8.100 Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services (06/01/2018, GCR 17-090)

8.100.1 Introduction and Applicability

Rule 8.100 implements the responsibilities of the Medicaid Program pursuant to 42 CFR § 438, Subpart F, regarding a grievance and internal appeal system for Medicaid beneficiaries seeking Medicaid services. The rule also sets forth requirements for Notices of an Adverse Benefit Determination, continuing services pending appeal and potential beneficiary liability, and responsibilities regarding State fair hearings.[1]

The services listed below are not subject to the grievance rule at 8.100.8 and the internal appeal rule at 8.100.4. A Medicaid beneficiary may request a State fair hearing, pursuant to 8.100.5, regarding these services.

(a) Services funded with state-only dollars because federal participation is prohibited, and
(b) Services that are a coverage exception to Medicaid covered services.

For rules that govern Medicaid applicant and beneficiary appeals regarding financial, non-financial, and categorical eligibility for community Medicaid and Medicaid for long-term care services and supports and Medicaid premium determinations, refer to Health Benefit Eligibility and Enrollment Rules at Code of Vermont Rules 13-001-001 to 13-001-008.

8.100.2 Definitions

The following definitions shall apply for use in 8.100:

(a) **"AHS"** means the Agency of Human Services as the Medicaid Single State Agency.

(b) **"Authorized Representative"** means an individual, either appointed by a beneficiary or authorized under State or other applicable law, to act on behalf of the beneficiary in the internal appeal, grievance, or State fair hearing processes as permitted pursuant to 42 CFR § 435.923. Unless otherwise stated in law, the authorized representative has the same rights and responsibilities as the beneficiary in obtaining a benefit determination or in dealing with the internal appeal, grievance, and State fair hearing processes.

(c) **"Designated Agency/Specialized Service Agency"** means an agency designated or deemed by the Department of Mental Health or the Department of Disabilities, Aging, and Independent Living to provide and administer services, including service authorization decisions, for beneficiaries with mental health needs or developmental disabilities.

(d) **"Final Administrative Action"** means a final AHS order entered by the Human Services Board or, if the Secretary of AHS reverses the order of the Human Services Board pursuant to 3 VSA § 3091(h), then the Secretary's order.

(e) **"Grievance"** means an expression of dissatisfaction about any matter that is not an adverse benefit determination, including a beneficiary's right to dispute an extension of time proposed by the Medicaid Program and the denial of a request for an expedited appeal.

(f) **"Internal Appeal"** means an internal review by the Medicaid Program of an adverse benefit determination.

(g) **"Medicaid Program"** means (1) DVHA in its managed care function of administering services,

[1] The Human Services Board Fair Hearing Rules are at Code of Vermont Rules 13-020-002 (Part 1000).

including service authorization decisions, under the Global Commitment to Health Waiver ("the Waiver"), (2) a State department of AHS (i.e., Department for Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; and Department of Mental Health) with which DVHA enters into an agreement delegating its managed care functions including providing and administering services such as service authorization decisions, under the Waiver, (3) a Designated Agency or a Specialized Service Agency to the extent that it carries out managed care functions under the Waiver, including providing and administering services such as service authorization decisions, based upon an agreement with a State department of AHS, and (4) any subcontractor performing service authorization decisions on behalf of a State department of AHS.

(h) **"Provider"** means a person, facility, institution, partnership, or corporation licensed, certified or authorized by law to provide services to a beneficiary.

(i) **"State Fair Hearing Request"** means a clear expression, either orally or in writing, by a beneficiary to have a decision by the Medicaid Program reviewed by the Human Services Board.

8.100.3 Notice Requirements

(a) General Requirements for Notices Sent by the Medicaid Program or AHS Pursuant to 8.100: The notice shall be compliant with 42 CFR § 438.10 including that the notice shall be:

(1) Written unless otherwise specified by this rule,
(2) In plain language,
(3) Accessible for persons with limited English proficiency.

(A) Persons with limited English proficiency shall be provided language services at no cost to the individual, including:

(i) Oral interpretation,
(ii) Written translations,
(iii) Taglines in non-English languages, including the availability of language services, and

(4) Accessible for persons with disabilities.

(A) Individuals with disabilities shall be provided with auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

(b) Notice of Adverse Benefit Determination: The Medicaid Program shall provide the beneficiary with timely and adequate written notice of an adverse benefit determination.

