

**VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF MENTAL HEALTH**

**GRIEVANCES AND
APPEALS**

**Under Vermont's Global
Commitment to Health**

**Revisions to Designated Agency Provider Manual
Third Edition, March 2004**

for

**Child, Adolescent, and Family Mental Health Programs
Community Rehabilitation and Treatment
Adult Outpatient Programs
Emergency Services**

March 2008



Department of Mental Health

Grievance and Appeals Procedures Under Vermont's Global Commitment to Health

Table of Contents

<u>Sections/Attachments</u>	<u>Pages</u>
3.5 Client Grievances and Appeals	1
Introduction.....	1
General Principles.....	1
Client Choice	2
Terminology	2
3.6 Grievance Procedures	3
Complaints Versus Grievances.....	3
Receipt of Grievances.....	4
Alleged Harm.....	4
Administrative Responsibilities.....	4
Written Acknowledgment.....	4
Withdrawal of Grievances	5
Written Response.....	5
Grievances Filed After 60 Days	5
Data Documentation	5
3.7 DMH Involvement in the Client Grievance Process	6
Receipt of Unresolved Grievances by DMH	6
DMH Grievance Review	6
Written Acknowledgment.....	6
Grievance Review Disposition	6
3.8 Appeal Procedures	6
Examples of Actions That May Be Appealed	7
Withdrawal of Appeals.....	7
Determinations of Medicaid Eligibility	7
DA/SSA Internal Review	7
DA/SSA Reconsiderations.....	8
DA/SSA Reconsideration Decisions and Notices	8
Client Notices	8
Client Appeals	9
Written Acknowledgment from DA/SSA.....	9

DMH Hearings on Appeals	9
Decisions on Appeals	10
Continuation of Services.....	10
Client Liability for Cost of Services.....	11
Receipt of Appeals.....	11
Time Frames	11
Expedited Appeals.....	12
Filed Appeals and Logs	12
Specific Procedures	13
Applicability of Procedures	13
Notices: Original Notice of a DMH Decision	13
Acknowledgment.....	14
Sending Notices.....	14
Hearing Appeals	14
Client Participation in Appeals.....	14
Administrative Support and Coordination.....	14
Summary of DMH Involvement in Oversight and Monitoring.....	15
3.9 Fair Hearing.....	15
ATTACHMENT 3.D. DA/SSA Grievance and Appeal Form	17
ATTACHMENT 3.E. Grievance Process Flow Chart	18
ATTACHMENT 3.F. Sample DA/SSA Grievance Acknowledgment Letter	19
ATTACHMENT 3.G. Sample DA/SSA Letter Acknowledging	
Oral Withdrawal of Grievance/Appeal, Request for Fair Hearing	20
ATTACHMENT 3.H. Sample DA/SSA Grievance Response.....	21
ATTACHMENT 3.I. Sample DA/SSA Letter Responding to Grievance Filed Late.....	23
ATTACHMENT 3.J. Sample DMH Grievance Review	
Request Form for Use by Clients	24
ATTACHMENT 3.K. Sample DA/SSA Letter Informing Client That Medicaid	
Eligibility Appeal Has Been Forwarded to Economic Services in the	
Department for Children and Families	25
ATTACHMENT 3.L. Sample DA/SSA Letter Acknowledging Appeal	26
ATTACHMENT 3.M. Appeal Process Flow Chart.....	28
ATTACHMENT 3.N. Sample DA/SSA Notice of Favorable Internal Review	29
ATTACHMENT 3.O. Sample DA/SSA Notice of Adverse Internal Review.....	30
ATTACHMENT 3.P. Sample DA/SSA Notice of Favorable Reconsideration.....	32
ATTACHMENT 3.Q. Sample DA/SSA Notice of Adverse Reconsideration	33
ATTACHMENT 3.R. Sample Service Change Notification Form	35
ATTACHMENT 3.S. Sample DA/SSA Letter Forwarding	
Appeal to Another Agency	37
ATTACHMENT 3.T. Sample DA/SSA Letter in Response to Appeal	
Filed After 90 Days	38
ATTACHMENT 3.U. Sample DA/SSA Letter Approving	
Request for Expedited Appeal.....	39
ATTACHMENT 3.V. Sample DA/SSA Letter Denying Request	
for Expedited Appeal.....	40

ATTACHMENT 3.W. Sample Client Request for a Fair Hearing..... 41
ATTACHMENT 3.X. Child, Adolescent and Family Mental Health
Services: Frequently Asked Questions..... 42
ATTACHMENT 3.Y. Questions from Providers and Answers from DMH
About the Revised Grievances and Appeals Processes 47

3.5 Client Grievances and Appeals

Introduction

The State Medicaid Program, as a managed care organization (MCO) under Vermont's Global Commitment to Health 1115 Waiver, must have an internal grievance and appeal process for resolving service disagreements between clients and MCO employees, representatives of the MCO, and designated agencies (DAs) or specialized services agencies (SSAs). (See Attachments 3.D-3.W, pages 17-41 for forms and letters that may be useful to DAs and SSAs. For more information specific to Child, Adolescent, and Family Mental Health Services, see Attachment 3.X, Frequently Asked Questions, page 42, and for information specific to adult mental health and emergency services, see Attachment 3.Y, page 47.) The overall goal of the grievance and appeal process is to resolve disputes fairly, to enhance client and public confidence in the equity and integrity of the service system, to ensure client access to clinically justified covered benefits, and to allow for the independent review of MCO staff decisions concerning appealable actions.

The designated agency serves as the initial point of response for grievances and appeals. Grievance and appeals policy should be flexible in adapting to client preferences and needs whenever possible. Policy should also state explicitly that any individuals initiating or pursuing a grievance or appeal will be free from any form of retaliation.

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

Proceedings for addressing grievances and making decisions on appeals should be confidential unless the client elects to make grievance issues or appeals public. If the client wishes to make proceedings public, he or she and the DA/SSA must agree upon a method of maintaining the confidentiality of identifying information about any other client who may be identified in connection with grievance issues or appeal proceedings. Finally, the result of the process shall be clearly communicated to the client (and his/her designated representative, if applicable) and arrived at within the specified time frames for resolving grievances and appeals.

Medicaid recipients are entitled under federal regulation to certain protections with respect to grievances and appeals. The procedures technically apply only to Medicaid and Vermont Health Access Plan (VHAP) recipients. DMH strongly recommends implementation of these procedures for all clients receiving mental-health services from designated agencies.

General Principles

The goal of the Agency of Human Services (AHS) is to have a common process for grievances and appeals from all individuals served by Medicaid-financed programs or services. The procedures are intended to be:

- ◆ clearly communicated and consistently applied by all MCO components including DAs and SSAs, programs, and representatives,
- ◆ easily accessible, with assistance available as needed,
- ◆ confidential,
- ◆ free of retribution,

- ◆ adequately documented, and
- ◆ resolved within the specified time frames.

The procedures include a level of review by those not involved in the grievance or appeal, first at the DA/SSA and then at the Department of Mental Health (DMH). The client may also seek a Fair Hearing before the Human Services Board.

Client Choice

Clients may choose to ask for both an appeal and a Fair Hearing at the same time, just an appeal, or just a Fair Hearing. They may also ask for an appeal while a Fair Hearing is pending. These procedures apply in those cases in which an appeal or an appeal and a Fair Hearing are requested. Clients are not required to complete the MCO internal appeal process before requesting a Fair Hearing.

If a request for a Fair Hearing has not been made prior to an appeal decision by the MCO, the Fair Hearing request must be made within 30 days of the decision.

Clients may call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

Terminology

The terms “action,” “appeal,” “grievance,” “internal DA review,” and “reconsideration,” are used as follows to describe the grievance and appeal process under the Global Commitment to Health:

An “action” is:

- ◆ an eligibility determination
- ◆ denial or limited authorization of a requested covered service or eligibility for service, including the type, scope or range of service
- ◆ reduction, suspension or termination of a previously authorized covered service or a service plan
- ◆ denial, in whole or in part, of payment for a covered service
- ◆ failure to provide a covered service in a timely manner
- ◆ failure to provide a covered service that is clinically indicated
- ◆ failure to act in a timely manner when required by state rule
- ◆ failure of DMH or a DA/SSA to act within the established time frames for grievances and appeals
- ◆ denial of a client’s request to obtain covered services outside the network. NOTE: “Network” means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to clients.

The DA/SSA is the entity that makes a decision on an action.

An “appeal” means a request for MCO review of an action. Clients or their representatives file appeals with the DA’s grievances and appeals coordinator.

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. Clients or their representatives file grievances.

An “internal DA review” is the first stage of an appeal concerning mental-health services. It is carried out at the DA/SSA level in the first 15 days of the 45-day time frame for making decisions on appeals. The DA or SSA, upon the request of a client or a client’s designated representative, looks again at the reason(s) for an action and a client’s (or potential client’s) current clinical needs for services and support, with the possibility of reversing the original decision to deny eligibility, or reduce or otherwise change services in a way that led to the client’s appeal.

Requesting a “reconsideration” is an informal way for clients to ask a DA/SSA to take another look at an action. At their option, clients may request a reconsideration without filing an appeal. If a client asks for reconsideration, the DA/SSA is obligated to follow through with it.

If a client addresses an initial appeal directly to DMH, DMH will require the DA or SSA to begin an internal DA review. If the original DA/SSA decision was not changed with this review, then the appeal continues with the DMH for decision within the remainder of the 45-day time frame for appeals (with the possibility of an extension of 14 days if requested by the client or by DMH).

3.6 Grievance Procedures

All DAs and SSAs must have a clear grievance process consistent with these procedures. To initiate a grievance, the client must include a clear statement that he or she wants a written response. Time frames are specified for addressing grievances and deciding appeals.

The DA/SSA should use a variety of methods to familiarize clients and their representatives with the grievance process. In addition to handbook distribution and an annual review of client rights to promote client awareness with the process, DAs/SSAs should provide a variety of methods, including an initial rights information orientation, posted notices, periodic staff training, and periodic consumer education to assure that clients and interested persons know about the grievance and appeal processes.

DA/SSA staff members should have support and training in identifying issues of concern with a client or his/her representative, various communication and listening skills, negotiation, and mediation. The process of addressing a grievance shall include impartial review of the grievance issues by persons, internal or external to the DA/SSA, who were not involved in the issue of concern. The DA/SSA should make efforts to include persons who are acceptable to the individual filing the grievance.

Complaints Versus Grievances

Complaints often emerge in the normal course of health and mental-health services. Complaints might include dissatisfaction with a service provider or service, but the client does not feel compelled to move the dissatisfaction forward in the grievance process.

If a client contacts the DA or SSA to express a concern, it is considered a complaint unless the client indicates that a written response is requested from the DA or SSA. The DA/SSA is responsible for making this determination during the conversation with the client.

If a client is dissatisfied with the manner in which a complaint is addressed, the client can seek a resolution through the grievance process within the 60-day time frame for filing grievances by requesting a written response. If a response is requested, the DA or SSA grievance and appeals coordinator will log the grievance into the MCO Grievance and Appeal database.

A DA/SSA may require that grievances be put in writing, with staff members being required to document the grievance if the client declines or is unable to complete this step. (See Attachment 3.D, DA/SSA Grievance/Appeal Form, page 17, and Attachment 3.E, Grievance Process Flow Chart, page 18.)

Receipt of Grievances

Issues related to dissatisfaction about any matter other than an action will be processed as grievances. Clients (or their duly appointed representatives) may file grievances orally or in writing within 60 days of the pertinent issue. A grievance must include a clear statement by the client that a written response is requested from the DA or SSA. Clients may wish to use the standard Grievance/Appeal Form shown in Attachment 3.D on page 17.

DA or SSA staff members will assist a client if the client or his or her representative requests such assistance. The DA/SSA will train staff in the practices and procedures to promote prompt informal and formal resolution of disagreements.

Alleged Harm

If a grievance concerns a clear report of alleged physical harm or potential harm, the DA/SSA will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult or Child Protective Services, for example).

Administrative Responsibilities

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

DA or SSA responsibilities include the following:

- Acknowledging grievances
- Gathering information
- Writing responses
- Mailing the responses
- Entering data into and managing the MCO Grievance and Appeals database as it applies to the DA or SSA

Written Acknowledgment

Grievances must be acknowledged by the DA/SSA in writing within five calendar days of receipt. If the issue is resolved within the five-day time frame, it is not necessary to send separate notices of acknowledgment and decision. The decision notice is sufficient in these cases. (See Attachment 3.F, Sample DA/SSA Grievance Acknowledgment Letter, page 19.) The DA/SSA is responsible for seeing

that a copy of the letter of acknowledgment goes to the Quality Management Director at DMH either by uploading it to the database or by sending a hard copy through the mail.

