choose to join the network or does not meet the qualifications, the beneficiary is given a choice of participating providers and is transitioned to a participating provider within 60 days.)

c. Because the only plan or provider available does not provide the service because of moral or religious objections; or

d. Because the beneficiary's provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk if received separately and not all related services are available within the network.

7. fails to act within the established timeframes for grievances and appeals.

Actions taken by the MCO are considered preliminary decisions subject to appeal or reconsideration. If no appeal is filed or request for reconsideration made within the timeframes set out in this document, they are considered final MCO decisions. If an appeal is filed, the final MCO decision is the decision rendered as a result of the appeal.

'Appeal' means a request filed with the MCO, for a review of an action by the MCO, including an action by any contractor performing service authorizations.

Appeals of actions can be filed by a beneficiary, a beneficiary's representative, or a provider acting on behalf of the beneficiary with the beneficiary's written consent, with the MCO or any contracted department or a designated agency.

'Designated Agency (DA)': As used in this document, a DA is a Division of Mental Health or Department of Disabilities, Aging and Independent Living designated Community Mental Health Center, Developmental Services Agency, or Specialized Service Agency (SSA).

'Expedited Appeal' is an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function including when the beneficiary is in imminent danger to self or others and in which the safety needs of the community or the beneficiary cannot be met under any proposed reduction or denial of services.

'Fair Hearing' means an appeal filed with the Human Services Board, whose procedures are specified in rules separate from the MCO internal grievance and appeal process.

'Grievance' is an expression of dissatisfaction about any matter that is not an action, such as the quality of a service provided or aspects of interpersonal relationships such as rudeness or the failure to respect a beneficiary's rights, the extent of services offered, the frequency of visits, and the availability of or access to services.

'Managed Care Organization (MCO)': The Office of Vermont Health Access is the MCO; the MCO also includes any state entity with which the OVHA has a contract or Intergovernmental Agreement under the Global Commitment 1115 waiver that results in that entity becoming part of the MCO and providing services under the Global Commitment waiver. It includes the Vermont Department of Health (e.g., Division of Alcohol and Drug Abuse Programs, Division of Mental Health, Children with Special Health Care Needs; Dental Health); the Vermont Department of Disabilities, Aging and Independent Living, excluding the 1115 Choice for Care waiver program; the Department for Children and Families; and the Office of Vermont Health Access, including beneficiaries financed through the State Child Health Insurance Program (SCHIP). It includes Developmental, Mental Health, and Specialized Service agencies

designated by the State (DAs/SSAs), any contractor performing service or prior authorizations on behalf of the MCO, and local transportation brokers who receive funds and perform service authorizations for Medicaid financed transportation. It also includes contractors providing beneficiary member services or other services to the extent that these services may be subject to a grievance.

'Medicaid' as used in this document means programs and services financed using federal matching funds under the Global Commitment for Health 1115 waiver and the State Child Health Insurance Program.

'Network' includes providers enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries. It does not include a provider who enrolls on a one time basis for the purpose of serving a specific beneficiary.

'The Office of Vermont Health Access (OVHA)': As used in this document, the OVHA refers to the component part of the MCO directly managed by OVHA. Actions of OVHA are appealable using the internal MCO appeals process described herein.

'Service' is a service covered under the 1115 Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by CMS, included in the State Medicaid Plan if required by CMS, authorized by state rule or law, or covered under the State Child Health Insurance Program.

III. Beneficiary Appeal Procedures

A. Receipt of Appeals, Acknowledgement, Resolution, Appeal Review, Expedited Appeals

1. Receipt of Appeals: Beneficiaries (or duly appointed representatives) may file appeals orally or in writing of any of the MCO actions that are subject to appeal. Appeals must be filed within 90 days of the date the notice of decision being appealed was mailed. A request for reconsideration by a provider, the beneficiary or the representative of the beneficiary may be made up to 60 days after the notice of the effective date of an MCO action subject to appeal. A request for reconsideration does not suspend the 90 day time frame for filing of appeals.

The date of the appeal, if mailed, is the postmark date.

