

COUNSELING SERVICE OF ADDISON COUNTY, INC.  
POLICY AND PROCEDURE MANUAL

*ORGANIZATION POLICY AND PROCEDURE*

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**SUBJECT:** Client Grievances and Appeals

Page 1 of 10  
Effective: 7/07  
Revised: 7/08, 7/09, 11/12,  
11/18

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**PURPOSE:**

To establish requirements for meeting standards for all Client Grievance and Appeals.

Grievance and appeal procedures may differ within the various divisions of the agency. Clients should be certain that they speak to someone in their appropriate department for specific information, or speak with the agency contact person or designee.

**DEFINITIONS:**

**“Adverse benefit determination”:** means any of the following:

- denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope, or level of service;
- reduction, suspension or termination of a previously authorized covered service;
- denial in whole or in part, of payment for a covered service;
- failure to provide services in a timely manner, as defined by the Agency of Human Services (AHS)
- failure to act in a timely manner when required by state rule including for standard resolution of grievances and appeals;
- denial of a beneficiary’s request to obtain covered services outside the network;
- denial of a beneficiary’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary liabilities.

NOTE: A provider outside of network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

NOTE: Collaborative decisions of any type made by multi-disciplinary groups which include Medicaid Program and non-Medicaid Program membership such as Local Interagency Teams (LIT), the State Interagency Team (SIT), the State of Local Team for Functionally Impaired, and the Case Review Committee are not eligible for internal Medicaid Program appeal or a fair hearing.

**“Grievance”:** an oral or written expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights.

If a grievance is not acted upon within the timelines specified in the rule, the beneficiary may ask for an appeal under the definition above of an action as being “failure to act in a timely manner when required by state rule.”

**“Appeal”:** a formal oral or written request from a client to a designated agency (as a Medicaid Program) to rethink its decision on an adverse benefit determination.

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**“Designated Agency/Specialized Service Agency” (DA/SSA):** an agency designated by the Department of Mental Health (DMH) or Department of Disabilities, Aging and Independent Living (DAIL) to provide services and/or service authorizations for eligible individuals with mental-health conditions or developmental disabilities.

**“Authorized Representative”:** an individual, either appointed by a beneficiary or authorized under state or other applicable law, to act on behalf of the beneficiary in obtaining a determination or in dealing with any of the levels of the appeal or grievance process. Unless otherwise stated in this rule, the authorized representative has all of the rights and responsibilities of a beneficiary in obtaining a determination or in dealing with any of the levels of the appeals process.

**“Expedited Internal Appeal”:** an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary’s life or health or ability to attain, maintain or regain maximum function.

**“Fair Hearing”:** an external appeal that is filed with the Human Service Board, and whose procedures are specified in rules separate from the Medicaid Program grievance and appeals process.

**Medicaid Program means:**

- 1) the Department of Vermont Health Access (DVHA);
- 2) any state department with which DVHA has intergovernmental agreement under Global Commitment, excluding the Department of Education, that results in that department’s administering or providing services under Global Commitment (i.e. Department of Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; Department of Mental Health);
- 3) a DA/SSA; and
- 4) any contractor performing service authorizations or prior authorizations on behalf of the Medicaid Program (ex. ACO).

**“Service”:** a benefit that is 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the intergovernmental agreement between the Department of Vermont Health Access and departments of the Agency of Human Services for the administration and operation of the Global Commitment to Health waiver.

**“Network”:** the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.

**“Provider”:** a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individual’s medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that self-manages services is not a provider for purposes of this rule.

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 Department 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 application; or because the individual is aggrieved by agency policy as it affects his or her situation.

**POLICY:**

A grievance or appeal will be appropriately reviewed and given due consideration in a timely manner (see procedures). Clients, and/or guardians or an authorized representative, if any, are informed in a variety of ways of the agency’s

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grievance and appeal procedures. The grievance and appeal procedures are available in service locations, along with the complaint procedure. Grievance and appeal procedures are reviewed by all agency service providers. Any questions around grievance and appeals should be directed to the Counseling Service of Addison County's grievance and appeals contact person or designee.

This process does not apply under education.

