Procedure Name	Consumer Grievance and Appeal Procedures
Procedure Owner	Director of Information Management and Compliance
Corresponding Policy	Consumer Grievance and Appeal Policy
Last Updated	4/23/2021
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CONSUMER GRIEVANCE AND APPEAL PROCEDURES

OBJECTIVE/PURPOSE:

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:

Adverse Benefit Determination: refers to 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.

AHS: Agency of Human Services

Appeal (for consumers with Medicaid only): a formal oral or written request from a consumer to the agency to review its decision on an adverse benefit determination.

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.

DA: Designated Agency. Howard Center is a designated agency.

DDSD: Developmental Disabilities Services Division

DRVT: Disability Rights Vermont

DMH: Department of Mental Health

Expedited Appeal (for consumers with Medicaid only): an appeal in an emergent situation in which taking time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Fair Hearing (for consumers with Medicaid only): 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.

Grievances: an oral or written expression of consumer dissatisfaction about any matter other than an adverse benefit determination. 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.

Grievance Review: an internal review of the grievance decision-making process by an unbiased third party within Howard Center.

PROCEDURE:

GRIEVANCES

A concern/complaint that gets resolved at the initial level does not need to be considered a grievance. A grievance does not need to be submitted in writing**.** In order to document the grievance for the agency's purposes, the grievance and appeal coordinator will provide the responsible staff person the grievance form. The staff person may assist the consumer in the form's completion or complete the form themselves if the consumer does not wish to or refuses to fill it out. Assistance may also include auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have TTY/TTD and interpreter capability. A grievance may be initiated by the consumer, the person's family, guardian or the consumer's designee. The staff person will then forward the written grievance to the grievance and appeal coordinator at ClientG&A@howardcenter.org. The coordinator will:

- Send the consumer a written acknowledgement within five (5) calendar days of receipt of the grievance,
- Inform the Chief Client Services Officer or their designee, of the grievance for

investigation initiation.

A grievance can be filed at any time after an event/incident. There is no time limit, unlike appeals.

All grievances will be investigated in good faith and responded to according to the timelines outlined in this policy.

Notification of Decision
The consumer will be notified of the decision in writing within no more than ninety (90) calendar days of original receipt. Different state departments may have different timelines for submitting and resolving grievances. Each Howard Center program must adhere to the timelines established by their governing state department. The written notice must include a summary of the grievance and the basis or rationale for the agency's decision. For consumers with Medicaid the notice will also contain the telephone number of the Health Care Advocate at Vermont Legal Aid, and information regarding the consumer's right to request a grievance review and how to initiate that process. If any timelines are violated in the grievance process, consumers with Medicaid can file an appeal.

Mediation
In the case of Developmental Services, the consumer/representative, Howard Center, or DDSD may request that an independent third party assist in discussions to reach a mutually agreeable solution. Both Howard Center and the consumer/representative must agree to participate in this process. DDSD will assign and pay for the trained mediator. This process must be completed within sixty (60) days of filing a request for mediation. Requests for mediation must be sent in writing directly to DDSD. DRVT is also available to assist Developmental Services clients throughout the Grievance process.

Withdrawal of Grievances
The consumer or their designated representative may withdraw a grievance orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal must be acknowledged in writing within five (5) calendar days.

Grievance Reviews
For consumers with Medicaid, if a grievance is decided in a manner adverse to the consumer, the consumer may request a grievance review. A Grievance Review is conducted by DMH and requested by the consumer within ten (10) calendar days of notification of decision. It is the agency's responsibility to notify the client of this next step in the written response. At this time, the agency will enter the grievance information into the state grievance and appeal database.

<u>Written Acknowledgement</u>
Grievance review requests will be acknowledged within five (5) calendar days of receipt.

DMH is to be notified of a DMH Grievance Review within ten (10) calendar days of the determination letter. DMH has five (5) calendar days to send an acknowledgement.

Notification of Decision

The consumer will be notified of the findings of the grievance review within ninety (90) calendar days. The grievance review determination is considered final. The consumer may file an appeal of this final decision only if Howard Center does not respond according to this timeline. Howard Center will notify the consumer of this right should it be applicable.

CONSUMER APPEALS

If a consumer with Medicaid is dissatisfied with an adverse benefit determination, the consumer, family, guardian, or the consumer's designee may request an appeal of the decision within sixty (60) calendar days of that decision. **As with grievances, an appeal does not need to be submitted in writing.** In order to document the appeal for the agency's purposes, the grievance and appeal coordinator will provide the responsible staff person with an appeal form. The staff person may assist the consumer in the form's completion or complete the form themselves if the consumer does not wish to or refuses to fill it out. The staff person will then forward it to the grievance and appeal coordinator at ClientG&A@howardcenter.org. The coordinator will:

- Log the appeal into the state's database,
- Send the consumer a written acknowledgement within five (5) calendar days of receipt of the appeal, and
- Inform the Chief Client Services Officer, or their designee, of the appeal so that they may appoint someone to review the adverse benefit determination and appeal.