(1) Content of notice of adverse benefit determination: A notice of adverse benefit determination shall contain clear statements of the following:

(A) An explanation of the adverse benefit determination the Medicaid Program has taken or intends to take,
(B) The reason for the adverse benefit determination,
(C) The specific rule that supports the adverse benefit determination,
(D) The right to appeal, including how to request an internal appeal and the timeframe,
(E) An explanation of when there is a right to request a State fair hearing, including the exhaustion requirement and when exhaustion is deemed,
(F) The circumstances under which an appeal will be expedited and how to request it,
(G) 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,

(H) The methods for requesting an appeal and procedures for exercising other rights in 8.100.4, and

(I) The right of the beneficiary to be provided, upon request and free of charge, reasonable and timely access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination, including medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.

(2) Timing of Notice of Adverse Benefit Determination, Including When Advance Notice is Required: The Medicaid Program shall mail the notice within the following timeframes:

(A) For a termination, suspension, or reduction of a previously authorized service, at least 11 days before the change will take effect.

(B) For denial of payment, at the time of any action affecting the claim.

(C) For standard service authorization decisions that deny or limit services, as expeditiously as the beneficiary's health requires but not more than 14 days following receipt of the request for service.

(D) For expedited service authorization decisions, as expeditiously as the beneficiary's health requires but not more than 72 hours after receipt of the request for service.

(E) For service authorization decisions not reached within the proper timeframes described in paragraphs (C) and (D) above, on the date that the timeframe expires.

(i) Service authorization decisions not reached within the proper timeframes constitute a denial and thus are an adverse benefit determination.

(F) If the Medicaid Program meets the criteria for extending the timeframe for standard and expedited service authorizations, it shall:

(i) Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if s/he disagrees with the decision to extend the timeframe, and

(ii) Issue and carry out its decisions as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

(c) Notice of Resolution of Internal Appeal

(1) Content of notice of resolution of internal appeal

(A) The written notice shall include clear statements of the following:

(i) The decision, including the basis for the decision, in sufficient detail for the beneficiary to understand the decision,

(ii) A summary of the beneficiary's appeal,

(iii) A summary of the evidence or documentation used by the reviewer in making the decision, including clinical review criteria used to make a decision relating to medical care,

(iv) The date the decision was completed and the effective date of the decision,

(v) The telephone number of the Health Care Advocate at Vermont Legal Aid, Inc., and

(B) For appeals not resolved wholly in favor of the beneficiary:

(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, and
(v) That the beneficiary 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.

(d) Notice of Resolution of Grievance: The Medicaid Program's written notice of resolution of a grievance shall contain clear statements of the following:

(1) The decision, including the basis or other rationale for the decision in sufficient detail for the beneficiary to understand the decision,
(2) A summary of the grievance,
(3) The telephone number of the Health Care Advocate at Vermont Legal Aid, Inc., and
(4) If the decision is adverse to the beneficiary, the notice must inform the beneficiary of his/ her right to initiate a grievance review pursuant to 8.100.8(j) and explain how to do so.

8.100.4 <u>Internal Appeals</u>

(a) Internal Appeal System: The Medicaid Program shall maintain an internal appeal system, including an expedited appeal process, for a beneficiary to appeal an adverse benefit determination. The system shall not have more than one level of internal appeal.

(b) Right to Internal Appeal; Exception for Change in Law

(1) A beneficiary may file an internal appeal of an adverse benefit determination with the Medicaid Program.

(2) 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 beneficiaries.

(c) Provider Decisions: Network provider decisions that do not require a service authorization are not adverse benefit determinations of the Medicaid Program and are not subject to the internal appeal process.

(d) Exhaustion Requirement; Deemed Exhaustion; Request for Review Made to Human Services Board Prior to Exhaustion

(1) Exhaustion Requirement: A beneficiary may only request a State fair hearing after receiving notice of resolution of an internal appeal under 8.100.3(c) that the Medicaid Program upheld an adverse benefit determination, except that the beneficiary shall be deemed to have exhausted the internal appeal process pursuant to paragraph (d)(2) below.

(2) Deemed exhaustion: If the Medicaid Program fails to comply with the requirements regarding notice content and timing at 8.100.3(c) and 8.100.4(n), (o) and (p), exhaustion of the internal appeal process shall be deemed and a beneficiary may immediately request a State fair hearing.