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

Withdrawal of Grievances

Clients 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 DA or SSA grievance and appeals coordinator in writing within five calendar days. A copy of this correspondence will be sent to the DMH Quality Management Director either electronically or through the mail. (See Attachment 3.G, Sample DA/SSA Letter Acknowledging Oral Withdrawal of Grievance/Appeal/Request for Fair Hearing, page 20.)

Written Response

The DA or SSA shall address all grievances within 90 calendar days of receipt. The DA/SSA must provide the client with a written response to the grievance. The written response shall include a brief summary of the grievance, information considered in making the response, and the disposition. If the response is adverse to the client, the notice must also include information on the client's right to initiate a grievance review with DMH and how to do so. (See Attachment 3.H, Sample DA/SSA Grievance Response, page 21.) Although the disposition of a grievance is not subject to appeal to the Human Services Board (HSB), the client may request a Fair Hearing for any issue raised that is appropriate for review by the HSB as provided in 3 V.S.A. § 3091(a):

An applicant for or a recipient of assistance, benefits, or social services from the Department for Children and Families, the Office of Vermont Health Access, the Department of Disabilities, Aging, and Independent Living, or the Department of Mental Health, or an applicant for a license from one of those departments or offices, or a licensee, may file a request for a fair hearing with the human services board. An opportunity for a fair hearing will be granted to any individual requesting a hearing because his or her claim for assistance, benefits, or services is denied, or is not acted upon with reasonable promptness; or because the individual is aggrieved by any other agency action affecting his or her receipt of assistance, benefits or services, or license or license application; or because the individual is aggrieved by agency policy as it affects his or her situation.

Copies of the disposition will be sent to the client and his or her designated representative if applicable. A copy should also be sent to DMH's Quality Management Director electronically or through the mail.

Grievances Filed After 60 Days

DAs/SSAs are not required to proceed on grievances that are not filed within the specified time frame of 60 days. See Attachment 3.I, Sample DA/SSA Letter Responding to Grievance Filed Late, page 23.

Data Documentation

Data on all grievances and appeals will be documented in the Grievance and Appeals database, as will Fair Hearing requests and outcomes for those cases. The MCO Grievance and Appeals Coordinator at

the Office of Vermont Health Access (OVHA) will maintain the database. All related correspondence and other pertinent documentation must be maintained in individual client files in the DA/SSA and be retrievable for audits and reviews by the MCO or other authorized entity.

3.7 DMH Involvement in the Client Grievance Process

Receipt of Unresolved Grievances by DMH

An unresolved grievance is one that has not gone through the DA/SSA grievance process at the DA/SSA level. DMH encourages clients to use the grievance and appeal process at the DA/SSA. The DA/SSA and the client and/or representative are expected to complete the grievance process, and the DA/SSA is expected to address the grievance within the grievance time lines specified (90 days from the date initially received). Unresolved grievances received by DMH will be acknowledged in writing to both the client and the DA/SSA within five calendar days of receipt. This notification shall cause the local DA/SSA grievance process to begin. The DMH Director of Quality Management will see that the information is entered into the MCO Grievance & Appeal database and assign the case to the DA/SSA grievance and appeal coordinator (with a copy to DMH).

DMH Grievance Review

If the grievance addressed by the DA/SSA is adverse to the client, he or she may request review by DMH. (See Attachment 3.J, Sample DMH Grievance Review Request Form for Use by Clients, page 24.) The client has 10 days to request such a review. Upon notification of the DMH grievance review request by the client or DMH, the DA/SSA will forward a copy of the way the grievance was addressed in addition to supporting documentation to DMH (Attention: Quality Management Director).

Written Acknowledgment

The DMH Administrative Support Coordinator will have responsibility for acknowledging grievance review requests within five calendar days of receipt. Copies of the acknowledgment will go to the client and his or her designated representative, as appropriate, in addition to the DA/SSA grievance and appeals coordinator.

Grievance Review Disposition

DMH will review the merits of the grievance issue(s), the process employed by the DA/SSA in reviewing the issue(s), and the information the DA/SSA considered in making its determination. *The primary purpose of the DMH grievance review shall be to ensure that the grievance process is functional and resolution impartial, rather than reversing a DA/SSA grievance resolution.*

The DA/SSA and client will be notified in writing of the findings of the DMH grievance review. The DMH grievance review determination is considered final.

3.8 Appeal Procedures

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 MCO entity—DA, SSA, or

DMH—receiving the appeal). This may include the client’s family members and referring service providers acting on the client’s behalf.

Examples of Actions That May Be Appealed

A DA/SSA determination of ineligibility for the CRT program or Children’s Services and/or a proposed change in the services range detailed in a client’s service plan are 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 client’s improvements in that area of treatment, but the client 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 client, with information about how to appeal that decision.

Similarly, a client may request a new service, but the treatment team does not feel that the service is indicated in the client’s current treatment plan. In such an instance, the client should be notified of the decision not to offer the service and provided with information about how to appeal that decision.

Withdrawal of Appeals

A client may withdraw an appeal orally or in writing at any time during the process. If the client withdraws an appeal orally, the DA/SSA will acknowledge the withdrawal in writing within 5 days. (See Attachment 3.G, Acknowledgment of Oral Withdrawal of a Grievance/Appeal/Request for Fair Hearing, page 20.)

Determinations of Medicaid Eligibility

Issues pertaining to Medicaid-eligibility determinations will be forwarded immediately to the Economic Services Division of the Department for Children and Families. The client will be informed that the issue has been forwarded and will be told whom to contact regarding resolution of the matter. (See Attachment 3.K, Sample DA/SSA Letter Informing Client That Medicaid-Eligibility Appeal Has Been Forwarded to Economic Services, page 25.)

DA/SSA Internal Review

DAs and SSAs must establish and maintain their own internal procedures for internal review of service decisions. These procedures shall follow the requirements of the Provider Manual. If the internal review overturns the original decision, with the client receiving services as requested, a new Notice of Decision shall be sent and the appeal “decided” as “Approved by Department/DA/SSA.” If the internal review upholds the original decision, the appeal continues at the DMH level.

The DA/SSA internal review is the first step of an appeal. The time frame for internal review is 15 calendar days from a client’s initiation of an appeal. The DA/SSA must acknowledge the appeal in writing within five days. (See Attachment 3.L, Sample DA/SSA Appeal Letter Acknowledging Appeal, page 26, and Attachment 3.M, Appeal Process Flow Chart, page 28.) A qualified DA/SSA staff member or panel not involved in the action that resulted in the appeal shall review the action taken and determine whether to let it stand or change it. The internal review decision shall be immediately communicated in writing to the client, with a copy going to the DMH Quality Management Director either electronically, through the Grievance and Appeals database, or through the mail. (See Attachment 3.N, Sample DA/SSA Notice of Favorable Internal Review, page 29, and Attachment 3.O, Sample DA/SSA Notice of Adverse Internal Review, page 30.)

If the original DA/SSA decision was not changed, then the appeal continues with DMH for decision within the remainder of the 45-day time frame for appeals (with the possibility of an extension of 14 days if requested by the client or by DMH). The DA/SSA shall send all appropriate clinical records and any other materials that were used in making the appeal decision to DMH. DMH shall review the DA/SSA's information and any new information that may become available in order to come to a decision on the client's appeal after the DMH meeting with the client making the appeal (see pages 9-10).

DA/SSA Reconsiderations

Clients or their representatives may, at their option, request reconsideration of a DA's/SSA's action. If a client requests a reconsideration, the DA or SSA must review the original decision to reduce, deny, or terminate service(s) or eligibility for a program. A request for reconsideration by the client or his/her representative is not considered an appeal. The decision resulting from the DA/SSA's reconsideration is also considered a decision subject to appeal if the resulting decision is not exactly the same as the original decision.

A request for reconsideration may be spoken or written. Generally, the reconsideration would be based on new information or a clarification of what is already known. All requests for reconsideration should be directed to the DA or SSA grievance and appeals coordinator.

If the client decides not to ask the DA/SSA to reconsider an action and goes directly to DMH with an appeal or requests a Fair Hearing, or both, the DA or SSA will be required to begin the appeal process with an internal review of the decision that resulted in the appeal. The decision resulting from a DA/SSA's review is not considered a decision subject to appeal if the resulting decision is exactly the same as the original decision. If the internal review of the original decision causes any change to the original decision, this new decision is subject to appeal.

DA/SSA Reconsideration Decisions and Notices

DAs/SSAs will provide clients notice of the results of their reconsideration, with a copy through the mail to the DMH Quality Management Director. (See Attachment 3.P, Sample DA/SSA Notice of Favorable Reconsideration, page 32, and Attachment 3.Q, Sample DA/SSA Notice of Adverse Reconsideration, page 33.) If a reconsideration leads to a new decision, the client has 90 days to appeal that decision. If the reconsideration affirms the original decision, the client has the rest of the 90 days from the original denial to appeal that decision.

Client Notices

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 client be sent notice at least 11 days prior to the change. Generally notices must explain the action the DA/SSA intends to take, the reasons for the action, the client's right to file an appeal and procedures for doing so, circumstances under which an expedited resolution is available and how to request one, and the client's right to request a Fair Hearing at any time. (On expedited appeals, see page 12.) DAs/SSAs must have and use a notice that meets legal requirements for Medicaid notices. (See Attachment 3.R, Sample Service Change Notification Form, page 35.)

Notice of changes may be given orally on the date of action under the following circumstances:

- The client requests in writing that the service be terminated
- The treatment team and physician prescribe a new individualized plan of care (IPC)
- The client requests a new service or range increase from a clinician and/or prescriber and the request is denied.

Client Appeals

If the client (or duly appointed representative) disagrees either orally or in writing with the planned reduction or termination of service and does not request a reconsideration first, the appeal process begins with the required internal review at the DA/SSA by someone with appropriate clinical expertise who was not involved in the original decision. With the DA's or SSA's adverse decision upon internal review, then DMH will hear the appeal. (See Attachment 3.N, Sample DA/SSA Letter Informing Client of Favorable Internal Review, page 29, and Attachment 3.O, Sample DA/SSA Letter Informing Client of Adverse Internal Review, page 30.) The appeal process at the DA/SSA level must provide for an impartial review of the action being appealed by individuals with appropriate clinical expertise who are not involved in any prior level of decision-making on the issue.

Appeal procedures should freely permit a person to be assisted by an advocate or representative of his or her choice. The appeal procedures should consider an individual's possible limited proficiencies in written and/or spoken language. All oral appeals will be recorded using the standard Grievance/ Appeal form.

The client must also be informed of how to request that covered services be continued while an appeal is in process, the client's right to appeal to DMH in regard to covered services or alternate services, and the circumstances under which the client may be required to pay the costs of those services pending the outcome of a Fair Hearing or DMH review. (On continuation of services and possible liability for payment, see pages 10-11.

Written Acknowledgment from DA/SSA

Requests for reconsideration and/or appeals must be acknowledged in writing by the DA/SSA within five days of receipt.

DMH Hearings on Appeals

If the internal review overturns the original decision, with the client receiving services as requested, a new Notice of Decision shall be sent and the appeal "decided" as "Approved by Department/DA/SSA." If the review upholds the original decision, the appeal continues at the DMH level within the remainder of the 45-day time frame for appeals (with the possibility of an extension of 14 days if requested either by the client or by DMH). The DA/SSA shall send all appropriate clinical records and any other materials that were used in making the DA's/SSA's decision to DMH. DMH shall review the DA's/SSA's information and any new information that may become available in order to come to a decision on the appeal.

DMH will schedule a meeting for considering the final decision on the client's appeal and will mail a letter detailing the date, time, and location of the meeting. If DMH's decision on the appeal is adverse to the client, he or she has 30 days to request a Fair Hearing unless one has already been requested.

Clients, their designated representative, or their treatment providers (if requested by the client) have the right to participate in person, by telephone, or in writing in the meeting in which DMH is considering the final decision regarding the appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. The DMH Quality Management Director, with the assistance of the Administrative Support Coordinator, is responsible for scheduling and coordinating participation in any meeting involving client participation.

The client, designated representative, or treatment provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to make a material difference in DMH's decision.

Upon request, the DA/SSA and DMH must provide the client or client-designated representative with all of the information in their possession or control about the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant clinical records. The client will not be charged for copies of any records or other documents necessary to resolve the appeal.