**PROCEDURE:**

It is the responsibility of the staff member receiving a grievance or appeal to immediately inform the agency's grievance and appeals contact person or designee.

The Counseling Service of Addison County (CSAC) Executive Office has a master copy of the Global Commitment To Health Medicaid Program Grievances and Appeals Manual. Our policy is located on our Help Page and available on our web page. Pamphlets outlining our policy and procedures are located at the reception areas of the Counseling Service of Addison County's main locations. Copies are made available to staff, consumers, guardians, and/or representatives.

Any individuals initiating or pursuing a grievance or appeal will be free from any form of retaliation.

Administrative Responsibilities

The CSAC grievances and appeals coordinator or designee is responsible for all administrative functions related to grievances. The grievances and appeals coordinator or designee will ensure that grievances filed with CSAC are addressed by the appropriate CSAC staff person.

CSAC is responsible for the following:

- Acknowledging grievances
- Gathering information
- Writing responses
- Mailing the responses
- Entering data into and managing the Medicaid Program Grievances and Appeals database as it applies to CSAC

Alleged Harm

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

Documentation and Reporting

CSAC will adhere to the documentation and reporting standards as outlined in the most current Global Commitment To Health Medicaid Program Grievance and Appeals Technical Manual.

**Filing Grievances**

A grievance may be expressed orally or in writing at any time. Staff members are available to assist a beneficiary if the beneficiary or his or her representative requests such assistance. This includes, but is not limited to, auxiliary aids and services such as interpreter services and TTY/TTD capable access.

(NOTE: CSAC may not require that grievances be put in writing before considering them formal grievances. CSAC may make forms available for this purpose, but a beneficiary is not required to complete the form. CSAC staff members are available to assist a client if the client or his or her representative requests assistance in filing a grievance. CSAC staff promote prompt informal and formal resolution of disagreements.

Written Acknowledgement

Written acknowledgment of the grievance must be mailed within five (5) days of receipt. The acknowledgment must be made by the part of CSAC responsible for the service area that is the subject of the grievance. If CSAC decides the

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issue within the five-day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases. CSAC is responsible for seeing that a copy of the letter of acknowledgment is uploaded to the database. The CSAC grievances and appeals coordinator or designee has responsibility for acknowledging all grievances. Copies will be sent to the client (and his or her authorized representative, if applicable).

#### Withdrawal of Grievances

Beneficiaries or their authorized representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by CSAC in writing within five (5) calendar days.

#### Disposition

All grievances shall be addressed as expeditiously as possible but not more than ninety (90) days of receipt. The decision-maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review as well as information on how to initiate such a review.

### **DMH Involvement in the Client Grievance Process**

#### Receipt of Unresolved Grievances

An unresolved grievance is one that has not gone through the CSAC grievance process at the DA/SSA level. DMH encourages clients to use the grievance and appeal process at the DA/SSA. CSAC and the client and/or representative are expected to complete the grievance process, and CSAC is expected to address the grievance within the grievance time lines specified. Unresolved grievances received by DMH will be acknowledged in writing to both the client and to CSAC within five (5) calendar days of receipt. This notification shall cause the local DA/SSA grievance process to begin. DMH will see that the information is entered into the Medicaid Program Grievance and Appeal database and assign the case to the CSAC grievance and appeal coordinator or designee.

#### Grievance Reviews

1. Filing a Grievance Review - If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the Medicaid Program within ten (10) days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.
2. Written Acknowledgment - The Medicaid Program will acknowledge grievance review requests within five (5) days of receipt.
3. Disposition – The grievance review shall assess the merits of the grievance issue(s), the process employed by CSAC in reviewing the issue(s), and the information CSAC considered in making its determination. *The primary purpose of the grievance review shall be to ensure that the grievance process is functional and resolution impartial, rather than reversing a DA/SSA grievance resolution.* The beneficiary will be notified in writing of the findings of the grievance review within ninety (90) days. The DMH grievance review determination is considered final.

#### Fair Hearing

Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the beneficiary may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V.S.A. §3091 (a).

Copies of the disposition will be sent to the client and his or her authorized representative if applicable.

