Medicaid Managed Care Model Provisions:

Grievances and Appeals

Issue No. 1

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Introduction

The National Health Law Program has focused on the legal provisions governing Medicaid managed care for nearly three decades. The Medicaid program has changed significantly and now requires millions of older people, people with disabilities, and those with Limited English Proficiency to enroll in managed care. Yet, the regulations have not been updated for more than a decade and no longer reflect the needs of the covered populations, or current clinical practices and technological capabilities. To address these deficiencies, NHeLP has developed a complete set of modernized model federal regulations.[1]

To focus advocates on areas that were significantly updated, NHeLP has prepared a series of issue briefs featuring selected model provisions governing five aspects of Medicaid managed care: beneficiary grievances and appeals, enrollment and disenrollment, network adequacy, accessibility, and quality and transparency.[2] We encourage policy makers and advocates to use these model provisions to update existing regulations, policies, and managed care contracts.

TOPIC #1: GRIEVANCES AND APPEALS

Background on Managed Care Grievances and Appeals:

All Medicaid beneficiaries, including those enrolled in managed care plans, are entitled to written notice and an opportunity for a hearing before an adverse action is taken against them. In managed care systems, federal law currently provides that an action is a denial or limited authorization of a service; reduction, suspension, or termination of a previously authorized services; partial or total denial of payment for services; failure to provide

[1] We used the current federal Medicaid managed care regulations at 42 C.F.R. part 438 as the starting point for developing our comprehensive model provisions. The regulations address state obligations, enrollee rights and responsibilities, quality assessment and improvement, external quality review, grievance systems, certification and program integrity, sanctions, and conditions for federal funding.

[2] Our issue brief on Quality and Transparency will be issued later in the fall of 2014.

services in a timely manner; or denial of a rural resident's request to obtain services out of network. Beneficiaries enrolled in managed care plans are also entitled to file grievances about any matter other than an action.[1]

Beneficiaries must receive written notice explaining the action, the reason for the action, and an explanation of hearing rights, right to representation, and the right to continued coverage of services pending a hearing decision (sometimes known as "aid paid pending").[2] The right to continued coverage of services that have been reduced, suspended, or terminated is a crucial component of due process because it enables vulnerable beneficiaries with ongoing need for services to challenge a decision before the services actually end.[3]

Allowing managed care plans to terminate coverage at the end of an authorization period but before a final hearing decision is made violates the constitutional guarantee of due process. And, such a policy makes no sense when more and more Medicaid managed care enrollees have disabilities and chronic conditions that will not improve and will require services to continue longer.

A hearing must be conducted at a reasonable time, date, and place by an impartial hearing official. At the hearing, claimants must be allowed to present witnesses and arguments, establish facts, and cross-examine adverse witnesses.[4] These rights are guaranteed not only by the Medicaid statute and regulations, but also by the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.[5]

A State Medicaid program's use of managed care does not affect the ultimate responsibility of the single state Medicaid agency to ensure that individuals receive due process, including timely and adequate notice, continued coverage pending a final hearing decision, and access to the State's fair hearing system.[6]

Recurring Problems: Managed care enrollees have faced barriers when attempting to obtain redress through Medicaid grievance and appeal systems. These include:

- Failure of managed care plans and other contractors to comply with requirements governing grievances and appeals;
- Failure of State agencies and managed care plans to treat significant decisions made by plans as actions giving rise to notice and hearing rights;
- Failure to include laws or rules supporting an action in the notice of action;
- Inability of Prepaid Ambulatory Health Plan (PAHP) enrollees to file grievances by because the federal regulations do not require that those entities provide access to grievance systems;
- Lack of uniformity and variation in quality between different plans' grievance systems resulting from the failure of the federal regulations to prescribe uniform standards;
- Inability of enrollees with disabilities and limited English proficiency to access the grievance and appeal system, contrary to the requirements of Section 504 of the Rehabilitation Act and Title VI of the Civil Rights Act; Widespread delays in obtaining hearings and hearing decisions and failure to issue decisions

in a timely manner, which persist despite advances in information technology and increasing use of the internet;
- Widespread delays in obtaining hearings and hearing decisions and failure to issue decisions in a timely manner, which persist despite advances in information technology and increasing use of the internet;
- Violation of the constitutional right to obtain continued coverage of terminated services pending a final appeal decision. This is due to the fact that current federal regulations require only that plans continue to cover services through the end of an authorization period, which may elapse long before a hearing decision is issued. This problem is increasingly common as plans attempt to limit services for costly populations. Allowing managed care plans to terminate coverage at the end of an authorization period *before* a final hearing decision is made violates the constitutional guarantee of due process. Moreover, it makes no sense when more and more Medicaid managed care enrollees have disabilities and chronic conditions that will not improve and will require services to continue longer term.