Timelines and department-specific requirements may vary depending on which program the appeal occurs in. The grievance and appeal coordinator will be responsible for reviewing and complying with different departmental requirements when not outlined in this policy.

Appeal Meeting

The consumer, their designated representative, and/or their provider have a right to participate in person, by phone or in writing in the meeting in which Howard Center considers the final decision regarding an appeal. Participation includes the right to present evidence and testimony and make factual and legal arguments. The consumer will 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.

Time Frame for Appeal Meeting
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) calendar days, by request of the consumer or by Howard Center if the extension is in the best interest of the consumer. If requested by Howard Center, Howard Center must provide the consumer with written notice of the reason for the delay. The maximum time period for the resolution of an appeal, including any extensions, is forty-four (44) calendar days. If a meeting cannot be scheduled within these time frames, a decision will be rendered by Howard Center without a meeting with the consumer.

Access to Documentation
Upon request, Howard Center will provide the consumer with all the information in our possession or control relevant to the appeal process and the subject of the appeal, at no cost to the consumer. This includes but is not limited to, the written decision already provided to the consumer, and any documentation entered into the grievance and appeals database.

Reviewer of Appeal
The individual who hears the appeal shall not have made the adverse benefit determination subject to appeal and shall not be a subordinate of the individual who made the original decision. Appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess (es) the requisite clinical expertise, as determined by Howard Center, in addressing the consumer's condition or illness. This person will make a decision about the appeal and send a written decision to the consumer within thirty (30) calendar days.

Any Appeal review for EFT services, E-bed extensions, or PNMI's will be performed by DMH and not Howard Center.

Medicaid Eligibility and Premium Determinations
If a consumer files an appeal regarding only Medicaid eligibility or premium determination, Howard Center will forward the appeal directly to DVHA and notify the consumer that the appeal will be treated as a fair hearing and will be addressed by DVHA directly.

Beneficiary Notice
The program issuing a services decision that meets the definition of an adverse benefit determination must provide the beneficiary of written notice of its decision. In cases involving a termination or reduction of service (s), such notice of decision must be mailed at least eleven (11) days before the change will take effect. When the decision is adverse to the beneficiary, the notice must inform the beneficiary when and how to file an appeal or fair hearing. In addition, the

notice must inform the beneficiary that they may request covered services be continued without change as well as describe the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any Howard Center appeal or fair hearing. Howard Center must have and use a notice that meets legal requirements for Medicaid notices.

Continuation of Services

Services will continue during an appeal if the:

- Agency has a statutory or contractual obligation to do so; and
- The consumer requests the continuation of services, and
- The appeal was filed in a timely manner, and
  - The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment, and
  - The services were ordered by an authorized provider and the annual plan of care or support agreement has not expired, and
- The consumer has paid any required premiums in full.

Services that are deemed to continue (per above) must be continued until one of the following occurs:

- The consumer withdraws the appeal,
- The agency issues an appeal decision adverse to the consumer, and the consumer does not request a fair hearing within the applicable time frame,
- The annual treatment plan expires,
- Any limits on the cost, scope or level of service, as stated in law or rule, have been reached, or
- A fair hearing is conducted and the Human Services Board issues a decision adverse to the consumer.

Payment of Services Rendered During an Appeal

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

If Howard Center notifies the consumer that a service may not be covered by Medicaid, the consumer can agree to assume financial responsibility for the service. If Howard Center fails to inform the consumer that a service may not be covered by Medicaid, the consumer is not liable for payment. Benefits will be paid retroactively for consumers who assume financial responsibility for a service and who are successful on such service coverage appeal.

Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, Howard Center is not required to initiate service delivery. Howard Center is not required to provide a new service or any service that is not a Medicaid-covered service while a fair hearing determination is pending.

Expedited Appeal
An expedited appeal occurs when the standard time for considering an appeal would jeopardize the consumer's life or health or ability to attain, maintain, or regain maximum functioning or would have potential for harm to others. An expedited appeal must be resolved within 72 hours.

Withdrawal of Appeal
The consumer or their designated representative may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal must be acknowledged in writing within five (5) calendar days.

FAIR HEARING
Consumers receiving mental health or developmental services from Howard Center also have the right to file requests for fair hearings related to program eligibility determinations and reductions or denials of mental-health services if:

- They are enrolled in Medicaid and
- They have exhausted the internal appeals process and
- Adverse benefit determinations pertain to the CRT Program or to Developmental Disabilities OR
- Adverse benefit determinations pertain to children's out-of-home placement and Enhanced Family Treatment services, Children's e-bed extensions, and Children's Residential Assessment & Treatment (PNMI).