#### Department Involvement in the ACO/DA/SSA Grievance Process

An unresolved grievance is one that has not gone through the ACO/DA/SSA grievance process at the ACO/DA/SSA level. The departments encourage members to use the grievance and appeal process at that level. The ACO/DA/SSA and the member are expected to complete the grievance process, and the ACO/DA/SSA is expected to address the grievance within the grievance timelines specified. Unresolved grievances received by department will be acknowledged in writing to both the member and the DA/SSA within five (5) calendar days of receipt. This notification

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shall cause the ACO/DA/SSA grievance process to begin. The department will enter the information and assign the case.

**Appeal Procedures**

**Medicaid Program or Provider Status**

If Program “adverse benefit determinations” are in:

- Developmental Disability Services----- DA is a Medicaid Program for decisions made by the DA
- CRT Program----- DA is included in the Medicaid Program
- CRT Hospitalization----- Hospitals are Providers (See Participating Provider Decisions)
- Adult Outpatient Program----- DA is Provider (See Participating Provider Decisions)
- Emergency Services Program----- DA is Provider (See Participating Provider Decisions)
- Children’s Outpatient Program----- DA/SSA is Provider (See Participating Provider Decisions)
- Children’s Out-of-Home/
- Enhanced Family Treatment (EFT) Services----- DMH is Medicaid Program and performs G&A reviews

CSAC will establish and maintain internal procedures for internal review of appeals consistent with AHS requirements outlined in Provider Manual Addendum for Grievance and Appeals. 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 Medicaid Program 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.

**Right to Appeal**

Clients, consumers or their authorized representatives may request an internal appeal of an adverse benefit determination. There is no right to an internal appeal when the sole issue is a federal or state law requiring an automatic change adversely affecting some or all members.

CSAC decisions that do not require a service authorization are not adverse benefit determinations and are not subject to the internal appeal process.

Exhaustions Requirement: Clients, consumers or their authorized representatives may only request a State fair hearing after receiving notice of resolution of an internal appeal under 8.100.3c that CSAC upheld an adverse benefit determination, except that the member shall be deemed to have exhausted the internal appeal process.

If CSAC fails to comply with the requirements regarding notice content and timing a client, consumer or their authorized representative may immediately request a State fair hearing.

**Request for Non-Covered Services**

An internal appeal under this rule may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to DVHA under the provisions of the Medicaid rules at 7104. A subsequent DVHA denial under 7104 to cover such service cannot be appealed using the appeal process set forth in this rule, but may be appealed through the fair hearing process.

**Medicaid Eligibility and Premium Determinations**

If a beneficiary files an appeal regarding only a Medicaid eligibility or premium determination, the entity that receives the appeal will forward it to the Department of Health Access (DVHA), Health Access Eligibility and Enrollment Unit (HAEEU). The entity that received the appeal originally will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by DVHA. These appeals will not be addressed through the internal appeal process and will be considered a request for fair hearing as of the date the Medicaid Program received it.

**Filing of Appeals**

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Beneficiaries may file appeals orally or in writing for any Medicaid Program adverse benefit determination. Providers and representatives of the member may initiate appeals only after a clear determination that the third-party involvement is being initiated at the member's request. Appeals of adverse benefit determinations must be filed with the Medicaid Program within sixty (60) days of the date of the Medicaid Program notice of adverse benefit determination. The date of the appeal, if mailed, is the postmark date (see Sample attachment 3.D Grievance and Appeal form). If a client, consumer, or their authorized representative waits longer than sixty (60) days to file an appeal, CSAC does not have to proceed.

The parties to an internal appeal are the beneficiary and his/her authorized representative, or the legal representative of a deceased beneficiary's estate.

CSAC staff members will provide reasonable assistance in completing forms and taking other steps to initiate and participate in the internal appeals process. Assistance includes auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that include adequate TTY/TTD. Beneficiaries may also 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.

#### Written Acknowledgement

Written acknowledgement of the appeal shall be mailed within five (5) days of receipt by the part of the Medicaid Program that receives the appeal (see Sample attachment 3 DA/SSA Appeal Letter Acknowledging Appeal and Appeal Process Flow Chart).

If a member files an appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct part of the Medicaid Program, identify the part to which it has been forwarded, and explain that the appeal will be addressed by that part. This does not extend the deadline by which appeals must be determined.