Providers and significant others may file appeals when they are acting on behalf of an individual and have the individual's consent to do so. A DA/SSA may require that appeals be put in writing, with staff members being required to document the appeal if the client declines or is unable to complete this step. (See Attachment 3.D, DA/SSA Grievance and Appeal form, page 17.)

The DA/SSA appeal process must include assistance, as needed, to the client to initiate and participate in the appeal. At no point in the pursuit of an appeal will the client be subject to retribution or retaliation in any form for appealing a DA/SSA action.

Decisions on Appeals

The Department of Mental Health has the responsibility for rendering decisions on appeals referred to DMH. The time frame is 45 days from the beginning of the appeal process at the DA/SSA level, with a possible 14-day extension requested either by the client or by DMH for scheduling purposes or pending receipt of necessary clinical information. DMH's decision on an appeal is regarded as final. In the case of adverse decisions, clients have the right to appeal to the Human Services Board for a Fair Hearing.

Continuation of Services

Services must be continued during an appeal regarding a Medicaid-covered mental-health service termination or reduction under the following circumstances:

- The appeal was filed in a timely manner, meaning on or before the tenth day after the notice of action was mailed or by the intended effective date of the proposed action
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- The annual plan of care has not expired
- The client requests the continuation of services

Service continuation applies only to services that are being terminated or reduced. The service must be continued until one of the following occurs:

- The client withdraws the appeal
- The client does not request Fair Hearing following an adverse appeal resolution
- The DMH appeal decision is made that is also adverse to the client and no Fair Hearing is requested
- The annual treatment plan expires

If an appeal is filed with regard to a denial of eligibility or for a denial of a service not covered by Medicaid, the DA/SSA is not obligated to initiate service delivery. If an individual files an appeal about a Medicaid-eligibility determination with a DA/SSA, the DA/SSA should forward the appeal to the Economic Services Division of the Department for Children and Families (DCF). The DA/SSA should then notify the individual that the issue has been forwarded and will be resolved by the Economic Services Division since a Medicaid-eligibility appeal is not a mental-health services issue or service action. (See Attachment 3.K, Sample DA/SSA Letter Informing Client That Medicaid Eligibility Appeal Has Been Forwarded to Economic Services in the Department for Children and Families, page 25.)

The DA/SSA is not required to provide a new service requested, if not clinically indicated, or a mental-health service that is not a Medicaid-covered service pending an appeal determination or Fair Hearing.

Client Liability for Cost of Services

If services are provided, the client may be liable for the cost of the services provided during the period from the effective date of the service reduction/termination notice or the date of the timely appeal through the resolution of the case, whichever is later. The DA/SSA must inform clients of their potential liability with notice of the adverse action and the right to appeal to DMH and/or to request a Fair Hearing. Liability will be incurred only if a DMH decision on the appeal and/or Fair Hearing upholds a DA's/SSA's action and the MCO determines that the client should be held liable for service costs.

Receipt of Appeals

Clients (or their duly appointed representatives) may file appeals orally or in writing within 90 days of the notice of adverse action on the part of the DA/SSA. DAs/SSAs receiving appeals are not required to continue services that are not properly requested within ten days.

Occasionally a DA/SSA may receive an appeal on a matter for which it is not the agency responsible for making decisions. In such a situation, the DA/SSA should refer the appeal to the appropriate agency and inform the client that the appeal has been referred elsewhere. (See Attachment 3.S, Sample DA/SSA Letter Forwarding Appeal to Another Agency, page 27.)

Time Frames

Clients have 90 days from the date on the decision letter informing them of a DA/SSA action to request an appeal or Fair Hearing. An acknowledgment or affirmative decision (if made) will be mailed within five calendar days of receipt of the appeal. If a client waits longer than 90 days to file an appeal, the DA/SSA does not have to proceed. (See Attachment 3.T, Sample DA/SSA Letter in Response to an Appeal Filed After 90 Days, page 38.) If a request for a Fair Hearing has not been made prior to an appeal decision, the Fair Hearing request must be made within 30 days of the decision.

The time frame for the entire appeal process at both the DA/SSA and the DMH level is 45 days. The DA/SSA has 15 days to reconsider its decision on the action. If the decision is unchanged, DMH then has 30 days to make a decision, with a possible 14-day extension requested either by the client or by DMH for scheduling purposes or pending receipt of necessary medical information. An extension by DMH necessitates a letter to the client explaining the reason for the extension.

If a meeting cannot be scheduled within the 45-day time limit and the 14-day extension, a decision will be rendered by the DMH without a meeting with the client, his or her designated representative, and/or treating provider.

Expedited Appeals

Expedited appeals may be requested in emergent situations in which the client (or the client's designated representative) indicates that taking the time for a standard resolution could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function. Likewise, if a designated agency initiates an immediate action that it determines to be clinically appropriate for a client and/or necessary to ensure program integrity and environmental safety and the client disagrees with that immediate action, the client disagreement constitutes an expedited appeal request. The action should be referred immediately to DMH for review.

Requests for expedited appeals may be made orally or in writing with the DA, SSA, or DMH for any actions subject to appeal. If the request initially goes to the DA or SSA, the DA or SSA will direct the request to DMH. DMH, with the participation and advice of the DA/SSA, will decide promptly if requested expedited appeals meet expedited criteria. If an appeal meets expedited criteria, it must be decided within three working days.

If the request for an expedited appeal process does not meet criteria, the DA or SSA will promptly inform the client that the request does not meet criteria for expedited resolution and that the appeal will be processed in the standard (45-day) time frame for resolution. An oral notice that the expedited appeal did not meet criteria will be promptly communicated to the client and followed up within two calendar days with a written notice from the DA or SSA. The DMH Quality Management Director will be sent a copy of the written notice either electronically or through the mail. (See Attachments 3.U and 3.V for DA/SSA Sample Letters Approving/Denying a Request for an Expedited Appeal, pages 39 and 40.)

The written notice for an expedited appeal decision will include a brief summary of the appeal, the decision and the basis for the decision, and the client's right to request a Fair Hearing subsequent to a final decision by DMH.

The DA/SSA or DMH will not take any punitive action against a provider who requests an expedited resolution or supports a client's appeal. The expectations for DA/SSA and DMH staff support for documenting requests for expedited appeals will be consistent with the standard appeal process.

Filed Appeals and Logs

If an appeal is filed with the DA or SSA, it should be logged into the MCO Grievance and Appeals database on the day received, whether it was filed orally or in writing. The DA or SSA grievance and appeals coordinator is responsible for logging all appeals into the MCO Grievance and Appeals

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

Specific Procedures

a) Hospital Admission of CRT clients

Denials of psychiatric hospital admission are **not** MCO decisions.

The Vermont State Hospital (802-241-1000) should be contacted during evenings, weekends, and holidays if the expedited appeal request involves the pending hospitalization of a participant in the CRT program.

b) Vermont's Act 264 Procedures: Local Interagency Teams and the State Interagency Team

Service recommendations concerning a youth's Coordinated Service Plan resulting from a Local Interagency Team's (LIT) or State Interagency Team's (SIT) process are **not** MCO decisions subject to appeal.

If, however, a contracted department of the MCO declines to provide or pay for a Medicaid-funded service included in the recommendations of the LIT or SIT, the client may appeal that decision.

The appeal should be directed to the specific department or agency that has denied, limited or declined to pay for the Medicaid service. (See Attachment 3.S, Sample DA/SSA Letter Forwarding Appeal to Another Agency, page 37.)

Applicability of Procedures

These procedures apply to consideration of appeals of actions that are subject to appeal that have been made by a DA or SSA. DAs and SSAs are responsible for internal reviews and reconsiderations of decisions made that are subject to appeal, for issuing notice letters, and for certain administrative functions in the appeal process. DAs and SSAs are not responsible for final decisions on appeals. This responsibility rests with DMH.

Notices: Original Notice of a DMH Decision

If DMH upholds a DA/SSA decision that meets the definition of an MCO action as described below, the DMH Quality Management Director has responsibility for issuing or ensuring that a notice letter is issued to the client. DMH's Quality Management Director will send a copy of the notice letter to the grievance and appeals coordinator of the DA/SSA.

An action that is subject to appeal includes one or more of the following:

- an eligibility determination (CRT or Children's Services programs)
- denial or limited authorization of a requested covered service or eligibility for service, including the type, scope or range of services
- reduction, suspension or termination of a previously authorized covered service or a service plan
- denial, in whole or in part, of payment for a covered service
- failure to provide a covered service in a timely manner

- failure to provide a covered service that is clinically indicated
- failure to act in a timely manner when required by state rule
- failure of DMH or a DA/SSA to act within the established timeframes for grievances and appeals
- denial of a client's request to obtain covered services outside the network. NOTE: "Network" means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to clients.

Acknowledgment

The DMH Quality Management Director, with the assistance of the Administrative Support Coordinator, is responsible for acknowledging appeals filed with DMH. An acknowledgment letter will be mailed to the client within five calendar days of receipt of the appeal, with copies of the letter going to the DA or SSA and the client's representative, if applicable.

Sending Notices

The DMH Quality Management Director will have responsibility for issuing notices related to any DMH activities requiring a notice to the client. Letters shall be in the format and with content approved by DMH and the Office of Vermont Health Access (OVHA).

Notice letters concerning DA or SSA actions are sent by the DA or SSA.

Hearing Appeals

The DMH Director of Quality Management has responsibility for hearing appeals. These appeals will be in regard to actions taken by a DA or SSA. The Director of Quality Management may appoint individuals with subject-matter expertise to hear any appeal requiring additional expertise. In all cases, appeals shall be decided by individual(s) who possess the requisite clinical expertise to review such decisions.

Client Participation in Appeals

The client, designated representative, and the DA or SSA treating provider have the right to participate in person, by phone, or in writing in the meeting in which DMH is considering the final decision regarding an appeal. Clients, their designated representative, and the DA or SSA may submit additional information that supplements or clarifies information that was previously submitted and is likely to have a material effect on the decision. The DA/SSA shall send all appropriate clinical records and any other materials that were used in making the DA's/SSA's decision to DMH. DMH shall review the DA's/SSA's information and any new information that may become available in order to come to a decision on the appeal.

The DMH Director of Quality Management has responsibility for scheduling and coordinating participation in any meeting involving client participation.

Administrative Support and Coordination

The appeal contact person in DMH for providers is the DMH Quality Management Director. With the assistance of the DMH Administrative Support Coordinator, the Quality Management Director will be

responsible for managing the appeal process, mailing acknowledgments and decisions, gathering information, writing the decision, arranging for consumer participation in meetings, and managing information on the MCO Grievance and Appeals database.

The DMH Quality Management Director and/or Administrative Support Coordinator may be reached by calling (802) 652-2000.

Summary of DMH Involvement in Oversight and Monitoring

DMH is available for review of adverse grievance resolutions and continuation of appeals after internal reviews of DA/SSA actions. DAs/SSAs and clients will be notified in writing of the results of DMH's determinations. In the case of a grievance review, DMH's determination is considered final. In the case of appeals, any client may request a Fair Hearing and should be given instructions in how to do so.

In cases of program eligibility, DMH will consult with the DA/SSA and other pertinent treatment providers contributing to the clinical information available to the DA/SSA at the time of application for services, program eligibility criteria, and the clinical and/or treatment rationales for the resulting program eligibility determination. In conjunction with the DMH Legal Unit, DMH will review the DA/SSA action, implications for the Fair Hearing process, and efforts by the DA/SSA to explore and resolve the disagreement. DMH will actively attempt to ameliorate or resolve the service disagreement between the client and DA/SSA prior to Fair Hearing.

3.9 Fair Hearing

Clients receiving mental-health 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 mental-health services if:

- ◆ they are enrolled in Medicaid and the Vermont Health Access Plan (VHAP) and
- ◆ the reductions or denials pertain to CRT or Children's Services program eligibility and Medicaid-covered mental-health services.

The Economic Services Division of DCF shall retain responsibility for representing the State in any Fair Hearings pertaining to determinations of Medicaid eligibility.

A client may make a request for a Fair Hearing within 30 days of receipt of the adverse appeal decision by DMH. (See Attachment 3.W, Sample Client Request for a Fair Hearing, page 41.) If the original client request for appeal was filed with the DA/SSA within 10 days, the client's services may not be changed until a determination regarding eligibility for Fair Hearing. Beneficiaries may request that covered services be continued without change pending the outcome of the fair hearing. They must be notified of the circumstances under which they may be required to pay the costs of those services.

In the event of a request for a Fair Hearing, DMH will initiate a review with the DA/SSA in a manner similar to a client-initiated request for grievances and appeals.

