Michigan Department of Health & Human Services

Appeals and Grievances Under the New Medicaid Managed Care Rules

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Medicaid Managed Care Rules

- May 2016: CMS published the final rule for 42 CFR Parts 431, 433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability
- Rule was effective for all MCO/PAHP/PIHP contracts beginning on or executed after July 1, 2017.
- Most pertinent for this discussion are the changes to the Grievance and Appeal rules for enrollees of Medicaid MCO, PIHP and PAHPs 438.400 et seq.
- All MCOs, PIHPs and PAHPs must implement a system to handle appeals and grievances as well as processes to collect and track information about appeals and grievances.

Grievances and Appeals Definitions

Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

State Fair Hearing means the process set forth in subpart E of part 431 of this chapter.

Grievances and Appeals Definitions Continued

ADVERSE BENEFIT DETERMINATIONS (ABD) as defined in *42 CFR 438.400(b)*

- Denial or limitation of a requested service
- Reduction/suspension/termination of a previously authorized service
- Denial of payment of service (whole or partial)
- Failure of the MCO/PIHP/PAHP to act in the mandatory timeframes for resolving grievances and appeals
- Denying a resident of a rural county with only one MCO option the right to obtain services outside the network

- PRACTICE NOTE: Denying a request to dispute a financial liabilities including cost sharing, premiums, etc. is also an adverse benefit determination, BUT at this time the entities do not have any responsibilities as it relates to determining or collecting these financial liabilities. HOWEVER, if you receive a complaint or grievance related to this area we would expect the health plan to assist the enrollee in understanding where such complaint/grievance should be sent.

Notice of Adverse Benefit Determination

- NOTICE MUST:
  - Describe the determination the MCO, PIHP, or PAHP has or intends to make
  - The reason for the adverse benefit determination
  - The enrollee's right to request an appeal that includes
    - Exhausting the appeal
    - Right to request a State Fair Hearing
  - How to exercise their appeal rights
  - The circumstances that an enrollee may expedite the appeal process and how to request an expedited appeal

- TIME FRAME FOR NOTICE DEPENDS ON THE ACTION BEING TAKEN
  - Termination, suspension, or reduction of previously authorized Medicaid-covered service - **10 days advance notice**
  - Denial of Payment—at the time of any action affecting the claim
  - Standard Authorization for Services - **14 days** (timeframe can be extended - enrollee can file a grievance about extension)
  - Expedited authorization - **72 hours**
  - If authorization timeframes (including extension) expire without a decision - Not sending a notice is considered a denial and an adverse benefit determination

MCO/PIHP/PAHP Internal Appeal

- MCO/PIHP/PAHP may have only one level of appeal for enrollees.
- An enrollee has 60 calendar days from the date on the Adverse Benefit Determination Notice to file an appeal with the MCO/PIHP/PAHP.
- The enrollee has 120 days to request a state fair hearing after receiving the notice of appeal resolution.
- Benefits may need to continue.
- Enrollees must exhaust the MCO/PIHP/PAHP's internal appeals process prior to requesting a state fair hearing. If a MCO/PIHP/PAHP doesn't meet the required notice and timing requirements, enrollees are deemed to have exhausted the internal appeal process.
- Practice Note: Enrollees may appeal externally to DIFS once the internal appeal is exhausted. The external appeal may occur simultaneously with the MCO/PIHP/PAHP for expedited internal appeals.

Once an appeal is received what must the MCO/PIHP/PAHP do?

- Assist an enrollee with the appeal process
- Acknowledge receipt of the appeal
- The appeal must be handled by with a person at the entity who has:
  - Not been involved in any decision making on the matter to this point
  - Appropriate clinical expertise in treating enrollee's condition/disease; and
  - Considered all information provided by the enrollee or their representative
- Ensure oral inquiries to appeal are handled correctly including proper guidance to the enrollee on how to follow-up on the oral request in writing
- Provide the enrollee an opportunity to be heard
- Provide records free of charge and sufficiently in advance of the resolution timeframes
- Include the enrollee, the representative or the legal representative of an enrollee's estate as parties

Appeal Resolution

1. The MCO/PIHP/PAHP must resolve all appeals as expeditiously as the enrollee's health condition requires.

2. A standard non-expedited appeal must be resolved in **30 days**.

3. A 14 day extension may be permissible. However, an enrollee may file a grievance of an entity's extension of the timeframe resolution.

4. Per the insurance code, the MCO/PIHP/PAHP are only permitted a 10 business day extension. Best practice may be to only extend for 10 days to comply with both Medicaid and the insurance code.

5. The appeal is considered exhausted and enrollee may file for a State Fair Hearing if the time frames are not met.

Practice Note: Time periods for appeal do not start until the MCO/PIHP/PAHP receives written authorization form for an appeal filed by a third party

Appeal Resolution-Standard (extension)

A 14 day extension of the 30 day time frame is permissible if/when:

a. The enrollee requests an extension; or

b. The MCO/PAHP/PIHP can show that additional information is needed and the delay is in the enrollee's interest.

