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MEDICAID BULLETIN

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Home and Community-Based Services (HCBS) Grievance System

On May 10, 2024, the Centers for Medicaid and Medicare Services (CMS) published the Ensuring Access to Medicaid Services Final Rule (Access Rule). Under this rule, states must develop a comprehensive grievance system to support all Fee-For-Service (FFS) individual home and community-based services (HCBS).

The purpose of this bulletin is to provide an overview of the new requirements that apply only to HCBS delivered as a FFS benefit. DMAS will release a future Medicaid provider memo with more details on requirements that providers will be required to follow to comply with this rule.

Virginia's Medicaid program provides Commonwealth Coordinated Care Plus (CCC Plus) waiver services through the Cardinal Care Managed Care program with a small percentage of CCC Plus enrolled individuals receiving services through the Fee for Service (FFS) delivery system without a corresponding managed care enrollment. The Developmental Disability (DD) Waiver services are always delivered in the FFS system while most individuals are enrolled in Cardinal Care for their general medical care services. Because of the enrollment rules, the majority of the CCC Plus HCBS grievances must be filed through the individuals selected Managed Care Organization while the DD Waiver service-related grievances will be filed using the new HCBS "FFS" Grievance System because all DD Waiver services are "carved out" and delivered outside of the Cardinal Care delivery system.

What is a Grievance?

In accordance with CFR § 441.301(c)(7)(ii), a grievance is an expression of dissatisfaction or complaint related to the State's or a provider's performance regarding the following, regardless of whether the individual requests that remedial action be taken to address the area of dissatisfaction or complaint:

- the person-centered service plan requirements at § 441.301(c)(1) through (3) which include: person-centered processes, person-centered plans and review and revisions to the person-centered plan; and

- the HCBS settings requirements at § 441.301(c)(4) through (6) which include: home and community-based settings requirements, settings determined to not be home and community based, and home and community-based settings compliance.

Who can file an HCBS Grievance?

Any individual receiving HCBS waiver services through the following waivers can file a grievance using the HCBS FFS Grievance System:

Developmental Disability Waivers

- Building Independence Waiver
- Community Living Waiver
- Family and Individual Supports Waiver

CCC Plus Waiver (FFS only)*

* *MCO enrolled individuals in the CCC Plus Waiver must follow their selected Cardinal Care Managed Care plan's grievance process.*

In accordance with CFR § 441.301(c)(7)(iii)(A)(1), another individual or entity may file a grievance on behalf of the waiver individual or provide the waiver individual with assistance or representation throughout the grievance process, with the written consent of the waiver individual or the waiver individual's authorized representative. In addition, per CFR § 441.301(c)(7)(iii)(B)(3), states will ensure that punitive or retaliatory action is neither threatened nor taken against an individual filing a grievance or who has had a grievance filed on their behalf.

Examples of who can file a grievance on behalf of an individual (at the individual's request):

- Providers
- Support Coordinators
- Family members and Guardians
- Mandated Reporters

Cardinal Care Grievance Process

CCC Plus Waiver individuals enrolled in one of the five Cardinal Care managed care plans, shall follow the prescribed grievance filing process as indicated by their selected managed care plan. Individuals can find these prescribed processes and instructions on how to file a grievance in their health plan's Member Handbook.

How can providers prepare?

Providers are required to comply with the investigation and resolution of a grievance made on behalf of a waiver individual. Under no circumstances may a provider discourage or prevent waiver individuals, their family/caregivers, or provider staff from filing a grievance.

A forthcoming Medicaid Memo and manual changes will require providers to add a section to their home and community-based rights disclosure that will inform individuals at least annually of their right to file a grievance and what constitutes a grievance. Providers will be required to review this information with the individual upon admission to the service and annually thereafter. In addition, providers are required to train their staff on the grievance process and how a grievance can be submitted on behalf of the individual.

DMAS has added a sample of this form to the HCBS toolkit at https://www.dmas.virginia.gov/media/05wbj5lq/grievance-rights-and-responsibilities.pdf

DMAS is developing the technology to support this system and will release more information prior to the release of this platform.

For Questions, please refer to the contact information below.

To avoid disruption to claims payment through FFS and the MCOs providers must periodically check the DMAS provider portal, also known as the Provider Services Solution (PRSS), to ensure that the provider's enrollment, contact information, and license information is up to date, for all of the provider's respective service locations. Under federal rules, MCOs and DMAS are prohibited from paying claims to network providers who are not enrolled in PRSS. Additional information is provided on the MCO Provider Network Resources webpage and includes links to resources, tutorials and contact information to reach Gainwell with any provider enrollment or revalidation related questions. Dental providers should continue to enroll directly through the DMAS Dental Benefits Administrator, DentaQuest.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	https://vamedicaid.dmas.virginia.gov/
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996

Provider Appeals

DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/

Managed Care Programs

Cardinal Care Managed Care and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

Cardinal Care Managed Care	https://www.virginiamanagedcare.com/en
PACE	Program of All-inclusive Care
Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	https://www.aetnabetterhealth.com/virginia/providers/index.html Prior Auth requests can be faxed or called to the following numbers: Phone: 1-800-279-1878 Med4/ FAMIS Fax: 1-866-669-2454 CCC Plus Fax: 1-855-661-1828
Anthem HealthKeepers Plus	http://www.anthem.com/ Prior Authorization information can be found here: https://providers.anthem.com/virginia-provider/resources/prior-authorization-requirements Call Provider Services: 1-800-901-0020 TTY: 711 Fax medical prior authorization request forms to: Inpatient fax: 1-866-920-4095 Outpatient fax: 1-800-964-3627 LTSS fax: 1-844-864-7853
Humana Healthy Horizons Provider Services Call Center	https://provider.humana.com/medicaid/virginia-medicaid Prior Authorization information can be found here: https://provider.humana.com/medicaid/virginia-medicaid/prior-authorization Submit request via Availaty porta, phone or fax: Phone requests: 1-855-223-9868 or 1-844-881-4482 (TTY: 711) Fax complete form to: 1-877-486-2621.
Sentara Community Plan	1-800-881-2166 https://www.sentarahealthplans.com/providers Submit authorizations via portal or phone Portal information can be found here: https://www.sentarahealthplans.com/en/providers/claims-authorizations/authorizations Phone request: 1-757-552-7474 or 1-800-229-8822
United Healthcare	www.uhcprovider.com/ 1-844-284-0146 To notify UHC or request a medical prior authorization: Portal information can be found here: UHCprovider.com/priorauth or call provider services 1-844-284-0146
Acentra Health Behavioral Health and Medical Service Authorizations	https://vamedicaid.dmas.virginia.gov/sa 1-804-622-8900

Dental Provider	1-888-912-3456
DentaQuest	
Fee-for-Service (POS)	https://www.virginiamedicaidpharmacyservices.com/
Prime Therapeutics	1-800-932-6648