DMH will review the Fair Hearing request with the DMH Legal Division and review the DA/SSA action that is the subject of the Fair Hearing. DMH will review the DA/SSA action, implications for the Fair Hearing process, and efforts by the DA/SSA to explore and resolve the disagreement. DMH

will actively attempt to ameliorate or resolve the service disagreement between the client and DA/SSA prior to Fair Hearing. DMH also agrees to cooperate with OVHA/Economic Services in any Fair Hearing proceedings, including preparation and submission of any client medical records or other documentation pertinent to the proceedings.

The DA/SSA must cooperate with DMH and the 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 CRT program eligibility determinations or services. The DA/SSA should arrange for its own legal representation.

A status conference will be held initially with a Hearing Officer prior to Fair Hearing. The DMH Legal Division will review the merits of the request for Fair Hearing considering the client'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 10 days to accept the Human Services Board's order or request a reversal of the order. DMH and the DA/SSA must comply with the final determination.

ATTACHMENT 3.D

DA/SSA GRIEVANCE AND 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:

Examples of Grievance Issues:

1. Dissatisfaction with a staff/contractor
2. Dissatisfaction with management
3. Dissatisfaction with program decision
4. Dissatisfaction with policy decision
5. Dissatisfaction with quality of services
6. Dissatisfaction with accessibility of services
7. Dissatisfaction with timeliness of response
8. Dissatisfaction with services not offered or not available

Examples of Appeal Issues:

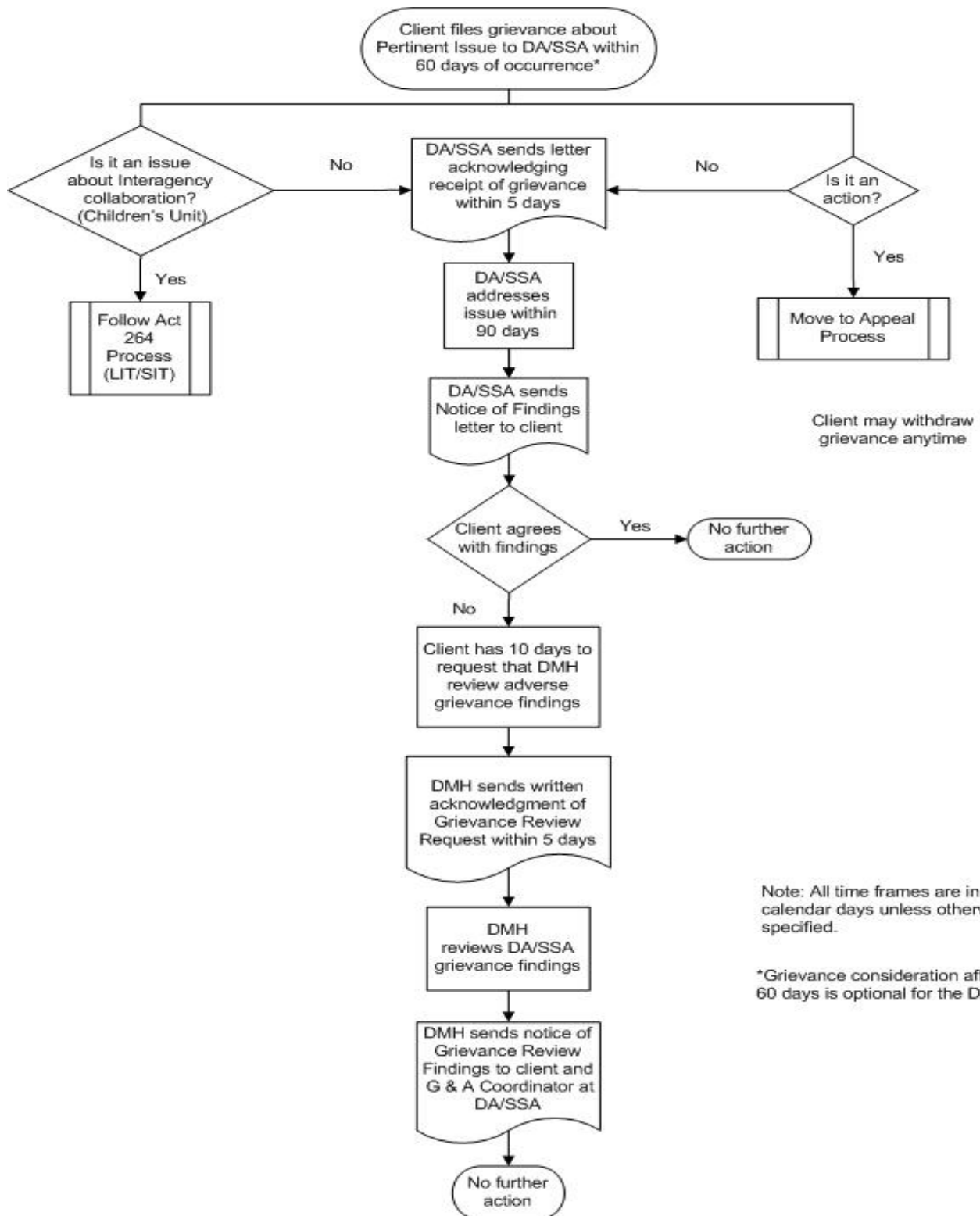
1. Denial or limited authorization of a requested covered service.
2. Reduction, suspension, or termination of an authorized service or service plan
3. Denial, in whole or in part, of payment for a service
4. Failure to provide services in a timely manner
5. Failure to provide clinically indicated covered services
6. 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 PROCESS FLOW CHART



ATTACHMENT 3.F

SAMPLE DA/SSA GRIEVANCE ACKNOWLEDGMENT LETTER

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thõ naøy raát quan troing. Neáu quyù vò khoâng hieáu noài dung trong ñoù, haøy ñem thõ naøy ñeán vaên phoøng taïi

ñòa phõng cuõa quyù vò ñeá ñõđic giuùp ñõđ.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have received your grievance about:

[GRIEVANCE ISSUE]

We will look into your grievance and mail you a letter by [GRIEVANCE DUE DATE: 90 calendar days from receipt of client's grievance].

If you have any questions, please feel free to call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Name of Staff

DA grievance & appeal coordinator

copy to: File
 DMH Quality Management Director

ATTACHMENT 3.G

SAMPLE DA/SSA LETTER ACKNOWLEDGING ORAL WITHDRAWAL OF GRIEVANCE/APPEAL/REQUEST FOR FAIR HEARING

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thõ naøy raát quan troĩng. Neáu quyù vò khoãng hieáu noãi dung trong ñoù, haøy ñiem thõ naøy ñeán vaên phoøng taïi ñòa phõng cuùa quyù vò ñeá ñõõic giuùp ñõõ.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have received your oral request to withdraw your grievance/appeal/request for a fair hearing. We will stop looking into your grievance/appeal about: [GRIEVANCE/APPEAL ISSUE]. [Or, if request for a fair hearing: We will communicate your withdrawal of your request to the Human Services Board, and the Board will let you know if the withdrawal is accepted.]

Thank you for contacting us. If you have any further questions, please feel free to call me, at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance & appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.H

SAMPLE DA/SSA GRIEVANCE RESPONSE

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thö naøy raát quan troing. Neáu quyù vò khoâng hieáu noãi dung trong ñoù, haøy ñiem thö naøy ñeán vaên phöông taïi

ñöa phöông cuûa quyù vò ñeã ñöðic giuùp ñöð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have reviewed the grievance you filed on [DATE] about [GRIEVANCE ISSUE].

Here is what we found: [INSERT RESULTS]

If you are not satisfied with this response you may ask for a **grievance review** by the Department of Mental Health (DMH) within the next 10 days. In a grievance review DMH will take another look at your grievance, how we addressed it and the information we based our response on, and any new information that you can now give us.

If you want to ask for a grievance review, you should take one of the following actions within ten days from the date of this letter. Either:

- ◆ Tell me either orally or in writing that you want DMH to review our response to your grievance, and I will inform the DMH Quality Management Director and send along documentation and other materials pertaining to your grievance. If you have additional information or clarification to offer at this time, please send the materials immediately to the DMH Quality Management Director at 108 Cherry Street, P.O. Box 70, Burlington, Vermont 05402-0070.

OR

- ◆ Tell the DMH Quality Management Director either orally or in writing that you want DMH to review the agency's response to your grievance. You may telephone the DMH Quality Management Director at (802) 652-2000 or (888) 212-4677. You may mail a letter to the DMH Quality Management Director at 108 Cherry Street, P.O. Box 70, Burlington, Vermont 05402-0070. If you have additional information or clarification to offer at this time, please send the materials immediately to the DMH Quality Management Director at the same address.

If you have questions, please call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance & appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.I

SAMPLE DA/SSA LETTER RESPONDING TO GRIEVANCE FILED LATE

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Làù thõ naøy raát quan troíng. Neáu quyù vò khoáng hieáu noãi dung trong ñoủ, haøy ñem thõ naøy ñeán vaên phoøng taï ñòa phõng cuõa quyù vò ñeã ñõđic giuùp ñõđ.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your request to file a grievance on [DATE] for [GRIEVANCE ISSUE].

Unfortunately, you did not file within the 60-day time frame, so we are unable to proceed with addressing this grievance.

Sincerely,

Staff Name

DA grievance and appeal coordinator

copy to: File

ATTACHMENT 3.J

SAMPLE DMH GRIEVANCE REVIEW REQUEST FORM FOR USE BY CLIENTS

[DATE]
[CLIENT ADDRESS]
[CITY, VT ZIP]

DMH Quality Management Director
Department of Mental Health
108 Cherry Street
P.O. Box 70
Burlington, Vermont 05401-0070

Dear Quality Management Director:

I do not agree with how [NAME OF DA] addressed my grievance about [DESCRIBE THE GRIEVANCE] for the following reason/s [TELL THE REASONS YOU DO NOT AGREE IT WAS THE RIGHT DECISION].

I received the decision on [DATE YOU WERE NOTIFIED]

- *Client should make request within 10 days for grievance review by the Department of Mental Health.*

I would like a GRIEVANCE REVIEW by DMH.

- *DMH will see if the grievance process was followed and the decision made with adequate information. The DMH grievance review is considered final. Clients may also request a Fair Hearing of a grievance issue before the Human Services Board, but generally Fair Hearings are reserved for appeals of actions related to reduction, suspension, or denial of service.*

Sincerely,

[CLIENT NAME]

Copy:

- *People you might want to send copies of your grievance review request:
DA grievance and appeal coordinator
DA CRT Director
DA Executive Director
Vermont Protection and Advocacy
Vermont Psychiatric Survivors*

ATTACHMENT 3.K

SAMPLE DA/SSA LETTER INFORMING CLIENT THAT MEDICAID ELIGIBILITY APPEAL HAS BEEN FORWARDED TO ECONOMIC SERVICES IN THE DEPARTMENT FOR CHILDREN AND FAMILIES

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieáu noãi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taï ñòa phöông cuûa quyù vò ñeá ñöôïc giuùp ñöð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your appeal request about [APPEAL ACTION].

We are not able to decide appeals about your eligibility for health care programs and/or what premiums you should pay. We have forwarded your appeal to the Economic Services Division of the Department for Children and Families because they decide these appeals. You will hear from them soon.

If you have any questions, please feel free to call [DCF-ESD Coordinator] at [phone number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance & appeal coordinator

copy to: File

[name], DCF-ESD Grievance & Appeal Coordinator

ATTACHMENT 3.L

SAMPLE DA/SSA LETTER ACKNOWLEDGING APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thõ naøy raát quan troïng. Neáu quyù vò khoâng hieâu noãi dung trong ñoù, haøy ñiem thõ naøy ñeán vaên phoøng taï ñòa phõng cuûa quyù vò ñeá ñõdic giuùp ñõð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS1]

[CLIENT ADDRESS2]

[CITY], [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your appeal filed on [DATE] about [ACTION]. We will begin an internal review of our action and send you a decision in writing within 15 days.

If the [AGENCY'S] decision is not changed, I will forward all the necessary documentation and other information that DMH needs to review in order to make a decision on your appeal. If you want to contact DMH about your appeal, please telephone the Quality Management Director at (802) 652-2000 or address a letter to:

Quality Management Director
Department of Mental Health
108 Cherry Street
P.O. Box 70
Burlington, Vermont 05602-0070

The entire process for an appeal should not take longer than 45 days from the date you filed your appeal at this agency, but it could take another 14 days if more time will help you.

If you have any questions about your appeal, you may contact me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays. You may send any additional information you have about your appeal to DMH at the above address.

The Office of the Health Care Ombudsman can also help you with appeals. The telephone number there is 1-800-917-7787.