2. Medicaid Eligibility and Premium Determinations: If a beneficiary files an appeal only about a Medicaid eligibility or premium determination with the MCO, including a contracted department or DA/SSA, the entity that receives the appeal will forward it to the Department for Children and Families, Economic Services Division. The OVHA, department or DA/SSA will then notify the beneficiary in writing that the issue has been forwarded and will be resolved by DCF. Covered beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who are successful on an appeal concerning the amount of their premium will be reimbursed by the DCF for any premium amounts overpaid.

3. Written Acknowledgement: Appeals must be acknowledged by the MCO in writing within five calendar days of receipt. If the issue is resolved within the five-day time frame, a single decision notice may be sent; a separate acknowledgement is not required.

If the appeal is filed with the OVHA, contracted department or a DA/SSA that will not be considering the appeal, the OVHA, the department or DA/SSA will notify the beneficiary in writing, acknowledge the appeal, and explain that the issue has been forwarded to another part of the MCO, will identify the component part of the MCO to which it has been forwarded, and explain that the appeal will be addressed by that entity.

4. Resolution: Appeals must be decided pursuant to the MCO appeals process, and written notice sent to the beneficiary, within 45 days of receipt of the appeal whether or not all information necessary to resolve the appeal has been received. If an appeal cannot be resolved within 45 days, the time frame may be extended up to an additional 14 days if the beneficiary requests the extension. It may also be extended by the MCO up to an additional 14 days if there is need for additional information and the extension is in the best interests of the beneficiary. The MCO must give the beneficiary written notice of the reason for the delay. The 45 day period begins with the receipt of the appeal, and includes any review at the level of the DA/SSA. The total time period for the resolution of an appeal, including any extension requested either by the beneficiary or the MCO, is 59 days.

The MCO will act promptly and in good faith to obtain the information necessary to decide the appeal.

5. MCO Appeals Review: MCO appeals from beneficiaries will be reviewed by designated individuals within the MCO. Appeals will be heard by the designated individual(s) from the department or agency responsible for the services that are the subject of the appeal. Individuals hearing appeals will be appointed by the OVHA Director, and will include one or more representatives from each contracted department, designated agency/specialized service agency or program entity that is part of the MCO. The representative shall be an individual not involved in the decision subject to appeal and not a subordinate of the individual making the original decision, but who possesses the requisite clinical expertise to review decisions. If necessary, reviewers will be made available for specialized cases where additional clinical expertise is required. The procedures ensure a level of review by those not involved in the decision appealed.

6. MCO Appeals Committee: The individuals considering appeals shall be designated as the MCO Appeals Committee. The Committee will meet when convened by the OVHA Director or designee to review previous appeal decisions, procedures and time frames, the subject matter of appeals and their resolution, and any other matters pertinent to the MCO appeals process. Information on all MCO appeal decisions made by designated individuals shall be sent to the MCO and maintained by the designated MCO Grievance and Appeals Coordinator.

7. Beneficiary Participation in Appeals: The beneficiary, their designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person or by phone in the meeting in which the MCO is considering a final resolution of their appeal. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies material that was previously submitted and is likely to materially affect the decision.

The beneficiary shall be notified as soon as the meeting is scheduled. Meetings will be held during normal business hours. If necessary, the meeting must be rescheduled to accommodate individuals wishing to participate. If a scheduling or rescheduling results in exceeding the 45 day limit, an automatic 14 day time extension is effective. If a meeting can not be scheduled with the

45 day time limit and 14 day extension, a decision will be rendered by the MCO without a meeting with the beneficiary, their designated representative, or treating provider.

8. Expedited Appeal Requests: Expedited appeals are indicated in emergent situations in which the beneficiary or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function including when the beneficiary is in imminent danger to self or others and in which the safety needs of the community or the beneficiary cannot be met under any proposed reduction or denial of services. Typically, expedited appeals involve requests for hospitalization and are resolved quickly, usually in less than 24 hours. Expedited appeals are likely to be oral and must be resolved within three working days.

The MCO will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

The expectations and staff support for documenting requests for expedited appeals will be consistent with the standard appeal process. Individuals with the authority to make decisions in cases of expedited appeals shall be part of the MCO Appeals Committee and shall be appointed by the OVHA Director.