(3) Request for Review Made to Human Services Board Prior to Exhaustion: If a beneficiary wrongly files a request for review with the Human Services Board prior to exhausting the internal appeal process, where exhaustion is required, AHS and the Medicaid Program shall provide the beneficiary with appropriate assistance with filing an internal appeal with the Medicaid Program.

(e) Filing of Internal Appeal, Including Time for Appealing

(1) Who May File Internal Appeal: A beneficiary or, as state law permits and with the written consent of the beneficiary, a provider or authorized representative (if not already specified in authorized representative's scope of authority), may initiate an internal appeal.

(A) When "beneficiary" is used in 8.100.4, it includes providers and authorized representatives except that providers may not request that services be continued pending appeal.

(2) How to Appeal: An internal appeal may be filed orally or in writing.

(A) An oral inquiry seeking to appeal an adverse benefit determination shall be treated as an appeal for purposes of establishing the filing date for the appeal.

(B) A beneficiary must follow an oral appeal with a written appeal except when the beneficiary requests expedited resolution of the appeal. The Medicaid Program shall have discretion to find that a beneficiary has good cause for not following an oral appeal with a written appeal.

(3) Time for Filing Appeal: A beneficiary must file an appeal with the Medicaid Program within 60 days of the date the Medicaid Program mailed the notice of adverse benefit determination. The date of the appeal, if mailed, and the date the Medicaid Program mailed the notice of adverse benefit determination, is the postmark date. For adverse benefit determination notices that are mailed by the Medicaid Program, the postmark date is one business day after the date of the notice.

(f) No Punitive Action Against Providers: The Medicaid Program shall ensure that no punitive action is taken against a provider who requests or supports a beneficiary's internal appeal.

(g) Assistance with Appeal and Requesting a State Fair Hearing:

(1) The Medicaid Program shall:

(A) Give beneficiaries any reasonable assistance in initiating and participating in the internal appeal and the State fair hearing processes including by helping the beneficiary to submit his/her request. Help shall include completing forms and taking other necessary steps,

(i) Assistance includes auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(B) Provide appropriate assistance in filing a request for a State fair hearing to any beneficiary who wrongly filed a request for review with the Human Services Board prior to exhaustion of the internal appeal, if the beneficiary wishes to pursue a State fair hearing, and

(C) Respond to any clear indication (oral or written) that a beneficiary wishes to present his/her case to a reviewing authority by helping the beneficiary to submit a request for an internal appeal (or a State fair hearing, where appropriate).

(2) Request for Review by Human Services Board Prior to Exhaustion: See 8.100.4(d)(3)

(h) Written Acknowledgement of Appeal: The Medicaid Program shall mail acknowledgement of the appeal to the beneficiary within five days of its receipt of the appeal.

(i) Withdrawal of Appeal: Appeals may be withdrawn orally or in writing at any time.

(1) If an internal appeal is withdrawn orally, the Medicaid Program shall acknowledge the withdrawal in writing within five days.

(j) Parties to the Appeal: The parties to an internal appeal are the beneficiary or his/her authorized representative, or the legal representative of a deceased beneficiary's estate.

(k) Information to Resolve Appeal: 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.

(l) Appeals Reviewer: Individuals who make a decision on an internal appeal:

(1) Shall not have been involved in any previous level of review or decision making, nor be a subordinate of any such individual,
(2) Shall have appropriate clinical expertise in treating the beneficiary's condition or disease when deciding an appeal of a denial based on medical necessity, and
(3) Shall consider all comments, documents, records, and other information submitted by the beneficiary or his/her representative or provider without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(m) Internal Appeal Process

(1) Participation in Appeal Meeting: The beneficiary, his/her authorized representative, or his/her provider, if requested by the beneficiary, 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.

(A) The Medicaid Program shall inform the beneficiary of the time available for participation in the internal appeal sufficiently in advance of the resolution timeframe for the appeal including, if an appeal meeting will be held, sufficiently in advance of the meeting.

(2) Submission of Information: The beneficiary, the authorized representative, or the provider may submit additional relevant information that supplements or clarifies information that was previously submitted.