Sincerely,

Staff Name

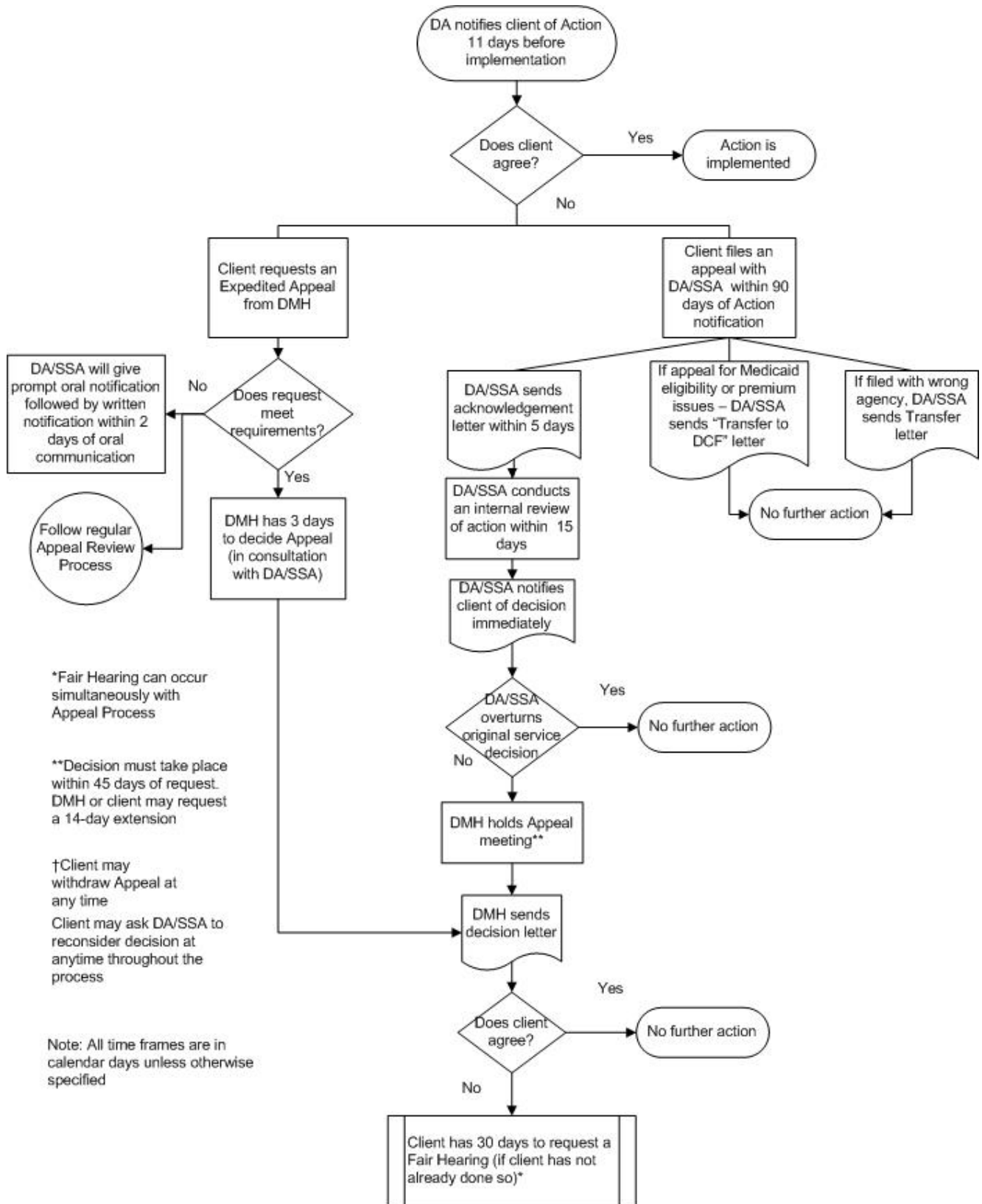
DA grievance & appeal coordinator

copy to: File

DMH Quality Management Director

ATTACHMENT 3.M

APPEAL PROCESS FLOW CHART



ATTACHMENT 3.N

SAMPLE DA/SSA NOTICE OF FAVORABLE INTERNAL REVIEW

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thö naøy raát quan troĩng. Neáu quyù vò khoàng hieáu naõi dung trong ñoù, haøy ñiem thö naøy ñeán vaên phoøng taõi ñòa phöông cuúa quyù vò ñeá ñöôic giuùp ñöð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

Your appeal request filed on [DATE] for [APPEAL ACTION] has been *approved*.

If you have any questions, please feel free to call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance and appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.0

SAMPLE DA/SSA NOTICE OF ADVERSE INTERNAL REVIEW

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieáu noãi dung trong ñoù, haøy ñem thö naøy ñeán vaên phöông taï ñòa phöông cuûa quyù vò ñeá ñöôïc giuùp ñöð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have conducted an internal review of your appeal filed on [DATE] about [ACTION APPEALED]. We reviewed your appeal in the following manner [DESCRIBE THE PROCESS]. Based on our internal review, we have decided that our action decision should stand because [TELL REASONS].

We will forward our information to DMH for continuation of your appeal. DMH will send you a letter letting you know when the appeal meeting will be held.

You also have the right to ask for a Fair Hearing with the Human Services Board at any time throughout the appeal process up until 30 days after DMH's decision on your appeal. To ask for a Fair Hearing, telephone the Human Services Board at (802) 828-2536 or mail a letter to 118 State Street, Drawer 20, Montpelier, VT 05620-4301.

[DA/SSA] is required to inform you that you may be liable for the cost of services that are continued, if requested, during the period in which you are appealing to DMH and/or requesting a Fair Hearing. You will be liable only if a DMH decision on your appeal and/or a Fair Hearing upholds [DA/SSA's] action and also determines that you should be held liable for service costs.

If you have any additional questions, please feel free to call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays. The DMH Quality Management Director may also be able to answer your questions.

The Office of the Health Care Ombudsman can help you with Fair Hearings too. The telephone number there is (800) 917 7787.

Sincerely,

Staff Name

DA grievance & appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.P

SAMPLE DA/SSA NOTICE OF FAVORABLE RECONSIDERATION

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Làù thõ naøy raát quan troing. Neáu quyù vò khoâng hieâu noãi dung trong ñoù, haøy ñem thõ naøy ñeán vaên phoøng taï

ñòa phõng cuõa quyù vò ñeã ñõđic giuùp ñõđ.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We are writing this letter in response to your request filed on [DATE] for reconsideration of [DA ACTION]. Upon reconsideration, the agency has decided in your favor and [EXPLAIN SERVICE CONTINUATION OR OTHER RESULT, AS APPROPRIATE].

If you have any questions, please feel free to call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance and appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.Q

SAMPLE DA/SSA NOTICE OF ADVERSE RECONSIDERATION

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thõ naøy raát quan troïng. Neáu quyù vò khoâng hieáu noãi dung trong ñoù, haøy ñiem thõ naøy ñeán vaên phoøng taïi

ñòa phõng cuõa quyù vò ñeã ñõđic giuùp ñõđ.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We are writing this letter in response to your request on [DATE] for reconsideration of [DA ACTION]. We reconsidered this action in the following manner [DESCRIBE THE PROCESS]. Based on our reconsideration, we have decided that our action decision should stand because [TELL REASONS].

If you disagree with the results of this reconsideration, you have the right to initiate an appeal by contacting me either orally or in writing and requesting a written reply from [DA]. The DA will conduct an internal review of your appeal within 15 days. If you have additional information or records to offer at this time, please send them to my attention immediately.

If the DA's original decision still stands, we will refer your appeal for review by the Department of Mental Health (DMH). DMH will schedule a meeting and make a decision within 45 days from the date you initiated your appeal, or [INSERT DATE TO EXPECT DMH DECISION].

You also have the right to ask for a Fair Hearing with the Human Services Board at any time throughout the appeal process up until 30 days after DMH's decision on your appeal. To ask for a Fair Hearing, telephone the Human Services Board at (802) 828-2536 or mail a letter to 118 State Street, Drawer 20, Montpelier, VT 05620-4301.

[DA] is required to inform you that you may be liable for the cost of services that you request to be continued during the period in which you are appealing to DMH and/or requesting a Fair Hearing. You will be liable only if a DMH decision on your appeal and/or a Fair Hearing upholds [DA] action and also determines that you should be held liable for service costs.

If you have any additional questions, please feel free to call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays. The DMH Quality Management Director may also be able to answer your questions.

The Office of the Health Care Ombudsman can help you with Fair Hearings too. The telephone number there is (800) 917 7787.

Sincerely,

Staff Name

DA grievance and appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.R

SAMPLE SERVICE CHANGE NOTIFICATION FORM

Your treatment team plans the following change in your CRT Program Services given your current treatment needs:

Date of Notice: _____

Staff Name: _____ **Staff Signature:** _____

Client Name: _____ **Client Signature:** _____

_____ *Check if he/she refused to sign*

You have the following rights available to you if you disagree with this planned treatment change:

- If you do not agree with the plan, you may ask the DA to reconsider.
- You have up to 90 days from the date of this notice to request an appeal. If you request an appeal after 90 days, the agency may or may not choose to consider your appeal.
- If you file an appeal before these changes take effect, and you request a continuation of services, your services will not be changed until your appeal is resolved. If you file an appeal after these changes take effect, services will continue as changed while your appeal is being resolved.
- Your appeal must be resolved within 45 days from the date of your appeal, unless an extension of no more than 14 additional days to resolve the appeal is needed.
- The DA [AGENCY] will notify you of the results of its internal review of your appeal within 15 days. If your appeal is forwarded to DMH for further review, DMH will notify you of its decision with 45 days of the date you filed your appeal with the DA. Your rights to a Fair Hearing will be maintained throughout the process at both the agency and the DMH level.

Also, if you requested a continuation of your services before the service change went into effect, your services will not be changed until DMH makes its decision on your appeal.

- You may make a request for a Fair Hearing at any time throughout the appeal process until 30 days after DMH's decision on your appeal. If you request a Fair Hearing after 30 days from DMH's decision, your rights to a Fair Hearing may be affected.
- If your appeal goes to a Fair Hearing and your appeal is upheld, DMH and your local DA/SSA must provide the mental-health services outlined in the current treatment plan.

If you need more information about appeals or assistance in asking for an appeal or fair hearing, you can contact the following people or agencies for help:

- ❖ The grievance and appeals coordinator at the DA/SSA

(Insert local name and contact information)

- ❖ The DMH Quality Management Director at 1-802-652-2000; or, for the State of Vermont only, call our toll-free number: 1-888-212-4677; TTY Relay Service at 1-800-253-0191; **or by mail to** DMH Quality Management Director, 108 Cherry Street, P.O. Box 70, Burlington, Vermont 05402-0070
- ❖ Office of Health Care Ombudsman at 1-800-917-7787 **or by mail at** P.O. Box 1367, 264 N. Winooski Avenue, Burlington, Vermont 05402
- ❖ Vermont Protection and Advocacy at 1-802-229-1355 **or by mail at** 141 Main Street, Suite 7, Montpelier, VT 05602
- ❖ Vermont Psychiatric Survivors at 1-800-564-2106 **or by mail at** 1 Scale Avenue, Suite 52, Rutland, VT 05701

To Request a Fair Hearing at any time, write to:

Human Services Board
118 State Street
Drawer 20
Montpelier, VT 05602

or call: 802-828-2536.

ATTACHMENT 3.S

SAMPLE DA/SSA LETTER FORWARDING APPEAL TO ANOTHER AGENCY

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thõ naøy raát quan troïng. Neáu quyù vò khoâng hieáu naï dung trong ñoù, haøy ñiem thõ naøy ñeán vaên phoøng taï ñòa phõng cuûa quyù vò ñeá ñõðic giuùp ñõð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your appeal request for [APPEAL ACTION].

We are not the agency to decide this appeal. We have forwarded it to [PROPER AGENCY] because they decide these appeals. You will hear from them soon. All appeals have a 45-day time frame for decisions. Your appeal should be decided by [DUE DATE].

If you have any questions, please feel free to call [OTHER AGENCY COORDINATOR] at [PHONE NUMBER] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance & appeal coordinator

Copy: File

Other Agency Coordinator

ATTACHMENT 3.T

SAMPLE DA/SSA LETTER IN RESPONSE TO APPEAL FILED AFTER 90 DAYS

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thõ naøy raát quan troĩng. Neáu quyù vò khoãng hieáu noãi dung trong ñoù, haøy ñiem thõ naøy ñeán vaên phoøng taõi ñòa phõng cuúa quyù vò ñeá ñõðic giuùp ñõð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your request to file an appeal on [APPEAL DATE]. Unfortunately, you did not request this appeal within the 90-day time frame, so we are not able to proceed. You have also exceeded the time frame to file a request for a fair hearing.