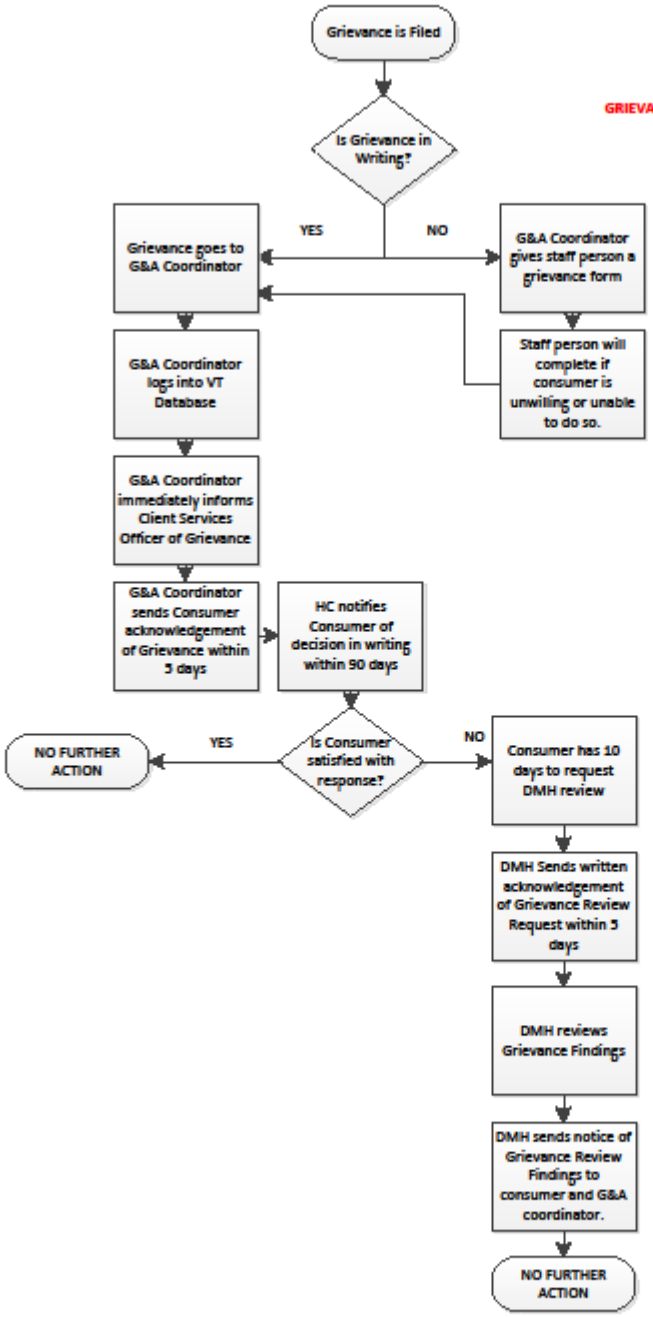
A consumer may make a request for a fair hearing within one hundred and twenty (120) days of receipt of adverse appeal decision. As referenced above, provisions for the continuation of services and potential beneficiary liability pending the outcome of a fair hearing continue to apply.

Howard Center must cooperate with DMH/DDSD and the DMH/DDSD Legal Unit in preparation of necessary documentation for a fair hearing. Howard Center 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/DDSD Legal staff shall represent the state in any fair hearing pertaining to determinations of eligibility for CRT program or services and Children's Services for youth experiencing a severe emotional disturbance and their families. Howard Center will arrange for its own legal representation. The DAIL Legal Staff shall represent the State in any fair hearings pertaining to eligibility for Developmental Disabilities Services.

A status conference will be held initially with a Hearing Officer prior to Fair Hearing. The DMH/DDSD Legal Division will review the merits of the request for Fair Hearing

considering the consumer's Medicaid eligibility status and Medicaid coverage for the services under appeal. Depending on the information provided at the status conference, the Fair Hearing may move forward and an advisory opinion may be offered to the Human Services Board. The Human Services Board will issue a Final order to the Secretary of the Agency of Human Services (AHS). The AHS Secretary then has ten (10) days to accept the Human Services Board's order or request a reversal of the order. DMH/DDSD and Howard Center must comply with the final determination.