If the request for expedited appeal process does not meet criteria and is denied, the MCO, or contracted department or DA/SSA will promptly inform the beneficiary that the request does not meet criteria for expedited resolution and that the appeal will be processed in the standard (45 days) time frame to resolve the appeal. Written notice to the beneficiary of the denial for expedited appeal must follow within two calendar days.

The written notice for any expedited appeal determination should include a brief summary of the appeal, the resolution and the basis for the resolution, and the beneficiary's right to request a Fair Hearing subsequent to a final decision by the MCO.

B. DA/SSA Decisions, Internal DA/SSA Reviews, Provider Decisions, Reconsiderations

1. DA and Contracted Department Decisions: A DA/SSA determination of ineligibility for a DA/SSA managed program and /or a proposed change in the services detailed in a beneficiary service plan are both examples of actions that may be appealed. For example, a case manager may want to decrease the range of specific services described in the current individualized treatment plan in response to a beneficiary's improvements in that area of treatment, but the beneficiary does not agree with the change in range identified in the treatment plan. This kind of action, a plan change, requires a notice to the beneficiary.

Similarly, a beneficiary may request a new covered service from a contracted department or agency treatment team. However such a request may be denied when the treatment team does not believe such a service is indicated in the beneficiary's current treatment plan based on the beneficiary's condition or diagnosis or in light of best practice guidelines. In such instances, the beneficiary should be noticed of the decision not to offer the service and provided with information about how to appeal that decision.

For any MCO contracted department or DA/SSA, any plan to deny a requested service or to authorize a service in an amount, scope or duration less than that clinically prescribed in the existing service plan requires that the beneficiary be mailed a notice of action on or before eleven

(11) days before the effective or start date of the proposed change, except as noted below. If there is information to verify probable beneficiary fraud, the notice period may be reduced to 5 days. Notices must explain the action the department or designated agency/specialized service agency has taken or intends to take, the reasons for the action, the beneficiary's right to file an appeal using these procedures, circumstances under which an expedited resolution is available and how to request one, and the beneficiary's right to request a Fair Hearing subsequent to a final decision by the MCO.

If a beneficiary disagrees with the planned reduction or denial of service notice of intended action, either orally or in writing, this constitutes an appeal.

2. Internal DA/SSA Reviews and Reconsiderations: DAs and SSAs may establish and maintain their own internal procedures to review or reconsider service decisions. These procedures are established under standards established by the respective supervising department in the MCO. These procedures are not a required step in the MCO grievance and appeals process. However, the final decision resulting from a DA/SSA internal reconsideration or review is considered a MCO decision subject to appeal consistent with the procedures outlined in this document. Any internal DA/SSA appeal process is part of the 45 day time frame for resolving appeals, and must be completed within 15 days.

DAs/SSAs will provide beneficiaries notice of the results of their internal review. If this results in a new decision, beneficiaries have 90 days to appeal that decision. If the review affirms the original decision, or if the beneficiary is dissatisfied with the decision and requests further review, it will be reviewed through the MCO review process.

If the beneficiary is uncertain as to whether or not they will accept the decision, they will have 30 days from the date of the DA/SSA decision notice to inform the MCO that they wish to pursue an appeal. The appeal review will be completed within 30 days of the date that the beneficiary notifies the MCO that they wish to have their appeal considered.

3. Participating Provider Decisions: A decision by an MCO contracted/participating provider (physician, hospital, or clinician but not including a DA or SSA) to not provide a service is not considered an MCO decision and is not appealable using this process. Providers also include state agencies providing services that are not prior authorized but are claimed at the Medicaid service matching rate.

C. Notices, Continuation of Services, Beneficiary Liability for Service Costs,

1. Beneficiary Notice: The beneficiary must be informed of how to request that covered services be continued while an appeal is in process, the beneficiary's right to request an internal MCO review for covered services or alternate services, and the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any internal MCO appeal and Fair Hearing.

2. Filing Appeals: Appeals may be filed orally or in writing. The MCO will require staff members to assist a beneficiary to file an appeal if this assistance is required. Providers and representatives of the beneficiary may file appeals when they are acting on behalf of an individual and have the individual's written consent. A release signed by the beneficiary is sufficient for designation of a representative. The MCO appeal process will include assistance, as needed, to the beneficiary to initiate and participate in the appeal. At no point in the pursuit of

an appeal will the beneficiary be subject to retribution or retaliation in any form for appealing a MCO action.