Sincerely,

DA grievance & appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.U

SAMPLE DA/SSA LETTER APPROVING REQUEST FOR EXPEDITED APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieáu noãi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taï ñòa phöông cuûa quyù vò ñeá ñöôïc giuùp ñöð.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your emergency (expedited) appeal request for [APPEAL ACTION].

We agree that this request meets expedited criteria. We have **approved** your request. You will also receive a new {Service Change Notification Form}.

If you have any questions, please feel free to call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance and appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.V

SAMPLE DA/SSA LETTER DENYING REQUEST FOR EXPEDITED APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Laù thõ naøy raát quan troïng. Neáu quyù vò khoâng hieáu noãi dung trong ñoù, haøy ñem thõ naøy ñeán vaên phoøng taï ñòa phõng cuõa quyù vò ñeá ñõõic giuùp ñõõ.

[DATE]

[CLIENT NAME]

[CLIENT ADDRESS 1]

[CLIENT ADDRESS 2]

[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your emergency (expedited) appeal request for [APPEAL ACTION].

Based on the information we have, we **do not agree** that taking 45 days to decide your appeal could seriously risk your life, health or ability to attain, maintain, or regain maximum function.

Your appeal will now be decided in the standard 45-day time frame. Your appeal should be decided by [DUE DATE]. This time frame may be extended by 14 days if needed. We will notify you of the appeal meeting date.

If you have any questions, please feel free to call me at {local phone number} or {toll-free number} Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

Staff Name

DA grievance and appeal coordinator

copy to: File
DMH Quality Management Director

ATTACHMENT 3.W

SAMPLE CLIENT REQUEST FOR A FAIR HEARING

Client's Address (Street or PO Box #)
City, State ZIP Code
Date

Human Services Board
118 State Street
Drawer 20
Montpelier, VT 05602

Dear Human Services Board:

I do not agree with how [DA OR DMH, WHICHEVER ONE DECIDED THE APPEAL] resolved my appeal about [DESCRIBE WHAT SERVICE WILL BE OR HAS BEEN DENIED, REDUCED, OR SUSPENDED BY THE DA].

[TELL THE REASONS YOU DO NOT AGREE IT WAS THE RIGHT DECISION REGARDING YOUR TREATMENT].

Additional comments or clarifying information.

I received the decision on [DATE YOU WERE NOTIFIED BY DA AND/OR DMH, WHICHEVER IS THE MOST RECENT].

You should make your request within 90 days of the original DA action notice or within 30 days of the DA appeal decision.

I would like a FAIR HEARING with the Human Services Board.

- *DMH will automatically begin collaborating with the DA if you request a Fair Hearing. DMH will work with you and the DA to try to resolve the disagreement regarding your treatment before going to Fair Hearing.*

Sincerely,

[YOUR NAME]

Copy: *People to whom you should send copies of the fair hearing request:*
DA grievance and appeals coordinator
DMH Quality Management Director
DMH Legal Unit
Your attorney

ATTACHMENT 3.X

CHILD, ADOLESCENT AND FAMILY MENTAL HEALTH SERVICES FREQUENTLY ASKED QUESTIONS

Applicability of the Grievance and Appeal Process

Q: Who is eligible for the MCO Grievance and Appeal Process?

A: All children and youth who receive mental-health services from a DA/SSA are eligible for the *Grievance* process.

Children and youth with Severe Emotional Disturbance (SED)—any child between the ages of 0 and 17 (inclusive) with a DSM IV-TR mental health diagnosis and a Global Assessment of Functioning (GAF) score of 60 or less—who are beneficiaries of Medicaid/Dr. Dynasaur, the Vermont Health Access Program (VHAP), or the State Children’s Health Insurance Program (SCHIP), and who receive mental-health services from a designated agency (DA) or specialized services agency (SSA) are eligible for the *Appeal* process.

Q: Are the rights of children who receive DA/SSA services that are paid by Medicaid different from those of children who are not covered by Medicaid?

A: Yes. Medicaid-covered clients have a right to a Fair Hearing process.

Q: Why does this definition of SED differ from the definition under Act 264?

A: This definition follows more narrow federal guidelines because it must conform to federal regulations for the operation of a managed care organization (MCO) when a child is entitled to a medically necessary service. The Act 264 definition reflects Vermont’s preferred method of casting a wider net for collaboration around a family when a child needs a coordinated approach to services to which the child may or may not have an entitlement and which may or may not be medically necessary.

DA or SSA Appeals

Q: Please provide clarifications/examples of the *Actions* that are subject to appeal and how a DA/SSA would provide proper notification.

A: Actions by the DA/SSA include:

- an eligibility determination;
- denial or limited authorization of a requested covered service or eligibility for service, including the type, scope or range of services
- reduction, suspension or termination of a previously authorized covered service or a service plan
- denial, in whole or in part, of payment for a covered service
- failure to provide a covered service in a timely manner
- failure to provide a covered service that is clinically indicated
- failure to act in a timely manner when required by state rule
- failure of DMH or a DA to act within the established timeframes for grievances and appeals
- denial of a client’s request to obtain covered services outside the network. NOTE: “Network” means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to clients.

- a. eligibility determination: A DA/SSA decides that a child or adolescent is not eligible for Children’s Mental Health Services because he or she exceeds the age limit or does not have a diagnosable mental-health condition.
- b. denial or limited authorization of a *requested covered service* or eligibility for service, including the type, scope or range of services;
 - a *requested covered service* occurs when a parent/client makes a direct request of the DA to provide a new service that is covered under the MCO. This request could be in written form (letter, referral, application to program) or it could be spoken.
 - Notification of the denial or limitation of authorization can be in the form of a written letter or documentation of a conversation explaining the reasons for the denial. If the guardian/client requests the notification in writing, this should be provided.
- c. reduction, suspension or termination of a previously authorized covered service or a service plan;
 - This refers to *planned* reduction, suspension or termination of a service included in an individual plan of care (IPC).
 - ◆ For example, school-based mental health services are included in the IPC during the school year to help a child remain in school and are suspended during times when school is not in session (summer).
 - It does not apply in unplanned situations of short duration, such as staff turnover or illness. If the unplanned change then leads to a planned long-term change to the service plan, however, notification is required.
 - ◆ For example, if the service plan included 20 hours of community integration, but the skills worker is unexpectedly ill or resigns from the position and a replacement can be found shortly, then the DA is not required to provide notice. In this situation if the DA does not intend to return to that level of service (*i.e.*, not provide staff coverage or hire a replacement) and decides to remove community integration from the service plan, this action requires notice.
 - A planned *increase* of service does not require notice under the MCO appeal process; however, best practice requires adjustment of the service plan.
 - Utilizing service ranges on the IPC will reduce the need to provide notification if services are provided within the specified range. If service ranges are written into the IPC and services provided fluctuate within this range, notification is not required. If services are provided at a frequency that is below the indicated range on the IPC, then the client must be notified of the planned change and provided with information about their rights of appeal. (See below for additional clarification).
 - Notification of the reduction, suspension or termination must be made in the form of a written letter and mailed to the guardian/client. It is acceptable to provide spoken notification to the guardian/client and adequate documentation of the content of this conversation in the clinical record *in addition* to the written notification.
- d. denial, in whole or in part, of payment for a covered service
 - DAs or SSA would not be authorizing or denying payment for covered services, so this provision would not apply unless there is a change in the authority delegated to the DA or SSA from the Department of Mental Health (DMH).

- e. failure to provide a covered service in a timely manner:
 - If the IPC indicates that a service is prescribed and the client does not actually receive it within a reasonable amount of time, this is subject to appeal.
- f. failure to provide a covered service that is clinically indicated
 - If the IPC indicates that a service is prescribed, but the service is not provided to the client (for example, a waiting list), this is subject to appeal.
 - No Notice Letter.
- g. failure to act in a timely manner when required by state rule

No Notice Letter.
- h. failure of DMH or a DA/SSA to act within the established time frames for grievances and appeals;
 - If the DA/SSA fails to follow the time frame established in the Grievance Process, the client may file an appeal.
- i. denial of a client’s request to obtain covered services outside the network. NOTE: “Network” means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.

Q: Please define what is an acceptable form of “**Notice**” of decision.

A: Notification of a decision must be written. In cases involving a termination or reduction of service(s), the notice must be mailed at least 11 days before the change takes effect. This may be a letter, a form or other written documentation.

Q: What must be included in **Notifications of adverse decisions**?

A: Notices must

- explain the action the designated agency has taken or intends to take,
- the reasons for the action,
- the client’s right to initiate an appeal (when and how),
- inform the beneficiary that he or she may request that covered services be continued without change as well as the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any MCO appeal or fair hearing.
- the circumstances under which an expedited resolution is available and how to request one, and
- the client’s right to request a Fair Hearing (when and how) at any time.

Q: Please give examples of acceptable **service ranges** to use on an IPC.

A: In regard to using service ranges in the Individual Plans of Care for children, the Medicaid Fee-For-Service Procedures Manual (DMH 2004, page 34) states that “it is acceptable to identify a range of treatment frequency for planned services or interventions.” In order to allow DA/SSA providers the flexibility to make appropriate and reasonable adjustments to services as a client’s clinical needs fluctuate, the services in an IPC can be prescribed with a range of frequency. The service ranges are designed to promote flexibility and to adhere to requirements for notifying clients about significant changes in services and their appeal rights while maintaining the boundaries implicit in a prescribed medically necessary service. DA/SSA use of service ranges in the IPC will reduce the need to provide notification if services are provided within the specified range.

A planned reduction of an identified range of service or elimination of a service prior to the expiration of the current treatment plan requires client/guardian notification of the proposed change and of the client/guardian’s right to appeal the treatment decision.

The range detailed in the service plan cannot be reduced without:

- ❖ Notification of the client/guardian of the change and also of their right to appeal;
- ❖ Renegotiation of the service plan.

Episodic increases or decreases in service, in response to a client’s clinical needs, and subsequent return to treatment plan levels do not require notification if the plan was not changed to reflect the increase. These fluctuations should be properly documented with explanation for the episodic change of service. The following ranges of particular interventions may be used as minimum guidelines for development of an individualized service plan.

TABLE: Examples of Ranges for Services

<u>Type of Service:</u>	<u>Examples of Ranges:</u>
Service Planning and Coordination	<i>Range should not span greater than 5 hours</i> Weekly (e.g., 1-3 hours per week) Monthly (e.g., 8-12 hours per month) Quarterly (e.g., 2 hrs 2-3 times per quarter)
Community Support (Individual, Group)	<i>Range should not span greater than 5 hours</i> Daily (e.g., 3-6 hours per week) Weekly (e.g., 15-20 hours per month) Monthly (e.g., 2 hrs 3-5 times per month)
Clinical Interventions (individual/ family/ group therapy)	<i>Range should not span greater than 2 sessions</i> Weekly (e.g., 1hr 1-2 times per week) Monthly (e.g., 1½ hrs 3-4 times per month)
Medication Evaluation, Management, and Consultation Services	<i>Range should not span greater than 2 sessions</i> Weekly (e.g., 30-60 min 1 time per week) Monthly (e.g., 30 min 1-2 times per month) Quarterly (e.g., 15 min 2-3 times per quarter)
Medication/Psychotherapy	<i>Range should not span greater than 2 sessions</i> Monthly (e.g., 1hr 1-2 times per month) Quarterly (e.g., 1hr 3-4 times per quarter)
Concurrent to Education Rehabilitation & Treatment (C.E.R.T.)	Weekly (e.g., 6 hrs 5 times per week during school year)
Consultation, Education, Advocacy	<i>Range should not span greater than 2 sessions</i> Weekly to Monthly (e.g., 1hr 1-2 times per month) Monthly to Quarterly (e.g., 2hrs 1-2 times per quarter)
Crisis Service	*Range not required as nature of crisis services precludes planned services.

Q: If the service provider or program changes, but the service modality and frequency remain the same as what is currently in the IPC, does this require notification?

A: If the new provider or program is not reducing, suspending, or terminating the service as written in the IPC, this does not require notification. Best practice would indicate that the new provider/ program review the IPC and make adjustments to goals/objectives as warranted.

Q: Is **Respite** included as a “covered” service?

A: No. Respite is not covered under Medicaid and, therefore, there is no action to appeal with regard to respite.