These model provisions address these problems by:

- Explicitly requiring managed care contractors to follow specific requirements governing grievances and appeals and to obtain State certification of compliance;
- Clarifying that certain important determinations and failure to act in a timely manner are actions triggering notice and hearing rights;
- Requiring inclusion of the laws or rules supporting an action in the notice of action;
- Providing for enrollees of PAHPs to file grievances;
- Imposing specific requirements governing grievance systems to ensure greater consistency and quality between plans and among different States' Medicaid managed care systems;
- Imposing detailed requirements upon plans and State agencies to ensure that they comply with federal requirements providing that people with disabilities and with Limited English Proficiency have access to information about the grievance and appeals systems, receive understandable and accessible notices, and are able to file grievances.
- Tightening timeframes within which grievance decisions must be provided;
- Providing for continued coverage of terminated or interrupted services pending a final appeal decision, regardless of whether an authorization period has expired.

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Medicaid Managed Care Grievance and Appeal Rights

Note: These model provisions are based on NHeLP's comprehensive set of modernized Medicaid managed care regulations.

General Definitions:

Prepaid Managed Care Plan (PMCP): A Medicaid managed care organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP), as defined by 42 C.F.R. § 438.2.

Primary Care Case Manager (PCCM): A physician, entity employing physicians, or (at state option) another health care practitioner that contracts with a State to provide case management services, as defined by 42 C.F.R. § 438.2.

LEP means Limited English Proficiency, as defined by the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003).

Section One: Definitions

(a) *Definitions*. As used in this subpart, the following terms have the indicated meanings:

Action means—

In the case of a Prepaid Managed Care Plan (PMCP)—

(1) The denial or limited authorization of a requested service, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service;
(4) The failure to provide services in a timely manner, as defined by the State;
(5) Denial of disenrollment or enrollment exemption requests;
(6) The failure of a PMCP to act within the timeframes provided in Section Four (b);
(7) A decision of the total budget for enrollees' services;
(8) Determination of a cost sharing amount;
(9) Failure of a PMCP to act within established timeframes, including failure to resolve a grievance; or
(10) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right to obtain services outside the network.

Appeal means a request for review of an action.

Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this Section. The term is also used to refer to the overall system that includes grievances and appeals handled at the PMCP level and access to the State fair hearing process. Possible subjects for grievances include, but are not limited to, the quality of services or continuity of care provided, the number and type of providers in the network, the amount of time required to travel to a provider, failure to provide information as otherwise required by these rules, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

Quality of care grievance means a grievance filed because the enrollee believes that any aspect of the care or treatment that he or she received failed to meet accepted standards of health care or caused or could have caused harm to the enrollee.

Section Two: General Requirements

(a) *The grievance system.*

(1) Each PMCP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system. Such a system must be based on written policies and procedures that, at a minimum, meet the conditions set forth in this subpart.

(2) Each PMCP must:

(i) obtain the State's written approval of the policies and procedures before implementing them;

(ii) provide for its governing body to approve and be responsible for the effective operation of the system;

(iii) provide for its governing body to approve and be responsible for the effective operation of the system;

(iv) ensure that punitive action is neither threatened nor taken against a provider to supports an enrollee's grievance or appeal or requests an expedited resolution;

(v) accept grievances and appeals, and requests for expedited disposition or resolution or extension of timeframes from an enrollee, an enrollee's representative, or provider acting on an enrollee's behalf;

(vi) provide to the enrollee and to his or her representative the notices and information required under this subpart;

(vii) refer, at the enrollee's request, for State review any quality of care grievance resolution within which the enrollee is dissatisfied.

(b) *Filing requirements*.

(1) *Authority to file.*

(i) An enrollee may file a grievance and a PMCP level appeal, and may request a State fair hearing.

(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.

(2) *Timing.* The State specifies a reasonable timeframe that may be no less than 30 days and not to exceed 90 days from the date on the PMCP's notice of action. Within that timeframe—

(i) The enrollee or the provider may file an appeal; and

(ii) In a State that does not require exhaustion of PMCP level appeals, the enrollee may request a State fair hearing.

(3) *Procedures.*

(i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the PMCP.

(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

Section Three: Notice of Action

(a) *Language and format requirements.*

(1) The notice must be in writing and must meet the language and format requirements of this Section to ensure ease of understanding.

(2) If the State, its contracted representative, or the PMCP or PCCM has information that the recipient has LEP, the notice must be provided in the recipient's non-English language and information on how to access all of the information in the recipient's language. For all other beneficiaries, an overview must include taglines in at least 15 languages informing individuals of the availability of written translations or oral assistance to understand the information provided and a toll-free telephone number to request assistance.