#### Withdrawal of Appeals

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the Medicaid Program in writing within five (5) days (see Sample attachment Acknowledgment of Oral Withdrawal Appeal/Request).

#### Member Participation in Appeals

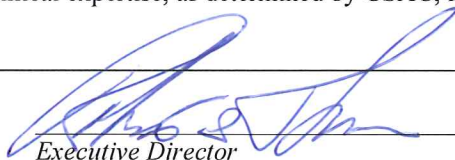
The member, his or her designated representative, or the member's treating provider, if requested by the member, has the right to participate in person, by phone or in writing in the meeting in which the Medicaid Program is considering the issue that is the subject of the appeal. Participation includes the right to present evidence and testimony and make factual and legal arguments. If the appeal involves a CSAC decision, a representative of CSAC may also participate in the meeting. Members, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to have a material effect on the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting. Upon request, CSAC shall provide the member or his/her designated representative with all the information in its possession or control relevant to 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 medical records. CSAC will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

#### Medicaid Program Appeals Reviewer

The individual who hears the appeal shall not have been involved in any previous level of review or made the decision subject to appeal and shall not be a subordinate of the individual who made the original decision. Appeals shall be decided by individual(s) designated by CSAC responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess(es) the requisite clinical expertise, as determined by CSAC, in treating the beneficiary's condition or illness. Individuals

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hearing the appeal shall consider all comments, documents, records and other information submitted or considered in the initial decision.

#### Resolution

The Medicaid Program shall act promptly and in good faith to obtain any necessary information to resolve the appeal. For purposes of this paragraph, "necessary information" may include the results of any face-to-face clinical evaluation or second opinion that may be required. Appeals shall be decided and written notice sent to the beneficiary within thirty (30) days of receipt of the appeal. The member shall be notified as soon as the appeal meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a meeting cannot be scheduled so that the decision can be made within the 30-day time limit, the time frame may be extended up to an additional fourteen (14) days, by request of the member or by the Medicaid Program if the extension is in the best interest of the member. If the extension is at the request of the Medicaid Program, it must give the member written notice of the reason for the extension. The maximum total time period for the resolution of an appeal, including any extension requested either by the member or the Medicaid Program, is forty-four (44) days. If a meeting cannot be scheduled within these time frames, a decision will be rendered by the Medicaid Program without a meeting with the member, the designated representative, or treating provider (see Sample attachment DA/SSA Letter Informing Client of Favorable Internal Review of Appeal and Sample attachment 3.O DA/SSA Letter Informing Client of Adverse Internal Review of Appeal).

For appeals not resolved wholly in favor of the members, notices must include:

- I. The right to request a State fair hearing, how to request a fair hearing, and the timeframe for doing so.
- II. The circumstances in which a State fair hearing will be expedited and how to request it.
- III. The right to have services continue pending resolution of the State fair hearing including how to request continuing services and the timeframe for doing so.
- IV. The timeframes, whether standard or expedited, in which AHS, which may include the Human Services Board, must take final administrative action.
- V. That the member may, consistent with State policy, be held liable for the cost of continued services if the State fair hearing process results in a final administrative decision that upholds the Medicaid Program's adverse benefit determination.

NOTE: Appeals on CRT Program Actions. CSAC will notify DMH of any appeal of a CRT Program action and provide all correspondence, either electronically or via fax transmittal, and any information considered in the initial action and internal review related to an adverse appeal resolution. This information will be necessary if there is a request for a Fair Hearing. At any point in the appeal process, CSAC may consult with DMH regarding a program action or request DMH involvement in determining a resolution decision.

NOTE: Appeals on Out-of-Home and Enhanced Family Treatment Services, Children's e-bed extensions, and Children's Residential Assessment & Treatment (PNMI) Actions. The Child, Adolescent, and Family Unit (CAFU) within DMH retains Medicaid Program authorization for child out-of-home placement and Enhanced Family Treatment (EFT) services. Following a request for these services and adverse decision by CAFU, a request for appeal to the Medicaid Program is the responsibility of DMH. CAFU as the Medicaid Program will follow member notice and appeals procedures outlined in this Provider Manual Addendum for these service appeals. Further elaboration of the procedures can be found in the Enhanced Family Treatment Services Manual or the Case Review Committee Guidelines and Procedures (for residential).