3. Continuation of Services: If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered health service termination or reduction under the following circumstances:

a. The appeal was filed in a timely manner, meaning on or before eleven (11) days after the notice of action was mailed or by the effective or start date of the proposed action.
b. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan; and
c. Any applicable annual plan of care has not expired at the time of the appeal.

Designated mental health and specialized service agencies and the Division of Alcohol and Drug Abuse may, at their discretion, continue services that are the subject of the appeal even though the request for continuation of services was not made within the specified time limits.

Service continuation applies only to services that are being terminated or reduced. The service must be continued following a timely appeal notice and beneficiary request until one of the following occurs:

a. The beneficiary withdraws the appeal;
b. Any limits on the service have been reached;
c. The MCO internal appeal decision is made that is also adverse to the beneficiary and no Fair Hearing has been requested within the applicable time frames;
d. The OVHA internal appeal decision is made, was adverse to the beneficiary, and a Fair Hearing has occurred which is also adverse to the beneficiary; or
e. An annual treatment plan, if applicable, has expired.

Beneficiaries may waive their right to continued benefits. If they do so and are successful on appeal, benefits will be paid retroactively. The MCO may recover the value of any benefits paid during the appeal period when the beneficiary withdraws the appeal before a Fair Hearing decision is made, and the MCO's position is affirmed by the Fair Hearing decision.

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 affecting some or all beneficiaries, when the decision does not require the minimum advance notice.

4. Appeals Regarding Proposed Services: The MCO is not required to provide a new service requested or a health service that is not a Medicaid-covered service while an appeal or Fair Hearing determination is pending. Beneficiaries would get coverage for unrelated services, i.e., those not the subject of the appeal or a Fair Hearing.

If an appeal is filed with regard to a denial of service eligibility the MCO is also not obligated to initiate service delivery.

If an appeal is filed with regard to a denial of service not covered for traditional Medicaid beneficiaries, the request should be directed to OVHA under the provisions of Medicaid rules at M108.

5. Beneficiary Liability for Cost of Services: The beneficiary may be liable for the cost of services subject to appeal after the effective date of the service reduction/termination contained in the notice or the date of the timely appeal, whichever is later, until the appeal is resolved.

The MCO must inform beneficiaries of their potential liability and the availability of the MCO Internal Appeal process and Fair Hearing in the adverse action notice. Potential liability will occur only if an MCO internal appeal, Fair Hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCO also determines that the beneficiary should be held liable for service costs.

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

D. School Based Health Services

The School Based Health Services Program is used by the State to receive Medicaid reimbursement for medically related services provided to eligible students. The eligible students must be: receiving special education services; enrolled in Medicaid; and receiving Medicaid billable services. School districts can only claim for students on IEPs (i.e., receiving special education services) not for students on 504 plans. A release of information is required before any claims can be processed. The parent has the right to refuse to give consent and if this happens, no billing for any services provided by the school district can be claimed for Medicaid reimbursement. In addition, a physician or a nurse practitioner must sign a physician authorization form, which establishes that the IEP services are medically necessary.

Because a School Based Health Service must be included in a Child's IEP prior to consideration for reimbursement, the Department of Education procedures will apply to appeals concerning services included in the IEP. Federal IDEIA statutes and regulations govern the process for assessing needs and developing plans of care (i.e., the IEP). Separate Department of Education due process and appeals procedures apply when there is a disagreement concerning the services included in the IEP. Parents of a child receiving special education services who disagree with decisions made by the school regarding a child's identification, eligibility, evaluation, Individualized Education Program (IEP) or placement have three options available for resolving disputes with the school. These options include mediation, a due process hearing and an administrative complaint.

IV. Beneficiary Grievance Procedures

A grievance is an expression of dissatisfaction about any matter that is not an action, such as the quality of a service provided or aspects of interpersonal relationships such as rudeness, or failure to respect a beneficiary's rights, the extent of services offered, and the availability of or access to services.