(3) If the State, its contracted representative, or the PMCP or PCCM has information that the recipient has a disability that requires an alternative format for notices, the notice must be provided in that alternate format and must include a large print tagline and information on how to request the notice in alternative formats.

(b) *Content of notice.* The notice must explain the following:

(1) The action the PMCP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) Any laws or rules that support or require the action.

(4) The enrollee's or the provider's right to file a PMCP appeal.

(5) If the State does not require the enrollee to exhaust the PMCP level appeal procedures, the enrollee's right to request a State fair hearing or if the State does require exhaustion, that the enrollee retains the right to request a fair hearing;

(6) The procedures for exercising the rights specified in this subpart.

(7) The circumstances under which expedited resolution is available and how to request it.

(8) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(9) How to obtain assistance in filing an appeal or requesting a State fair hearing.

(c) *Timing of notice.* The PMCP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 C.F.R. §§431.211, 431.213, and 431.214 of this chapter.

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

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R. §438.210(d)(1).

(4) If the PMCP extends the timeframe in accordance with §438.210(d)(1), it must—

(i) 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; and

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

(5) For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. § 438.210(d).

Section Four: Handling of Grievances and Appeals

(a) *General requirements.* In handling grievances and appeals, each PMCP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability, as well as ensuring that forms and notices are available in alternative formats.

(2) Acknowledge receipt of each grievance and appeal within 3 calendar days.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's specific condition or disease and the specific services requested by the recipient.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(4) Have an adequately staffed office that is designated as the central point for enrollee issues, including grievances and appeals; and

(5) Provide for submission of grievances and appeals in a non-English language or alternate format to accommodate the needs of individuals who have LEP or individuals with disabilities.

(b) *Special requirements for appeals.* The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing by the PMCP, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The PMCP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's State.

(5) Provide that enrollees who have LEP are provided language services throughout the appeals process including translated notices, oral language services at the appeal.

(6) Provide that enrollees who have disabilities and need written information in alternative formats or augmentative or auxiliary aids for communication are provided those aids throughout the appeals process including notices in alternative format, assistance at the appeal.

Section Five: Resolution and Notification: Grievances and Appeals.

(a) *Basic rule.* The PMCP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this Section.

(b) *Specific timeframes*.

(1) *Standard disposition of grievances.* For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 30 days from the day the PMCP receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 days from the day the PMCP receives the appeal. This timeframe may be extended under paragraph (c) of this Section.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the PMCP receives the appeal. This timeframe may be extended under paragraph (c) of this Section.

(c) *Extension of timeframes*.

(1) The PMCP may extend the timeframes from paragraph (b) of this Section by up to 14 calendar days, or 3 calendar days in the case of an expedited appeal, if—

(i) The enrollee requests the extension; or

(ii) Only in the case of a standard resolution under (b)(2), the PMCP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. In the case of an expedited appeal under (b)(3), the PMCP must show (to the satisfaction of the State agency, upon its request) that there is need for additional information and that the delay is in the enrollee's interest and will not jeopardize the enrollees' life or health or ability to attain, maintain, or regain maximum functions..

(2) *Requirements following extension.* If the PMCP extends the timeframes, for any extension not requested by the enrollee, it must give the enrollee written notice of the reason for the delay.

(d) *Format of notice*.

(1) *Grievances.* The State must establish the method PMCPs will use to notify an enrollee of the disposition of a grievance but any such method must provide for notice to be in writing.

(2) *Appeals.*

(i) For all appeals, the PMCP must provide written notice of disposition.

(ii) For notice of an expedited resolution, the PMCP must also make reasonable efforts to provide oral notice within 24 hours and a written notice no longer than 2 calendar days after the disposition.

(3) For individuals who have LEP, the notice must be:

(i) translated into the enrollee's language if the enrollee's language is prevalent; or

(ii) include a tagline in the enrollee's language informing the enrollee how to obtain the information contained in the notice in the enrollee's language.

(4) For individuals with disabilities who need written materials in an alternate format, the notice must be provided in that format.

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the PMCP action.

(f) *Requirements for State fair hearings*.

(1) *Availability.* The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 60 or in excess of 90 days from whichever of the following dates applies—

(i) If the State requires exhaustion of the PMCP level appeal procedures, from the date of the PMCP's notice of resolution; or

(ii) If the State does not require exhaustion of the PMCP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, within 90 days from the date on the PMCP's notice of action.

(2) *Parties.* The parties to the State fair hearing include the PMCP as well as the enrollee and his or her representative or the representative of a deceased enrollee's State.

