

Fact Sheet: Subpart F–Grievance and Appeal System

This rule finalizes several modifications made to the grievance and appeal system for Medicaid managed care to further align and increase uniformity between rules for Medicaid managed care and rules for Medicare Advantage managed care, private health insurance, and group health plans. A streamlined process would make navigating the appeals system more manageable for consumers who may move between coverage sources as their circumstances change.

CMS' proposed changes in Subpart F of part 438 would adopt new definitions, update appeal timeframes, and align certain processes for appeals and grievances.

§438.400–Statutory basis, definitions, and applicability.

(b) Definitions. Provides for the definition of terms as follows:

- *Adverse benefit determination*
- *Appeal*
- *Grievance*
- *Grievance and appeal system*
- *State fair hearing (SFH)*

(c) Applicability. These provisions apply to the rating period for contracts **beginning on or after July 1, 2017.**

- CMS extends the application of appeal and grievance standards of Subpart F, part 438 to *Pre-paid Ambulatory Health Plans (PAHPs)* in addition to *managed care organizations (MCOs)* and *Pre-paid Inpatient Health Plans (PIHP)*, to which the standards currently apply.
 - **An MCO** is defined as an entity that has or is seeking to qualify for a comprehensive risk contract that is a federally qualified health maintenance organization (HMO) or meets the qualifications set out by the secretary of Health and Human Services to extend health services it provides to Medicaid enrollees.
 - **A PAHP** provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates. PAHPs are not responsible for inpatient hospital or institutional services for its enrollees and do not assume a comprehensive risk contract.
 - **A PIHP** provides enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use state plan payment rates that PIHPs are responsible for under the provision of inpatient hospital or institutional services for its enrollees, and does not assume a comprehensive risk contract.
- CMS noted that because some PAHPs receive a capitated payment to provide only *non-emergency medical transportation (NEMT)* services to Medicaid beneficiaries; for those NEMT PAHPs, an internal grievance and appeal system does not seem appropriate. Beneficiaries receiving services from NEMT PAHPs will continue to have direct access to the State fair hearing process to appeal adverse benefit determinations.

§438.402 General requirements.

Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for their enrollees.

(b) Level of appeals.

- **One level of internal review**–This process ensures that appeals will not be unnecessarily extended by limiting the internal process to one level of review.
- **State fair hearing (SFH)**–Permits an enrollee to request an SFH after exhausting a managed care entity's internal appeal process.

Procedural changes in the final rule.

- **Request for a grievance or appeal:**
 - **Grievance**–An enrollee may file a grievance with the MCO, PIHP or PAHP at any time. CMS is declining to add a timeframe cap that requires enrollees to file a grievance within a specific amount of time.
 - **Standard grievance or appeal**–Following the receipt of a notification of an adverse benefit determination by an MCO, PIHP or PAHP, an enrollee has **60 calendar days** in which to request an appeal **orally or in writing**

(which includes online), with the requirement that a standard appeal request made orally must be followed up in writing.

- **Expedited appeal**—An appeal may be requested orally or in writing, and if done orally, the consumer does not need to follow up in writing.
 - **A provider requesting on behalf of an enrollee**—As with the current rule, the final rule requires a provider to obtain the enrollee’s written consent before requesting an appeal on their behalf.
- **Resolution Timeframes:** The final rule imposes several significant modifications as follows:
- Changes in the timeframes to resolve appeals and expedited appeals,
 - i. **Grievance**—An enrollee may file a grievance with the MCO, PIHP or PAHP at any time. CMS is declining to add a timeframe cap that requires enrollees to file a grievance within a specific amount of time.
 - ii. **Standard appeal**—This process shortens the timeframe in which a decision must be made regarding a standard appeal **from 45 to 30 calendar days**.
 - iii. **Expedited appeal**—This provision amends language in the current rule pertaining to the resolution period for an expedited appeal to require that MCOs, PIHPs and PAHPs **resolve all expedited appeal requests in 72 hours** as opposed to the current allowable period of three business days.
 - Strengthens notice standards for extensions.
 - Changes the processes for receiving a SFH for enrollees.
- (A) **Deemed exhaustion of appeals processes.** In the case of an MCO, PIHP or PAHP that fails to adhere to the notice and timing requirements in the final rule, including specific timeframes for resolving standard and expedited appeals, the enrollee is *deemed* to have exhausted the MCOs, PIHP’s or PAHP’s appeal process.
- (B) **External medical review.** The state may offer and arrange for an external medical review:
- The review must be the enrollee’s option and must not be before or used as a deterrent to proceeding to the SFH.
 - The review must be independent of both the state and MCO, PIHP or PAHP.
 - The review must be offered without any cost to the enrollee.
 - The review may not extend any of the timeframes or disrupt the continuation of benefits.

Costs of the appeal process—Specific issues associated with the cost of the appeal should be addressed between the state and managed care entity.

§438.404 Timely and adequate notice of adverse benefit determinations.