1. Filing Grievances: A grievance may be filed orally or in writing, and may be informal (any oral grievance that can be resolved within 72 hours of receipt) or formal (any grievance not resolved after 72 hours). Informal grievances that are not resolved within 72 hours become formal grievances. Formal grievances must be tracked and resolution reported no less frequently than semi-annually to the MCO Grievance and Appeals Coordinator by each component of the

MCO. The MCO will require staff members to assist a beneficiary to file grievances if this assistance is required.

2. Receipt of Grievances: Beneficiaries (or duly appointed representatives) may file grievances orally or in writing, within 60 days of the pertinent issue. Formal grievances will be documented on a standard Grievance/Appeal Form published by the MCO.

3. Written Acknowledgement: Formal grievances must be acknowledged in writing within five calendar days of receipt. The acknowledgement must be made by the component part of the MCO responsible for the service area that is the subject of the grievance. If the issue is decided within the five-day time frame, it is not necessary to send separate notices of acknowledgement and decision. The decision notice is sufficient in these cases.

4. Resolution: All grievances will be resolved within 60 calendar days of receipt. Written notice of the resolution decision must be sent for formal grievances. The written notice will include a brief summary of the grievance, information considered in making a decision, and the resolution. If the decision is adverse to the beneficiary, the notice must also include information on the beneficiary's right to file a grievance review with the MCO and how to do so.

If a grievance cannot be decided within the 60-day timeframe, the relevant component of the MCO must request an extension of the time frame from the beneficiary and inform the beneficiary of the status of the issue and the reason for the delay. The extension may not exceed an additional 30 days.

5. MCO Grievance Review: If the grievance resolution is adverse to the beneficiary, a beneficiary may request a grievance review. The beneficiary should request a review within 10 days of the decision through the component part of the MCO that addressed the grievance. The grievance review will be performed by the applicable component of the MCO by an individual not involved in the resolution of the grievance or a subordinate of the individual who responded to the grievance.

> **a. Written Acknowledgement:** The MCO will acknowledge receipt of grievance review requests within 5 calendar days.
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> **b. Resolution:** The grievance review will assess the merits of the grievance issue/s, the process employed in reviewing the issue/s, and the information considered in making a final resolution determination. The primary purpose of the grievance review shall be to ensure that the grievance process is functional and resolution impartial and consistent with the issues or facts presented. The beneficiary will be notified in writing of the findings of the grievance review, which is considered final.

Any beneficiary, however, may request a Fair Hearing of his/her grievance issue if it meets the requirements of the Fair Hearing process. Fair Hearings are typically reserved for appeals of actions related to reduction, suspension, or denial of service described in the previous section, so the Human Services Board may decline to hear a grievance based on jurisdiction.

6. MCO Components with Responsibility for Addressing Grievances: The following departments and agencies have responsibility for addressing grievances filed under these procedures.

Vermont Department of Disabilities, Aging, and Independent Living: Division of Disability and Aging Services and Designated Developmental and Specialized Service Agencies; TBI Program; Attendant Care Program; Personal Care Services;

Vermont Department of Health: Division of Alcohol and Drug Abuse Programs; Division of Mental Health and Designated Mental Health and Specialized Service Agencies; Dental Health; Children with Special Health Care Needs;

Department for Children and Families;

Office of Vermont Health Access: *PC Plus*; other programs; and

Any other part of the MCO receiving funds under the Global Commitment for Health.

V. Fair Hearing

A request for Fair Hearing may be made by the beneficiary within 30 days of receipt of the adverse decision resulting from the MCO appeal process. If the beneficiary's original request for appeal was filed within 10 days, the beneficiary's services will not be changed until a determination regarding eligibility for Fair Hearing. If the appeal is timely, current levels of service will continue until the Fair Hearing decision is made.

The MCO will cooperate with the attorneys representing the MCO in any Fair Hearing proceedings, including preparation and submission of any beneficiary medical records or other documentation pertinent to the proceedings.

The OVHA, contracted department or DA/SSA must cooperate with the MCO and its designated AAGs or legal counsel in preparation of necessary documentation for Fair Hearing. The OVHA, contracted department or DA/SSA will prepare and submit any beneficiary medical/clinical records and other documentation pertinent to the proceedings of a Fair Hearing before the Human Services Board. The OVHA or contracted department legal staff shall represent the State in any Fair Hearings pertaining to appealable actions. If necessary, DAs/SSAs should arrange for their own legal representation.