(3) *Language Access and Disability Access.*

(i) For individuals who have LEP, the State must provide language services including translated notices and oral language services at the appeal.

(ii) For individuals who have disabilities and need written information in alternative formats or augmentative or auxiliary aids for communication, the State must provide those aids throughout the appeals process including notices in alternative format, assistance at the appeal.

Section Six: Expedited Resolution of Appeals

(a) *General rule.* Each PMCP must establish and maintain an expedited review process for appeals, when the PMCP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* The PMCP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution.* If the PMCP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with Section Four (b)(2);

(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

Section Seven: Information about the Grievance System to Providers and Subcontractors

(a) The PMCP must provide required information about the grievance system to all providers and subcontractors at the time they enter into a contract.

(b) To whom information must be furnished. (1) Each PMCP must provide the information specified in paragraph (b) of this Section to enrollees and to all providers and subcontractors at the time they enter into a contract.

(2) Each PMCP or, at State option, the State or its contracted representative must provide the information specified in paragraph (b) to all potential enrollees.

(c) *Required information.* The information that is provided under paragraph (a) of this Section must explain the grievance system through a State-developed or State-approved description and must include the following:

(1) With respect to State fair hearing:

(i) The right to hearing;

(ii) The method for obtaining a hearing; and

(iii) The rules that governing conduct of the hearing, including the right to representation.

(2) The right to file grievances and appeals.

(3) The requirements and timeframes for filing a grievance or appeal.

(4) The availability of assistance in the filing process.

(5) The right to represent himself or herself or to be represented by legal counsel or a relative or friend or other spokesperson.

(6) The fact that filing a grievance or appeal or requesting a State fair hearing will not adversely affect or impact the way the PMCP and their providers or the State agency treat the enrollee.

(7) The fact that, when requested by the enrollee:

(i) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and

(ii) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

(c) *Language, format, and timing requirements.* The information furnished under this Section must meet the language and format requirements and must be furnished to enrollees and potential enrollees at the times require by these rules.

(d) *Aggregate information.* Upon request, the PMCP must provide to enrollees, potential enrollees, and the general public, aggregate information based on the information required under Section Six.

Section Eight: Recordkeeping and Reporting Requirements

The State must require PMCP to maintain records of grievances and appeals as public records and must review the information as part of the State quality strategy.

Section Nine: Continuation of Benefits While the PMCP Appeal and the State Fair Hearing Are Pending

(a) *Terminology.* As used in this Section, "timely" filing means filing on or before the later of the following:

(1) Within ten days of the PMCP mailing the notice of action.

(2) The intended effective date of the PMCP's proposed action.

(b) *Continuation of benefits.* The PMCP must continue the enrollee's benefits if—

(1) The enrollee or the provider files the appeal timely;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized service;

(3) The services were ordered by an authorized provider;

(4) The enrollee requests extension of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the PMCP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal.

(2) Ten days pass after the PMCP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached after receiving timely notice of such right to seek a fair hearing pursuant to 42 C.F.R. § 431.210.

(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.

(d) *Enrollee responsibility for services furnished while the appeal is pending.* If the final resolution of the appeal is adverse to the enrollee, that is, upholds the PMCP action, the PMCP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b). To recover costs from an enrollee who has LEP or has a disability that requires information provided in alternate formats, the PMCP may only recover the cost of the services furnished to the enrollee while the appeal is pending if the PMCP can document that it provided the enrollee with information about recovery in the enrollee's language or in an alternate format to meet the needs of an individual with a disability.

Section Ten: Effectuation of Reversed Appeal Resolutions.

(a) *Services not furnished while the appeal is pending.* If the PMCP or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PMCP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but in no event more than ten days from the date of the fair hearing decision.

(b) *Services furnished while the appeal is pending.* If the PMCP or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the PMCP or the State must pay for those services, in accordance with State policy and regulations.

ENDNOTES

[1] 42 C.F.R. § 438.400, *see also* 42 C.F.R. § 438.408(f) (providing that all enrollees have the right to request a fair hearing).
[2] 42 C.F.R. § 438.404.
[3] *See Goldberg v. Kelly*, 397 U.S. 254, 264 (1970) (holding that only a pre-termination hearing affords proper due process.)
[4] *Id.* § 438.
[5] 42 C.F.R. § 431.240.
[6] 42 C.F.R. §§ 438.228, 438.402; *see also* 42 U.S.C. § 1396a(a)(1); *see also, e.g.*, *Salazar v. District of Columbia*, 596 F. Supp. 2d 67, 69 (D.D.C. 2009) (holding ("[S]tates cannot contract away to managed care organizations … their responsibilities to Medicaid beneficiaries or the rights of Medicaid beneficiaries.").