#### Expedited Appeal Requests

The Medicaid Program must expedite an appeal request when it determines that the standard for an expedited appeal is met, when the request is by the enrollee, or a provider indicates the standard is met, when a provider requests an expedited appeal.

The standard for expedited resolution of an internal appeal is that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Requests for

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expedited appeals may be made orally or in writing with the Medicaid Program for any adverse benefit determination subject to appeal. The Medicaid Program will not take any punitive action against a provider who requests an expedited resolution or supports a member's appeal.

If the request for an expedited appeal is denied because it does not meet the criteria, the Medicaid Program will inform the member that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard thirty (30) day time frame. An oral notice of the denial of the request for an expedited appeal must be promptly communicated to the member and followed up within two (2) days of the oral notification with a written notice.

If the expedited appeal request meets the criteria for such appeals, it must be resolved, and the Medicaid Program must notify the member, within seventy-two (72) hours. If an expedited appeal cannot be resolved within 72 hours, the time frame may be extended up to an additional fourteen (14) days by request of the member, or by the Medicaid Program if the Medicaid Program shows that there is a need for additional information and how the delay is in the best interest of the member. If the extension is at the request of the Medicaid Program, it must give the member written notice of the reason for the extension. An oral notice of the expedited appeal decision must be promptly communicated to the member and followed up within two (2) days of the oral notification with a written notice of the reason for its decision to extend the timeframe and an explanation of the member's right to file a grievance if they disagree with the extension of time. The written notice for expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the member's right to request an expedited State fair hearing.

A member may request an expedited State fair hearing when the Medicaid Program approved the request for an expedited resolution on an internal appeal:

- But the decision is wholly or partially adverse to the member, or
- The expedited internal appeal is not timely resolved by the Medicaid Program.

### **Participating Provider Decisions**

Provider decisions shall not be considered Medicaid Program actions and are not subject to appeal using this process.

A state agency shall be considered a provider if it provides a service that:

1. is claimed at the Medicaid service matching rate;
2. is based on medical or clinical necessity; and
3. does not have prior authorization.

Designated Agencies (DA)/Specialized Service Agencies (SSA)/Hospitals are providers when their decisions do not affect member eligibility or services. In the case of Adult and Children's Outpatient services and Emergency Services, a DA/SSA/Hospital action does not affect a member's eligibility to receive these services by another Medicaid provider. The only actions that may be appealed are those that effectively deny or limit eligibility, payment or access to a service and must be authorized by the Medicaid Program.

### **Notices, Continued Services, and Member Liability**

#### Member Notice

The part of the Medicaid Program issuing a service decision that meets the definition of an adverse benefit determination must provide the member with written notice of its decision. The notice of adverse benefit determination shall contain clear statements of the following: The adverse benefit determination the Medicaid Program has taken or intends to take, the reason for the adverse benefit determination, the specific rule that supports the adverse benefit determination, the right to appeal, including how to request an internal appeal and the timeframe. An explanation of when there is a right to request a State fair hearing, including the exhaustion requirement and when exhaustion is

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deemed. The circumstances under which an appeal will be expedited and how to request it. The right to have services continue pending resolution of the appeal, including how to request continuing services, the timeframe for requesting continuing services, and under what circumstances the beneficiary may be required to pay the costs of services that are provided pending resolution of the appeal. The methods for requesting an appeal and procedures for exercising other rights.

In cases involving a termination or reduction of service(s), such notice of decision must be mailed at least eleven (11) days before the change will take effect. When the decision is adverse to the beneficiary, the notice must inform the beneficiary when and how to file an appeal or fair hearing. In addition, the notice must inform the beneficiary that he or she may request that covered services be continued without change as well as describe the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any Medicaid Program appeal or fair hearing. CSAC will have and use a notice that meets legal requirements for Medicaid notices (see Sample attachment).