When an extension happens the MCO/PIHP/PAHP must:

(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.

(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

When can an appeal be expedited?

- An appeal may be expedited if it involves a matter where the time frame for standard resolution could “jeopardize the enrollee’s life, physical or mental health or ability to attain/maintain/regain maximum function.”
- The appeal should either be from a Provider or should include a Provider’s support that the appeal should be expedited if it is from the enrollee.
- Practice Note: An expedited appeal may be requested orally and does NOT need to be followed up in writing.

Appeal Resolution-EXPEDITED

What to do if appeal is NOT an expedited

Within 72 hours…

1. Deny the appeal as an expedited appeal
2. Move the appeal to the standard resolution time frame

What to do if appeal is expedited

Within 72 hours…

1. Provide an appeal resolution to the enrollee; or
2. Extend the timeframe to resolve the expedited appeal up to 14 days if

   -enrollee requests an extension

   -MCO/PIHP/PAHP can show that additional information is needed and the delay is in the enrollee's interest

Appeal Resolution-EXPEDITED

When timeframe for expedited appeal is extended, the Plans **MUST:**

-Resolve the appeal as expeditiously as the enrollee's health condition requires;

-Make reasonable efforts to provide oral notice of the delay;

-Send written notice to enrollees within **2** calendar days of the decision to extend the timeframe;

-Inform the enrollee of the right to file a grievance if he or she disagrees with the decision.

Notice of Appeal Resolution-Standard

- Must be in writing;
- State the result of the appeal and date;
- If the appeal is not favorable to the enrollee the MCO/PIHP/PAHP must include the following information in the notice of appeal resolution:
  - The right to request a fair hearing and how to make such a request;
  - The right to request and receive benefits while the state fair hearing is pending and how to make such a request;
  - That the enrollee may be liable for costs of continued benefits.

Practice Note: At this time, the Medicaid Provider Manual, significantly limits when a beneficiary or enrollee may be charged for services provided during the pendency of an appeal or a MCO/PIHP/PAHPs ability to charge and collect such costs.

Resolution of Appeal-Expedited

- MCO/PIHP/PAHP must make reasonable efforts to provide oral notice of the expedited appeal's resolution.
- MCO/PIHP/PAHP must establish process and procedures for handling and resolving expedited appeals.
- MCO/PIHP/PAHPs may not take any punitive or retaliatory action against any provider who requests an expedited appeal or supports an enrollee's expedited appeal.

CONTINUATION OF BENEFITS

To continue benefits during the pendency of the an appeal or state fair hearing, and enrollee must:

- Timely file an appeal an adverse benefit determination. Which is the **later** of:

  (i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination.

  (ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination.

- Additional Requirements:
  - Appeal must involve a previously authorized service that is being terminated/reduced/suspended.
  - Services had been ordered by an authorized provider.
  - Period covered by the original authorization has not expired.
  - The enrollee must request a state fair hearing and continuation of benefits within 10 calendar days of the date the notice of adverse resolution was mailed.

GRIEVANCES

- An enrollee may file a grievance at any time either orally or in writing.
- MCO/PIHP/PAHP MUST:
  - Acknowledge receipt of the grievance;
  - Ensure the initial decision makers or their subordinates are not involved in the grievance review or resolution process;
  - Provide opportunity to provide further information in support of their grievance;
  - Grievance disposition must occur in 90 calendar days and be provided in a format that meets the minimum standards of 42 CFR 438.10.

Practice note: Per NCQA standards, an enrollee has the right to appeal a grievance decision.

To recap…WHAT CHANGED

Notice of Action

No exhaustion required by State of Michigan

Enrollee could file for a state fair hearing and need not file an appeal to the entity at all

Old Timeframes

- Enrollee had to be given no less than 20 days but not to exceed 90 days to file an appeal
- No less than 20 days but not to exceed 90 days to resolve an appeal
- 3 work days to resolve an expedited appeal
- Time period specified by the State to file for a State Fair Hearing (no less than 20 days or in excess of 90 days)
- Continuation of benefits: 10 days

Notice of Adverse Benefit Determination

Exhaustion required

Enrollee must file and complete the MCO/PIHP/PAHP appeal process

New Timeframes

- Enrollee has 60 days to file an appeal
- 30 days to resolve an appeal
- 72 hours to resolve an expedited appeal
- Enrollee 120 days to file for a State Fair Hearing
- Continuation of benefits is 10 **calendar** days

OTHER MCO/PIHP/PAHP requirements

- Plans must provide information related to the grievance and appeal system to your providers and subcontractors
- **Plans must maintain records and conduct ongoing monitoring related to the grievance and appeal system.** Record of each grievance or appeal, means the following information is to be maintained:
  - General description of the appeal or grievance
  - Name of the enrollee or covered person the appeal or grievance involved
  - Dates: Date the appeal/grievance was received, the date of each review and review meeting (if one occurs), and the date of resolution (at each level)
  - Resolution of the appeal or grievance

  Practice Note: These records must be kept in a manner that is accessible to the State and available upon request to CMS.

Questions?