(3) Right to Examine and Get Copies of Record: Prior to the appeal meeting, the Medicaid Program shall timely provide the beneficiary, his/her authorized representative, or his/her provider with an opportunity to examine, and, if requested, get copies of all the information in its possession or control relevant to the appeal process and the subject of the appeal. The Medicaid Program shall not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal. These records shall include:

(A) The beneficiary's case record, including medical records, other records and documents, and any new or additional evidence considered, relied on, or generated by the Medicaid Program, or at its direction, that is related to the appeal, and

(B) Other information relevant to the beneficiary's adverse benefit determination, including relevant policies or procedures which shall include medical necessity criteria and any processes, strategies, or evidentiary standards used in setting service limits.

(4) Scheduling the Appeal Meeting: The Medicaid Program shall timely notify the beneficiary when the appeal meeting is scheduled. If necessary, the appeal meeting will be rescheduled to accommodate individuals wishing to participate.

(A) If an appeal meeting cannot be scheduled within the timeframe for resolving the appeal, including if the timeframe is extended pursuant to paragraph (o) below, the Medicaid Program shall make a decision that resolves the appeal without a meeting with the beneficiary, his/her authorized representative, or provider. The beneficiary, his/her authorized representative, or provider shall have an opportunity to submit evidence and argument by other means to the appeals reviewer for consideration in making a decision.

(n) Standard Time for Resolution of Internal Appeal

(1) The Medicaid Program shall decide an internal appeal and provide written notice as expeditiously as the beneficiary's health condition requires, but not longer than 30 days after it receives the appeal.

(o) Extension of Time to Resolve Internal Appeal

(1) The Medicaid Program may extend the time for resolving an internal appeal by up to 14 days under the following circumstances:

(A) By request of the beneficiary, or
(B) If the Medicaid Program shows that there is need for additional information and how the delay is in the best interest of the beneficiary.

(2) If the extension is not at the request of the beneficiary, pursuant to paragraph (1)(A) above, the Medicaid Program shall:

(A) Make a reasonable effort to give the beneficiary prompt oral notice of the delay,
(B) Give the beneficiary written notice, within two days of a decision based on paragraph (1)(B) above, of the reason for its decision to extend the time and an explanation of the right to file a grievance if the beneficiary disagrees with the decision, and
(C) Resolve the appeal as expeditiously as the beneficiary's health requires and no later than the date the extension expires.

(3) Maximum Time for Resolution of Appeals

(A) The maximum time, including any extensions, is:

(i) 44 days for standard resolution of an appeal (30 days plus 14 days), or
(ii) 17 days for expedited resolution of an appeal (72 hours plus 14 days).

(p) Expedited Resolution of Internal Appeal

(1) The Medicaid Program shall have an expedited process for resolving internal appeals when:

(A) It determines that the standard for expedited resolution is met, when the request is from the beneficiary, or
(B) The provider indicates that the standard for expedited resolution is met, when a provider makes a

request on a beneficiary's behalf or supports a beneficiary's request.

(2) Standard for Expedited Resolution: The standard for expedited resolution of an internal appeal is that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(3) Denial of Request for Expedited Resolution of Appeal, Including Timeframe

(A) If the Medicaid Program determines that the standard for an expedited appeal is not met, the Medicaid Program shall:

(i) Resolve the appeal in accordance with the standard timeframe,
(ii) Make reasonable efforts to give the beneficiary prompt oral notice of the denial, and
(iii) Send written notice of the reason for the denial to the beneficiary within two days of the oral notice. The notice shall explain that the request does not meet the criteria for expedited resolution, that the appeal will be processed within the standard 30-day timeframe, and give notice of the right to file a grievance of the denial of the request for expedited resolution.

(4) Approval of Request for Expedited Resolution of Appeal, Including Timeframe

(A) If the Medicaid Program determines that the expedited appeal request meets the standard for expedited resolution, the Medicaid Program shall resolve the appeal and notify the beneficiary of the decision within 72 hours of its receipt of the expedited appeal. The Medicaid Program shall make reasonable efforts to give the beneficiary prompt oral notice of the denial which shall be followed by written notice.

(5) Right to Expedited State Fair Hearing: A beneficiary may request an expedited State fair hearing pursuant to 8.100.5(k) when the Medicaid Program approved the request for expedited resolution of an internal appeal:

(A) But the decision is wholly or partially adverse to the beneficiary, or
(B) The expedited internal appeal is not timely resolved by the Medicaid Program.