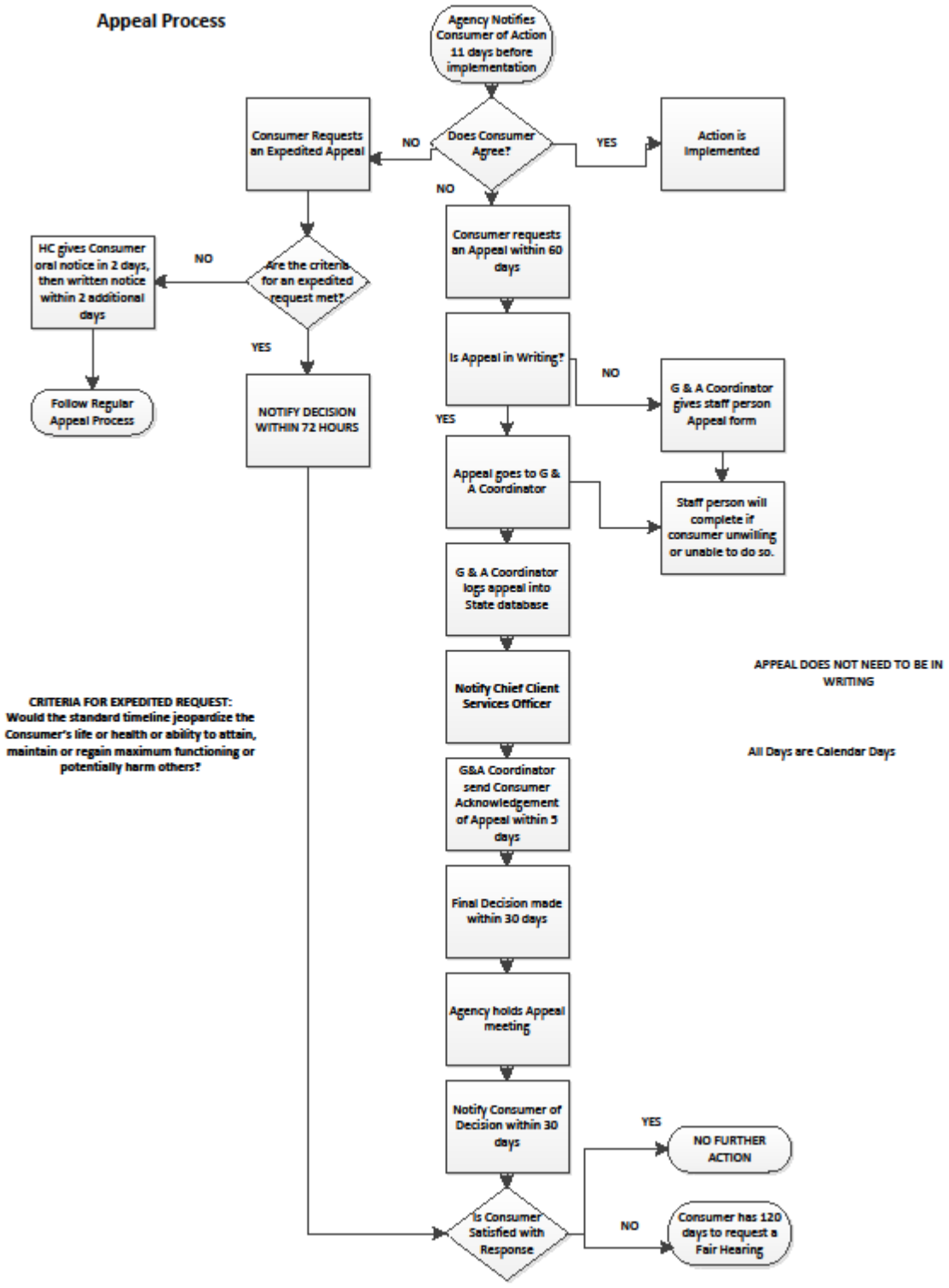
Grievance Process



GRIEVANCE DOES NOT NEED TO BE IN WRITING

Consumer may withdraw Grievance at any time.

All time frames are in calendar days unless otherwise specified.


Appeal Process
Agency Notifies Consumer of Action 11 days before implementation
Does Consumer Agree?
NO
YES
Action is Implemented
Consumer Requests an Expedited Appeal
NO
Consumer requests an Appeal within 60 days
Are the criteria for an expedited request met?
NO
HC gives Consumer oral notice in 2 days, then written notice within 2 additional days
Follow Regular Appeal Process
YES
NOTIFY DECISION WITHIN 72 HOURS
Is Appeal in Writing?
NO
G & A Coordinator gives staff person Appeal form
YES
Appeal goes to G & A Coordinator
Staff person will complete if consumer unwilling or unable to do so.
G & A Coordinator logs appeal into State database
Notify Chief Client Services Officer
G&A Coordinator send Consumer Acknowledgement of Appeal within 5 days
Final Decision made within 30 days
Agency holds Appeal meeting
Notify Consumer of Decision within 30 days
YES
NO FURTHER ACTION
Is Consumer Satisfied with Response
NO
Consumer has 120 days to request a Fair Hearing
CRITERIA FOR EXPEDITED REQUEST:
Would the standard timeline jeopardize the Consumer's life or health or ability to attain, maintain or regain maximum functioning or potentially harm others?
APPEAL DOES NOT NEED TO BE IN WRITING
All Days are Calendar Days