Q: If a client is referred for a service and it is found to be an appropriate service for the clinical needs of the client, but the client is put on a **waitlist** for the service due to limited resources, is this an action subject to appeal?

A: If the service is a Medicaid-reimbursed service, it does not matter if the waitlisted service is on the IPC yet; this is an action that can be appealed. For example, a client could appeal waiting for individual therapy (a Medicaid service) but not for respite (not a Medicaid service). The DA/SSA should make efforts not to have a waitlist for Medicaid services. For example, if the service is not available from the DA/SSA within a reasonable time frame and there is a Medicaid provider of the requested service available in the community, the DA/SSA may make reasonable attempts to refer the client for this service and avoid using a waitlist.

Q: If a school-based clinician decides to start a community skills group (specialized rehabilitation) and can start as soon as next week, does this require 11-day notice and therefore delay the potential start of the group?

A: No. Notice is not required for an increase in service, only a decrease, suspension, or termination.

Q: If we provide a copy of the Rights of Grievance & Appeal to the guardian/client upon intake and annually when the other consent forms are completed, do we need to provide it every time there is a change? Is there a more streamlined way that we can meet this expectation without excessive administrative costs?

A: The intent of the procedure is to remind consumers that they have the right to express dissatisfaction and/or ask that a decision be reviewed and adjusted. It is acceptable for the DA/SSA to provide the client with a copy of the Grievance and Appeal Process on an annual basis and remind the client of the right to initiate this process each time an action occurs. The DA/SSA is obligated to ensure that the client has received the most current version of the Process.

ATTACHMENT 3.Y

QUESTIONS FROM PROVIDERS AND ANSWERS FROM DMH ABOUT THE REVISED GRIEVANCES AND APPEALS PROCESSES UNDER VERMONT'S GLOBAL COMMITMENT TO HEALTH

QUESTIONS AND ANSWERS*

1. It is really confusing the differences between a reconsideration and an appeal. How are they part of the same process and how are they separate processes? The original OVHA definition of reconsideration was much simpler – “This is an informal way to ask the person who made the decision to rethink it. More information can be submitted that would clarify or add to what had already been sent in. A reconsideration is not required – it’s your choice” Can the DAs keep the original OVHA definition of a reconsideration

DMH changed the language describing the appeal process so that the first step of an appeal at the DA/SSA level is now called an “internal DA review.” This change should remove any sources of confusion with reconsideration as an informal option a client may exercise to ask a DA to review an action.

Thank you.

You’re welcome.

2. There is no form or option on the electronic log for a reconsideration. How does this get logged in? As an appeal? If it is as an appeal, will the computer identify the proper 15 days for the DA to make a reconsideration decision on the appeal?

A reconsideration requested by a client is an optional, informal process, not a part of the formal process for appeals. Reconsiderations do not have to be entered into the Grievance and Appeals database.

3. It says on page 7. “The time frame for reconsideration as the first step of an appeal is 15 calendar days from a client’s initiation of an appeal ... If the client is not satisfied with the reconsideration, then the appeal continues at DMH ...”

Given this, it is unclear what the Other DA/SA Reconsiderations refers to “Clients may, at their option, request reconsideration of a DAs/SSA’s action at any time throughout the appeal process. If a client requests a reconsideration the DA or SSA must review the original decision to reduce, deny, or terminate service(s) or eligibility for a program. A client may also ask for reconsideration without initiating an appeal.”

*These written questions came from providers after their preliminary review of the new draft *Designated Agency Provider Manual* in December 2007. The original wording of the questions has been retained here, though some have been renumbered so as not to cause confusion among future readers of the *Manual*. Questions, other comments, requests for clarification, and the like from providers appear in Times New Roman font. Answers, other comments, and clarifications from DMH appear in Ariel font.

First, the first step of the appeal process is always a DA reconsideration. If the client disagrees with the reconsideration, the appeal automatically goes to DMH as part of the 45 day appeal process. Does this mean, the client can request a reconsideration of the DA's initial reconsideration and the DA needs to address the 2nd reconsideration during the DMH's review of the appeal?

Second, it states the reconsideration is the first step of the appeal process which takes up to 15 days, how can the client initiate a reconsideration of an appeal at any time throughout the any time throughout the appeal process if the reconsideration is the first step of the appeal process?

This section on page 7 now reads: "The DA/SSA internal review is the first step of an appeal. The time frame for internal review is 15 calendar days from the client's initiation of an appeal." Reconsiderations as an optional, informal process available to clients are described on page 8.

4. It states on page 8 "If the reconsideration request is made or if a client files an initial appeal to DMH, however, the DA or SSA will be required to review and reconsider the decision that resulted in the appeal. The decision resulting from a DA/SSA's reconsideration or review is also considered a decision subject to appeal."

See revised page 8: "If the client decides not to ask the DA/SSA to reconsider an action and goes directly to DMH with an appeal or requests a Fair Hearing, or both, the DA or SSA will be required to begin the appeal process with an internal review of the decision that resulted in the appeal. The decision resulting from a DA/SSA's review is not considered a decision subject to appeal if the resulting decision is exactly the same as the original decision. If the internal review of the original decision causes any change to the original decision, this new decision is subject to appeal."

If the person decides to appeal, is the intent that when there are two decisions they would go forward as one appeal or is the intent that they would be addressed as two separate appeals?

The process allows for one decision per appeal.

5. Does this mean that a client can appeal an action of the DA, the DA conducts a reconsideration, the original decision is upheld, the appeal goes to DMH and *then the client can appeal the DA's reconsideration*? If so, does the DA do a reconsideration of their original reconsideration and this automatically becomes a second appeal to DMH appealing the 2nd reconsideration of the original appeal? How would you log into the electronic data base the appeal on the reconsideration of the first appeal?

See revised page 8.

6. On page[s] 10[-11] it says "If an appeal involves a DA/SSA decision . . ." When would an appeal not involve a DA/SSA decision?

When the appeal involves the timeliness of the Grievance and Appeal process, for example. Likewise, a decision made by a DA and/or DMH can be overturned by a Fair Hearing.

7. On page 10, it says “DMH’s decision on an appeal is regarded as final.” Does this mean there is a possible scenario where the DA is required to provide a service that it cannot provide or believe is contraindicated?

Technically, yes. If, to take a rare example, the DA denies CRT eligibility to someone, DMH can overturn that decision during an appeal.

We understand this would operate in accordance with provisions in provider contracts with the state. Perhaps such a statement should be added.

Your concerns are noted. On the rare occasions when these issues might arise, DMH would address them on a case-by-case basis. We do not anticipate any further clarification at this time.

8. On page 11 it says “A DA/SSA may receive an appeal on a matter for which it is not the agency responsible for making decisions . . . DA/SSA should refer the appeal to the appropriate agency and inform the client . . .” Does the DA enter the appeal electronically or do they notify the other agency and that agency enters the appeal electronically?

The DA enters the information it has, assigns the case to the grievance and appeals coordinator at the appropriate agency, and sends a transfer letter to the client. See revised wording on page 11 and Attachment 3.S, page 37.

9. On page 13, it says “DMH Quality Management Director has the responsibility for issuing or ensuring that a notice is issued to the client.” How will the DA find out? Do they also receive a letter?

The full sentence reads, “If DMH upholds a DA/SSA decision that meets the definition of an MCO action as described below [see examples given on pages 13-14 of the revised manual], the DMH Quality Management Director has responsibility for issuing or ensuring that a notice letter is issued to the client.” A copy of the notice letter will also be sent to the DA/SSA grievance and appeals coordinator.

The January 2008 copy distributed to us continues to state that “If DMH upholds a DA/SSA decision that meets the definition of an MCO action as described below, the DMH Quality Management Director has responsibility for issuing or ensuring that a notice letter is issued to the client.” We recommend adding that the DMH Quality Management Director will send a copy to the DA/SSA.

Language added. See page 13 of revised manual.

10. On page 4 Written Acknowledgement. It states “the DA/SSA is responsible for sending a copy of the letter to the Quality management director at DMH. Since the grievance is logged in the data base, DMH will receive a copy electronically of the grievance, when the letter is written and when it was resolved. Why does the DA also have to send the letter?”

See revised page 4: This sentence has been revised to read: “The DA/SSA is responsible for seeing that a copy of the letter of acknowledgment goes to the Quality Management Director at DMH either by uploading it to the database or by sending a hard copy through the mail.”

11. If a client is acting in an unsafe manner and violating the program's protocols, policies and rules and is asked to leave the service until they are stable and the client appeals that action as the removal of a service in their tx plan, Is this an appealable action? If so, does the client have the right to continue to receive that service until the appeal is resolved? Can the DA be viewed as a provider and not a MCO in this case? – The service is still available to the client, but clinically not indicated at this time. An example would be if I saw my doctor and wanted my arm x-rayed and the Doctor says no, it's just a sprain. The service of getting an x-ray is still available to my insurance coverage but in this case the provider is saying it is not clinically necessary.

The DA for mandated program populations is acting as the MCO; therefore, an action is appealable. The description of the scenario above lends itself to a request for an expedited appeal. The DA has made a decision, the client disagrees, and that disagreement constitutes a request for expedited appeal given the immediacy of the issue. The information should be conveyed and reviewed with DMH for immediate determination. For mental-health programs other than those for mandated populations, the DA would be acting as a provider and those decisions are not subject to appeal.

We appreciate the additions made to the Expedited Appeals section to clarify that situations such as those identified above would be subject to expedited appeal. There continues to be some concerns expressed though.

DMH addressed the concerns expressed by one CRT Director. We have not received any further expressions of concern from the field on this point.

12. If a client has in their tx plan 1-1 support and the funding for this service is terminated by DMH and consequently the service is terminated with the client, and the client wants to appeal the loss of the 1-1 support, is the MCO DMH and the DA the provider and the appeal is with MCO for terminating a client service which is prescribed in the service plan?

The DA determines the individualized service plan (ISP). Any additional funding to support a client treatment plan is dependent on the DA treatment plan services and DMH agreement to fund that treatment plan. It is therefore an unlikely scenario that a funding issue would lead to discontinuation of services unless the provider modified the treatment plan.

When budgets are reduced, we do indeed need to reduce services in accordance with our funding. We understand that we would generally be expected to carry out the action for DMH; however, we still are not clear on the appeal process since DMH would have been party to the decision.

DMH would not terminate a specific service through a reduction in funding. Rather, it is for the DA to determine how to use the available resources for services covered by the CRT case rate to follow the prescribed treatment plan for any individual client.

13. Page 1 – Introduction – talks about the MCO and then DAs or SSAs – seems to imply that DAs and SSAs are not part of the MCO for MH. This is implied throughout.

DAs, SSAs, and DMH are all part of the managed care organization (MCO) for mental health.

Yes we are aware of that. We think the procedures should be written to clearly reflect that DAs and SSAs are part of the MCO and not entities separate from the MCO.

See new language at the bottom of page 1 of the revised manual.

14. States that “DMH strongly recommends implementation of these procedures for all clients receiving mental-health services from designated agencies.” How would these procedures apply and work for someone who has their therapy services cut by the health insurance provider?

Although the appeals process is specifically for Medicaid/VHAP clients, the DA/SSA may be able to help clients appeal to their insurance company. All insurance companies in Vermont have to have an appeal process. Individuals may also appeal to the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) if all of the appeals through the insurance company fail.

In other words, you do not mean that these procedures should be applied to others who receive services, but rather that you would encourage designated agencies to help non-Medicaid clients who may want to appeal to the payer of their services when the insurer reduces coverage of services.

Correct.

15. Page 2 – Terminology – States in the definition of an action that “The DA/SSA is the entity that initiates an action.” Are there situations where DMH initiates an action?

The only likely DMH action would be to support a DA action or to render a determination.

This does not seem congruent with question 6.

DMH does not see the conflict here.

16. Grievance - States “clients file grievances.” Are there others who could file on a client’s behalf?

See revised page 2: “Clients or their representatives file grievances.”

17. Reconsideration – This definition and other statements in the procedures seem to imply that “reconsideration” is required before someone could appeal or ask for a fair hearing. How does that impact their right to appeal?

See revised pages on reconsiderations and internal DA reviews (primarily pages 2-3 and 6-15).

18. Page 3 – Grievance Procedures – Appeals are mentioned several times in this section which is confusing. This section does not appear to address grievances against DMH. How are they addressed?