(q) Notice of Resolution of Internal Appeal: See 8.100.3(c).

8.100.5 <u>State Fair Hearings</u>

(a) State Fair Hearing System: AHS shall maintain a fair hearing system, including an expedited fair hearing process, that meets the requirements of the United States Constitution, the Vermont Constitution, 42 CFR § 431, Subpart E, the due process standards set forth in <u>Goldberg v. Kelly</u>, 397 U.S. 254 (1970), the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act, and implementing regulations.

(b) State Fair Hearing Entity: The Human Services Board is an independent part of AHS that is designated by state law to conduct State fair hearings when the final resolution of an internal appeal is adverse to the beneficiary.[2]

(c) Other Applicable Rules: Fair hearings shall be conducted in accordance with rules promulgated by the Human Services Board pursuant to 3 VSA § 3091(b).[3]

(d) Notification of State Fair Hearing Rights

[2] 3 VSA § 3090(b), 3091(a)
[3] Human Services Board Fair Hearing Rules, Code of Vermont Rules 13-020-002 (Part 1000)

(1) AHS shall issue and publicize its hearing procedures.

(2) AHS shall, at the times specified at paragraph (d)(3) below, inform every applicant or beneficiary in writing of the following:

(A) The right to a State fair hearing and right to request an expedited State fair hearing;
(B) The methods for requesting a State fair hearing,
(C) That the beneficiary can represent him or herself or use counsel, a relative, a friend, or other spokesperson, and
(D) The timeframes in which AHS must take final administrative action on a State fair hearing request.

(3) AHS shall provide the information at paragraph (d)(2) above:

(A) At the time an individual applies for Medicaid, and
(B) When a beneficiary requests a State fair hearing.

(e) Right to a State Fair Hearing; Exhaustion Requirement: Except for a beneficiary who seeks review of a service not subject to the internal appeal process pursuant to 8.100.1, a beneficiary shall have a right to request a State fair hearing only after exhausting the internal appeal process or if s/he is deemed to have exhausted the process pursuant to 8.100.4(d).

(f) When a Hearing is Required; Exception: AHS shall grant an opportunity for a hearing to any beneficiary who is dissatisfied with the final resolution of the internal appeal. There is no right to a hearing if the sole issue is a state or federal law requiring an automatic change adversely affecting some or all beneficiaries. A beneficiary retains the right to a State fair hearing in an appeal of the application of the law to the facts of an individual's case.

(g) Filing of State Fair Hearing Requests, Including Ongoing Continuing Services, and Timeframe

(1) Who May Request a State Fair Hearing: A beneficiary may request a State fair hearing, and a provider or an authorized representative may request a State fair hearing on behalf of the beneficiary, as consistent with state law and with the written consent of the beneficiary.

(2) How to Request a State Fair Hearing and ongoing continuing services:

(A) A beneficiary may request a State fair hearing and ongoing continuing services orally or in writing:

(i) By telephone,
(ii) Via mail,
(iii) In person,
(iv) Via the internet, and
(v) Through other commonly available electronic means.

(B) Time for Requesting a State Fair Hearing and ongoing continuing services: A beneficiary must request a State fair hearing within 120 days of the date the Medicaid Program mailed the notice of resolution of the internal appeal, or, when regarding services not subject to the internal appeal process pursuant to 8.100.1, within 120 days from the date the Medicaid Program mailed the notice of decision. A beneficiary who is receiving continuing services must request a State fair hearing and the continuation of services pending the outcome of the State fair hearing within 11 days after the Medicaid Program mails the notice of resolution of the internal appeal. The date of mailing by the Medicaid

Program is the postmark date. The postmark date is one business day after the date of the notice.

(h) AHS Responsibilities Related to State Fair Hearing Requests: AHS shall:

(1) Assure that the methods for requesting a State fair hearing include an opportunity for the beneficiary to request an expedited State fair hearing,
(2) Assist the beneficiary in submitting a State fair hearing request, and
(3) Not limit or interfere with a beneficiary's freedom to request a State fair hearing.

(i) Parties to the State Fair Hearing: The parties to the State fair hearing are the Medicaid Program and the beneficiary or his/her authorized representative or the legal representative of a deceased beneficiary's estate.