#### Continuation of Services

1. If requested by the member, services must be continued during an appeal regarding a Medicaid-covered service termination, suspension, or reduction under the following circumstances:
  - a. the appeal was filed in a timely manner, meaning before the effective date of the proposed action;
  - b. the member has paid any required premiums in full;
  - c. the appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan; and
  - d. the services were ordered by an authorized provider and the original period covered by the authorization has not expired.
2. If properly requested, a service must be continued until any one of the following occurs:
  - a. the member withdraws the appeal or a fair hearing request;
  - b. any limits on the cost, scope or level of service, as stated in law or rule, have been reached;
  - c. the Medicaid Program issues an appeal decision adverse to the member, and the member does not request a fair hearing within the applicable time frame;
  - d. a fair hearing is conducted and the Human Services Board issues a decision adverse to the member; or
  - e. the time period or service limits of a previously authorized service have been met.

Members may waive their right to receive continued benefits pending appeal.

#### Change in Law

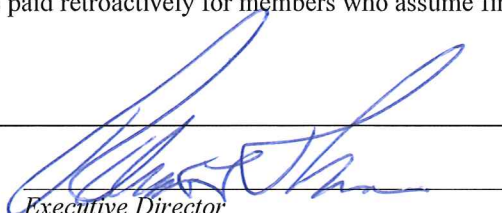
Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law or rule affecting some or all beneficiaries, or when the decision does not require the minimum advance notice.

#### Member Liability for Cost of Services

A member may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

CSAC may recover from the member the value of any continued benefits paid during the appeal period when the member withdraws the appeal before the relevant internal appeal or fair hearing decision is made, or following a final disposition of the matter in favor of the Medicaid Program. Member liability will occur only if an internal appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the Medicaid Program also determines that the member should be held liable for service costs. If CSAC notifies the member that a service may not be covered by Medicaid, the member can agree to assume financial responsibility for the service. If CSAC fails to inform the member that a service may not be covered by Medicaid, the member is not liable for payment. Benefits will be paid retroactively for members who assume financial responsibility for a service and who are successful on their appeal.

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Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the Medicaid Program is not required to initiate service delivery.

The Medicaid Program is not required to provide a new service or any service that is not a Medicaid-covered service while an internal appeal or a fair hearing determination is pending.

**Services Not Furnished While Appeal Pending:** If the Medicaid Program or AHS, including the Human Services Board, reverses a decision to deny, limit, or delay services that were not furnished while the internal appeal or State fair hearing was pending, or if AHS decides in the member's favor before the hearing, the Medicaid Program shall authorize or provide the disputed services as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date the Medicaid Program receives notice reversing the determination.

**Services Furnished While Appeal Pending:** If the Medicaid Program or AHS, including the Human Services Board, reverses a decision to deny, limit, or delay services that were furnished while the appeal was pending, the Medicaid Program shall pay those services in accordance with State policy.

**Fair Hearing**

State Fair Hearing Request means a clear expression, either orally or in writing, by a member to have a decision by the Medicaid Program reviewed by the Human Services Board.

**Exhaustion Requirement; Deemed Exhaustion**

**Exhaustion Requirement:** A member may only request a State fair hearing after receiving notice of resolution of an internal appeal under 8.100.3 that the Medicaid Program upheld and adverse benefit determination, except that the member shall be deemed to have exhausted the internal appeal process pursuant to the next paragraph

**Deemed Exhaustion:** If the Medicaid Program fails to comply with the requirements regarding notice content and timing, exhaustion of the internal appeal process shall be deemed, and a member may immediately request a State fair hearing.

Clients receiving mental-health services from CSAC also have the right to file requests for Fair Hearings related to program eligibility determinations and reductions or denials of mental-health services if:

- ◆ they are enrolled in Medicaid and
- ◆ they have exhausted the internal appeal process and
- ◆ actions pertain to the CRT Program or to Developmental Disabilities Services OR children's out-of-home placement and Enhanced Family Treatment services.

CSAC will cooperate with DMH and the DMH Legal Unit in preparation of necessary documentation for Fair Hearing. CSAC 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 determinations of eligibility for CRT program or services and Children's Services for youth experiencing a severe emotional disturbance and their families. As needed, CSAC will have 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 CSAC must comply with the final determination.

Approved by:

  
Executive Director

Date Approved: 12.13.2018

File Name: C-4 Client Grievances and Appeals