MCO beneficiaries also have the right to file requests for Fair Hearings related to eligibility and premium determinations if they are Medicaid, Pharmacy program, SCHIP and VHAP Uninsured enrolled beneficiaries. DCF shall retain responsibility for representing the State in any Fair Hearings pertaining to Medicaid/VHAP/SCHIP eligibility and premium determinations.

PART II
MCO ADMINISTRATIVE FUNCTIONS

I. Documentation and Reporting

A. Grievance and Appeal Logs: The OVHA, Departments and Designated Agencies must submit no less frequently than semi-annually summary logs on grievances and appeals. The MCO will maintain the logs. The MCO will review the logs 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 MCO or contracted department may audit grievance logs as part of any scheduled or unscheduled program reviews.

B. Appeal Logs: All appeals will be documented on the grievance and appeal form and summarized in the appeal log. Appeals must be coded (using the MCO reason codes) and must be identifiable by department and program. The appeal form and log includes the following information:

- Name of beneficiary and contact information
- Source of appeal (source code)
- Date received
- Appeal category (category code)
- Name of the person resolving the appeal
- Date when resolution was completed, and if it was done within timelines
- Name and contact information for any beneficiary representative
- Name and contact information for the beneficiary's provider

In addition, all related correspondence and other pertinent documentation must be maintained in individual beneficiary files.

A summary of the appeal log will be submitted to the MCO using the specified reporting format. Designated MCO staff may use both grievance and appeal logs/forms, and related files and correspondence, in assessing MCO performance or during any on-site program audits.

C. Grievance Logs: All formal grievances must be documented on the grievance and appeal form and must be summarized in a log maintained by the OVHA, DA/SSA, or contracted department of the MCO. Grievances must be coded (using the MCO reason codes) and must be identifiable as related the specific program in question. The grievance and appeal form and log must include the following information:

- Name of beneficiary and contact information
- Applicable program, service, or division
- Source of grievance (source code)
- Date received
- Category of the grievance (type code)
- Name and contact information of person filing grievance if not the beneficiary
- Person addressing the grievance
- Date when resolution was completed

In addition, all related correspondence and other pertinent documentation must be maintained in the OVHA, contracted department or DA/SSA files and be retrievable for audits and reviews by the MCO.

A summary of the grievance log will be submitted to the MCO no less frequently than semi-annually, containing information as required by the MCO, including such possible items as summaries of actions taken in response to grievances addressed during the reporting period, descriptions of any quality improvement actions initiated in response to grievances, and any recommended quality improvement that might be undertaken by the MCO to address grievances that have been filed.

II. Quality Improvement

As part of the Quality Improvement process, the MCO will review the grievance and appeal reports to ensure that the OVHA, contracted departments and DAs/SSAs are resolving beneficiary issues in a timely fashion and to identify any developing trends that may require further investigation.

III. Staff Support and Information Sharing

A. Timely response: The OVHA, contracted departments or DA/SSA are expected to complete the appeals process and render a decision within the appeal time lines. Likewise, The OVHA, contracted departments or DA/SSA and the beneficiary and/or representative are expected to complete the grievance process and to render a resolution determination within the grievance determination time lines.

B. Receipt of appeals or grievances by the MCO: If a appeal or grievance is filed with a component part of the MCO that will not be considering the appeal/grievance, it will notify the beneficiary in writing that the issue has been forwarded to another part of the MCO, will identify the component part of the MCO to which it has been forwarded, and explain that the appeal/grievance will be addressed by that entity. Appeals or grievances received by the MCO will be acknowledged in writing within 5 calendar days to the beneficiary and the applicable component part of the MCO. This notification will cause the MCO internal appeal or grievance process to begin.

C. Staff Support: The MCO has a Grievance and Appeals Coordinator, who is responsible for monitoring the timely resolution of all MCO internal appeal requests, clarifying appeal and grievance time frames and processes, and providing technical support on the appeal and grievance process to the component parts of the MCO.

D. Hospital Admission of CRT beneficiaries: The Vermont State Hospital (802-241-1000) should be contacted during evenings, weekends and holiday if the expedited appeal request involves the pending hospitalization of a participant in the Division of Mental Health Community Rehabilitation and Treatment (CRT) program.