(j) Standard Timeframe for Final Administrative Action[4]; Extension of Time

(1) AHS, which may include the Human Services Board, shall take final administrative action within 90 days from the date the beneficiary filed an internal appeal with the Medicaid Program, not including the number of days the beneficiary took to subsequently file for a State fair hearing. For services not subject to the internal appeal process pursuant to 8.100.1, AHS shall take final administrative action within 90 days from the date the beneficiary requests a State fair hearing.

(2) Extension of Time: AHS, which may include the Human Services Board, shall take final administrative action within the timeframes in paragraph (j)(1) above except in unusual circumstances. If there are unusual circumstances, AHS shall document the reason for the delay in the beneficiary's record. Unusual circumstances occur when:

(A) AHS cannot reach a decision because the beneficiary requests a delay or fails to take an action that is required for resolution of the State fair hearing request, or
(B) There is administrative or other emergency that is beyond the control of AHS.

(k) Expedited Resolution of State Fair Hearing, Including Timeframe

(1) Standard for Expedited Resolution: AHS shall maintain an expedited State fair hearing process for a beneficiary to request expedited resolution of a State fair hearing when the Medicaid Program has determined that the time for standard resolution may jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

(A) Right to Expedited State Fair Hearing: A beneficiary may request expedited resolution of a State fair hearing when the Medicaid Program has determined that the standard for such resolution, described at paragraph (k)(1) above has been met, and, for services that are subject to the internal appeal process:

(i) The Medicaid Program did not adhere to the time limit for resolution for an expedited internal appeal, or
(ii) The Medicaid Program timely resolved the expedited internal appeal but the notice of resolution was wholly or partially adverse to the beneficiary.

(2) Time for Expedited Resolution: AHS, which may include the Human Services Board, shall take final administrative action as expeditiously as the beneficiary's health requires but not later than three working days after AHS receives, from the Medicaid Program, the case record and information for an appeal that the Medicaid Program indicates met the standard for expedited appeal.

[4] The State fair hearing process is subject to 3 VSA § 3091(h).

(3) Extension of Time for Resolution: AHS, which may include the Human Services Board, must take final administrative action within the timeframe in paragraph (k)(2) above except in unusual circumstances. Unusual circumstances are defined at paragraph (j)(2) above. If there are unusual circumstances, AHS may extend the time for resolution consistent with paragraph (j)(2) above. AHS shall document the reason for the delay in the beneficiary's record.

(l) Request for Review Made To Human Services Board Prior to Exhaustion: See 8.100.4(d)(3)

8.100.6 Continuation of Services While Internal Appeal or State Fair Hearing is Pending; Beneficiary Liability for Services

(a) Request for Continuing Services: The Medicaid Program shall continue the beneficiary's services if the following circumstances are met:

(1) The beneficiary appeals in a timely manner,
(2) The beneficiary timely files for continuing services which means within 11 days of the Medicaid Program sending the notice of adverse benefit determination, or before the effective date of the proposed adverse benefit determination, whichever is later,
(3) The appeal involves the termination, suspension, or reduction of a previously authorized service,
(4) The services were ordered by an authorized provider, and
(5) The period covered by the original authorization has not expired.

(b) Duration of Continuing Services: At the beneficiary's request, the Medicaid Program shall continue or reinstate services while the internal appeal and State fair hearing is pending, until one of the following occurs:

(1) The beneficiary withdraws the internal appeal or request for a State fair hearing,
(2) The beneficiary fails to request a State fair hearing and continuation of benefits within 11 days of the date the Medicaid Program mails the notice of resolution of the internal appeal.
(3) There is a final administrative decision on the State fair hearing request that is adverse to the beneficiary.

(c) Exception: Continuation of services without change does not apply when the appeal is based solely on a federal or state law requiring an automatic change adversely affecting some or all beneficiaries, or when the decision does not require the minimum advance notice pursuant to 42 CFR § 431.213.

(d) Beneficiary Liability for Services Furnished While Internal Appeal or State Fair Hearing is Pending:

(1) The Medicaid Program may recover from the beneficiary the cost of services furnished to the beneficiary while the internal appeal and State fair hearing were pending if the following criteria is met:

(A) The services were furnished solely because of the beneficiary's request for continued services,
(B) The beneficiary withdraws the appeal before the internal appeal decision or State fair hearing decision is made, or following the final resolution of an internal appeal or a State fair hearing upholding the Medicaid Program's adverse benefit determination, and
(C) Recovery from the beneficiary is consistent with AHS policy on recovery and the Medicaid Program determines that the beneficiary should be liable for the service costs.