These procedures were developed specifically for providers working with covered enrollees. See revised section on Grievance Procedures on page 3. As for grievances against DMH, the central office staff of DMH will respond to grievances in the same manner as providers are required to do. **If a client wants to register dissatisfaction with some aspect of DMH, he or she should address concerns to the DMH Quality Management Director.**

Given the procedures are for providers to use with enrollees, it seems that how to register a grievance with DMH should be specified so that providers know how to guide a person receiving services who may want to file a grievance against DMH.

Once again, contact the DMH Quality Management Director (see bolded sentence, above).

19. In the 2nd paragraph it identifies a “Grievance and Appeals Coordinator,” which is then referenced throughout the procedures. Why is a specific job title being used versus stating that the DA must appoint people to be responsible? This section also talks about this position as associated with CRT which suggests that the procedures only apply to CRT and leaves a question about other MH programs.

DA “grievance and appeals coordinator,” not capitalized in the revised manual, is not intended to be a job title but, rather, an indication of essential functions to be carried out by identified staff (one or more) of DAs/SSA. The responsibilities apply to all programs.

20. States that DAs/SSAs can require that grievances be put in writing. Is this consistent with Rule?

While it is true that some DAs/SSAs require that grievances be put in writing, the DA/SSA cannot require the client to provide the written documentation. See page 4: "Staff members shall be required to document the grievance if the client declines or is unable to complete this step."

Thanks for the change clarifying this.

You're welcome.

21. Page 5—Written Response—This section states that the client can request a review with DMH if the DA/SSA does not respond to their grievance in the way they want. Is this second grievance process consistent with Rule? This section also states that the disposition of a grievance is not subject to appeal to the HSB but the client can request HSB hearing for any issue raised that is appropriate for HSB review. The statement is not very clear.

Yes, the section on requesting DMH review of the disposition of a grievance is consistent with the Rule. On Fair Hearings, while, generally, people can ask for a fair hearing for whatever they want, in practice the Human Services Board has not chosen to become involved with grievances. Bottom line: It is up to the Human Services Board to decide which issues to pursue. See 3 V.S.A. § 3091(a), quoted on page 5 of the revised manual.

22. Page 6 – Why is there a DA/SSA grievance process if DMH is going to review the dispositions and can reverse a DA/SSA decision with no recourse available to the DA/SSA? Is it consistent with the Rule to have DMH addressing grievances within DA/SSAs?

DMH reviews grievances only if a client makes a specific request that it do so. As stated on page 6, "The primary purpose of the DMH grievance review shall be to ensure that the grievance process is functional and resolution impartial, rather than reversing a DA/SSA grievance resolution." See also Rule M184.5.

23. Appeals procedures talk about CRT. How do the procedures fit for non-CRT programs?

The appeals process is available only to clients of mandated programs (CRT and children with a serious emotional disturbance). These individuals may also appeal to BISHCA. Grievance procedures are applicable to all persons served by the DA.

Thank you for clarifying the procedures by adding Children's Services.

Your response indicates that grievance procedures are applicable to everyone served by the DA. If these are MCO Grievance and Appeal Procedures how would the grievance procedure apply to all people served by the agency? Further that is not consistent with the statement on page 1 that says "The procedures technically apply only to Medicaid and Vermont Health Access Plan (VHAP) recipients." The statement on page 1 also does not appear to be reflective of implications that not all Medicaid services fall under these MCO procedures. It actually appears that Medicaid and VHAP are only the first narrowing of applicability.

DMH encourages DAs to use the same guidelines for non-CRT clients who file grievances as for CRT clients who file grievances. It would seem more efficient and much easier for DAs to follow through on the process according to one set of guidelines instead of trying to follow two or more.

Based on your response, we assume that outpatient services provided via contract with DMH are not subject to this appeal process. Unfortunately, that becomes unclear based on the questions and answers on page 46 for children when the answer to the 2nd question says that waiting for individual therapy can be appealed. Our contracts say we will provide services within the funds available. We wait list when funds are not available and also provide information about private providers. If wait lists can be appealed, the state will need to be prepared to provide funding for individuals who prevail in the internal appeal or Human Service Board hearing.

This is not a change in procedure; it is simply now clearly documented. The DA/SSA/DMH are mandated to provide mental-health services to children with serious emotional disturbance within existing resources. If the resource does not exist, we need to demonstrate reasonable attempts to ameliorate the situation through alternative strategies such as referring out for the service and/or providing other supports while on the waitlist. The client or representative has a legal right to appeal being placed on a waitlist for a clinically recommended service.

It would be helpful to have clarity on what services are exempt from these procedures. For example, are services provided to individuals in DCF custody; schools; Success Beyond Six; etc. included? It might be helpful to have an applicability section at the beginning that lists which Medicaid funded MH services the state contracts with us for are and are not covered under these procedures. It might also be helpful to reference any other grievance and appeals procedures that may be available for individuals using Medicaid funded services that are not applicable to these procedures. We recognize that the Children's question and answer attachment has some information about applicability for children. However, it would be helpful to put information up front where people can easily access it and where it is in one spot for all ages.

There are two different procedures: the Grievance Procedures (3.6) are applicable to all Medicaid-covered services, and the Appeals Procedures (3.8) are applicable to Medicaid-

covered services provided to youth experiencing a serious emotional disturbance and CRT recipients. The **grievance** procedures apply to all Medicaid-funded services, including Success Beyond Six and any Medicaid services provided to youth in the custody of the Department for Children and Families. The **appeals** procedures apply only to individuals who meet the definition of a child or youth with serious emotional disturbance. The grievance and appeals procedures do not cover non-Medicaid services such as respite, therapeutic foster care, specialized evaluations, etc., or services funded by a source other than Medicaid. DMH encourages the DAs/SSA to use this set of guidelines for all recipients of mental-health services, not just those with Medicaid/VHAP.

To summarize client eligibility in regard to grievance and appeals procedures for children and adults:

Grievance Procedures:

All children, youth, and adults who receive Medicaid-funded mental-health services from a DA/SSA.

Appeal Procedures:

Children and youth with serious emotional disturbance, defined as any child between the ages of 0 and 17 (inclusive) with a DSM IV-TR mental-health diagnosis and a Global Assessment of Functioning (GAF) score of 60 or less, who are beneficiaries of Medicaid/Dr. Dynasaur, the Vermont Health Access Program (VHAP), or the State Children’s Health Insurance Program (SCHIP), and who receive mental-health services from a DA or SSA**

Adults who are assigned to Community Rehabilitation and Treatment programs

24. Page 7 – References a “Provider Manual.” What is this?

The *Designated Agency Provider Manual*, Third Edition (March 2004) focused primarily on Community Rehabilitation and Treatment programs. DMH has revised the sections having to do with grievances and appeals so as to make them applicable to other mental-health programs under Vermont’s Global Commitment to Health.

25. Why would a reconsideration decided at the DA/SSA level require notification saying that “the appeal decided as approved by the Department?”

This language has been changed to “Approved by DA/SSA/Department.”

**Youth who are receiving mental-health services and who have primary diagnoses of developmental disorders—including autism spectrum disorders, substance-related disorders, or other non-mental health disorders—are not eligible to appeal mental-health service decisions. Youth who meet the criteria for serious emotional disorder and have a co-occurring disorder above would be eligible to appeal mental-health service decisions under this process.

26. Is there really a reconsideration process or is the reconsideration really step one in an appeal? How does that fit with the Rule?

See revised sections on appeals, primarily pages 6-15. Yes, clients may ask for reconsiderations but they are not considered part of the appeals process.

27. Page 10 – Providers can file appeals. Is that consistent with the Rule?

Yes. See Rule M.181(D) on Filing of Appeals.

It might be helpful to say providers not acting as the MCO.

Rule M.181(D) specifies that:

Beneficiaries may file appeals orally or in writing for any MCO action. Providers and representatives of the beneficiary may initiate appeals only after a clear determination that the third-party involvement is being initiated at the beneficiary's request. Appeals of actions must be filed with the MCO within 90 days of the date of the MCO notice of action. The date of the appeal, if mailed, is the postmark date.

The MCO appeal process will include assistance by staff members of the MCO, as needed, to the beneficiary to initiate and participate in the appeal. Beneficiaries will not be subject to retribution or retaliation for appealing an MCO action.

28. Page 11 – What does the sentence “The DA/SSA is not required to provide a new service requested, if not clinically indicated, or a mental health service that is not a Medicaid-covered service pending an appeal determination or Fair Hearing” mean?

If the client asks for a new service that is available under the state plan but not clinically indicated, or if the client asks for a service that is not covered by Medicaid or offered by the DA, then the DA/SSA is not required to provide the service until after a favorable decision has been rendered in an appeal or fair hearing. It is still unknown if a fair hearing would require a DA to provide a service not covered by Medicaid or offered by a DA.

This implies that a DA/SSA might be required to provide a service that is not clinically indicated or not funded by Medicaid. We understand that this would be addressed in accordance with our contract and funding would be provided for any non-Medicaid services. Perhaps this clarification should be added.

Your concerns are noted. On the rare occasions when these issues might arise, DMH would address them on a case-by-case basis. We do not anticipate any further clarification at this time.

29. Why would a non-Medicaid service fall under these procedures?

See above.

30. Page 12 and 13 – How does the first statement on page 13 about an expedited appeal associated with hospitalization fit with the statement on page 12 that denial of hospital admission is not an MCO decision. Are non-MCO decisions appealable?

It is not entirely clear to which statement on page 12 or 13 this question might refer. In general, it would be well to remember that the majority of requests for expedited appeals pertain to hospitalization or immediate service needs. In the case of admission decisions, any emergent hospital admission decision is guided by the provider and not the MCO. This would include the Vermont State Hospital (VSH) because it is acting as a provider in an emergent situation. Non-MCO decisions are provider decisions and therefore not appealable.

These statements now appear under “Specific Procedures” at the top of page 13 and are still confusing. Why would VSH be contacted if “the expedited appeal request involves the pending hospitalization of a participant in the CRT program?” If psychiatric hospitalization denials are not MCO decision, why would there be an “expedited appeal request?”

Merely making a request for an expedited appeal does not mean that it meets criteria for expedited appeal. The example offered is just that, an example, and not an endorsement.

31. Page 13 – How can there be an appeal if a “contracted department of the MCO” does not provide or pay for services that were recommended by group processes that are not “MCO decisions subject to appeal”?

Placement recommendations made by Local Interagency Teams (LIT) and the State Interagency Team (SIT) are not MCO decisions. If the LIT or SIT makes a placement recommendation and DMH does not want to pay the treatment portion, then that DMH decision is appealable.

This still is not clear. Why is a non-MCO decision appealable through the MCO appeal process? If the LIT or SIT made a **referral** to the MCO, and the MCO took some sort of “action” based upon having addressed eligibility, needs, etc. then the MCO “action” would be appealable. Making the non-MCO recommendations something that can be appealed in the MCO process allows for appeals on behalf of people who potentially are clearly not eligible for services, etc. It also begs the question of what other exemptions might be made or are being made that non-MCO decisions are able to be appealed.

Your statement “if the LIT or SIT made a **referral** to the MCO, and the MCO took some sort of ‘action’ . . . then the MCO action would be appealable” is correct. The LIT/SIT decisions are not MCO decisions and therefore are not subject to the MCO appeal process. The LIT/SIT has its own appeal process related only to the coordination of services. If, however, the LIT/SIT decision leads to a referral to the MCO and the MCO makes a decision not to fund/provide that requested service, this MCO decision is subject to appeal. MCO decisions are made based on sound clinical judgment regarding eligibility and needs and, as in any other case (e.g., a straight referral without involvement of LIT/SIT), such decisions are subject to appeal.

32. Throughout the procedures there are references to letters that need to be sent to DMH. How do these fit with the database letters?

The letters at the back of the revised manual (in Attachments 3.E-3.W) were based on suggested letters that OVHA sent to all departments of the Agency of Human Services. The

MCO database can store these letters if the DAs/SSA uploads them. The database cannot send the letters or e-mail them to recipients.

33. Another couple questions about Attachment 3.X, specifically about the chart on page 45. We understand that these are examples of ranges and not ranges that we are expected to adopt. Is that correct? Also, are ranges for services required by Medicaid?

That is correct. Medicaid requires very prescriptive language in regard to services. For example, "3 times a week." The use of ranges gives flexibility for mental-health service delivery so that notices of service plan changes are not necessary for individuals with a fluctuating course of mental illness (for example, daily-weekly service range). The flexibility allows services to change in response to the individual's changing needs. So, in effect, the DA has the option of using either ranges or an identified number of services to be delivered within a specified time. Using service ranges is not required by Medicaid if the provider opts to identify the number of services to be delivered within a specified time. A number must be specified in order to inform the provider of when notice is indicated or inform the client of when he or she may appeal reductions in service levels.