(2) If an internal appeal or a State fair hearing relates to a concurrent review determination for emergency services or urgent care, the service shall be continued without liability to the beneficiary until the Medicaid Program has notified the beneficiary of its final resolution, consistent with State fair hearing rules.

8.100.7 Providing or Paying for Services Following Resolution of an Internal Appeal or a State Fair Hearing

(a) 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 beneficiary's favor before the hearing, the Medicaid Program shall authorize or provide the disputed services as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date the Medicaid Program receives notice reversing the determination.

(b) 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 for those services in accordance with State policy.

8.100.8 Beneficiary Grievances

(a) Grievance System and the Right to Grieve: The Medicaid Program shall have a grievance system that allows beneficiaries to grieve a matter that is not an adverse benefit determination including denial of a request for an expedited appeal, an extension of time by the Medicaid Program for deciding a service authorization or resolving an internal appeal, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the failure to respect a beneficiary's rights.

(b) Filing a Grievance

(1) Who May Grieve: A beneficiary, authorized representative, or provider may file a grievance with the Medicaid Program consistent with the requirements at 8.100.4(e)(1).

(2) How to Grieve: A beneficiary may file a grievance orally or in writing.

(3) Timeline for Filing Grievance: A beneficiary may file a grievance at any time.

(c) Assistance: The Medicaid Program shall give beneficiaries assistance in the grievance process consistent with the requirements of 8.100.4(g).

(d) Written Acknowledgement: The Medicaid Program shall mail the beneficiary acknowledgement of the grievance within five days of receipt of the grievance.

(e) Withdrawal of Grievances: Grievances may be withdrawn orally or in writing at any time. The Medicaid Program shall acknowledge a beneficiary's oral withdrawal in writing within five days.

(f) No Punitive Action Against Providers: The Medicaid Program shall ensure that no punitive action is taken against a provider who files a grievance or supports a beneficiary's grievance.

(g) Grievance Process

(1) Grievance Reviewer:

(A) Individuals who are making the decision on a grievance shall not have been involved in any previous level of review or decision making, nor be a subordinate of such individual.

(B) A grievance shall be decided by an individual who possesses the requisite clinical expertise in treating the beneficiary's condition when deciding:

(i) A grievance regarding the denial of a request for expedited resolution of an appeal, or
(ii) A grievance that involves clinical issues.

(2) Information to Resolve Grievance: The Medicaid Program shall act promptly and in good faith to obtain any necessary information to resolve the grievance. “Necessary information” may include information described at 8.100.4(k).

(3) Opportunity to See Records: The Medicaid Program shall provide the beneficiary, free of charge, with all the information in its possession or control relevant to the grievance process and the subject of the grievance, including:

(A) The beneficiary’s case record, including medical records and other records and documents related to the grievance, and
(B) Other information relevant to the beneficiary’s grievance including relevant policies and procedures.

(h) Time for Resolving; Grievance Not Timely Resolved; Extension of Timeframe

(1) Time for Resolving: The Medicaid Program shall decide the grievance and provide notice of the decision as expeditiously as the beneficiary’s health condition requires but not more than 90 days from its receipt of the grievance.

(2) Grievance Not Timely Resolved: If the Medicaid Program does not act upon the grievance within the time for resolution, the beneficiary may request an internal appeal pursuant to the definition of adverse benefit determination at 1.101.

(3) Extension of timeframe: The Medicaid Program may extend the timeframe for deciding a grievance consistent with the requirements of 8.100.4(o).

(i) Requirements of Notice of Resolution: See 8.100.3(d).

(j) Grievance Review Process

(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 11 days after the Medicaid Program mails the notice of resolution of the grievance. The mailing date of the notice is the postmark date. The postmark date is one business day after the date of the notice.

(2) Written Acknowledgement: The Medicaid Program shall acknowledge a grievance review request within five days of receipt.

(3) Grievance Reviewer: The grievance review shall be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of such individual.

(4) Disposition

(A) The grievance review shall assess the merits of the grievance issue, the process employed in reviewing the issue, and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented.

(B) The beneficiary shall be notified in writing of the findings of the grievance review within 90 days.