- (a) **Notice.** The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements.
- (b) **Content of notice.** The notice must explain the following:
- (1) **Notice of adverse benefit determination**—The adverse determination the MCO, PIHP or PAHP intends to make.
 - (2) **Reasons for adverse determination**—Clarifies that the reasons for the adverse benefit determination which include:
 - The right of the enrollee to be provided the reasons upon request and free of charge.
 - Reasonable access to and copies of all documents, records and other information relevant to the enrollee’s adverse benefit determination.
 - (3) **The enrollee’s right to appeal**—A notice of an adverse benefit determination must include the enrollee’s and provider’s right to request an appeal of the managed care plan’s adverse benefit determination. It also must include information on procedures for exercising those rights to exhaust the level one of managed care plan appeal, the circumstances under which an appeal process may be expedited, and the enrollees’ rights to request a State fair hearing (SFH).
- (6) **The enrollee’s right to have benefits continue**—An explanation of the enrollee’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.
- **Additional documentation would include:**
- Information regarding medical necessity criteria, and
 - Any processes, strategies or evidentiary standards used in setting coverage limits.

CMS will issue guidance regarding the model language and content of these notices to avoid dissuading enrollees from pursuing appeals.

(c) Timing of notice.

- Strengthens the notification responsibilities following an extension of the timeframe for resolution of a grievance or appeal, when the extension is not requested by the enrollee.
- The final rule adds a standard requiring MCOs, PIHPs or PAHPs to make reasonable efforts to give the enrollee prompt notice of a delay and requires that managed care plans provide enrollees written notice of the delay within two calendar days.
- The final rule adds a provisions requiring that grievance notices (as established by the state) and appeal notices (as directed in the regulation) from MCOs, PIHPs or PAHPs ensure meaningful access for people with disabilities and people with limited English proficiency.

Issues for state contracts.

- **Recoupment of costs from enrollee**—The final rule adds the phrase “*consistent with State policy*” regarding the ability to recoup from the enrollee under a final adverse decision which must be addressed in the contract between a state and the managed care entity. These practices must be consistent across both fee-for service (FFS) and the managed care delivery systems within the state Medicaid program. While notice of the possibility of recoupment is an important beneficiary protection, CMS recognizes that these notices may deter an enrollee from exercising the right to appeal.

§438.406 Handling of grievances and appeals.

- (a) General requirements.** In handling grievances and appeals, each MCO, PIHP and PAHP must give enrollees any reasonable assistance, including auxiliary aids and services upon request, in completing forms and taking other procedural steps. This includes, but is not limited to, interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- (b) Special requirements.** Requires MCOs, PIHPs, and PAHPs to:
 - Send an acknowledgment receipt for each appeal and grievance.
 - Ensure that individuals who are involved in any previous level of review and their subordinates are excluded from making decisions on subsequent grievance or appeal decisions.
 - Ensure that individuals making appeal determinations have the appropriate clinical expertise, as determined by the state, in treating the enrollee’s condition or disease.
 - All comments, documents, records and other information submitted by the enrollee be taken into account regardless of whether the information had been considered in the initial review.
- (4) Testimony**—Adds “*testimony*” to the pieces of evidence permissible for an enrollee to present for reconsideration in grievance proceedings.

Grievance Filings—CMS declined to add a timeframe cap that requires enrollees to file a grievance within a specific amount of time. CMS is encouraging states to consider how they might set standards with their managed care plans.

§438.408 Resolution and notification: Grievance and appeals.

- (a) Basic rule.** Each MCO, PIHP or PAHP must resolve each grievance and 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 the rule.
 - The final rule imposes several significant modifications, and are as follows:
 - changes in the timeframes to decide appeals and expedited appeals,
 - strengthen notice standards for extensions, and
 - changes in the processes for receiving a State fair hearing (SFH) for enrollees.
- (b) Specific timeframes.**
 - **Standard resolution of grievances**—For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the state but may not exceed 90 calendar days from the day the MCO, PIHP or PAHP 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 calendar days** (shortened from 45 days) from the day the managed care entity receives the appeal. The final provision allows for an extension of the timeframe under certain circumstances.
- **(3) Expedited appeal requests**—For expedited resolution of an appeal and notice to affected parties, the state must establish a timeframe that is **no longer than 72 hours** (reduced from three days) after the managed care entity receives the appeal. This timeframe may be extended under certain circumstances.
- **(c) Extension of timeframes**—The MCO, PIHP or PAHP may extend the timeframes **by up to 14 calendar days** if:
 - The enrollee requests the extension.
 - The MCO, PIHP or PAHP 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.
 - If the MCO, PIHP or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:
 - i. Make reasonable efforts to give the prompt oral notice of the delay.
 - ii. Within **two 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.
- **Notification requirements**—Strengthens the notification responsibilities following an extension of the timeframe for resolution of a grievance or appeal, when the extension is not requested by the enrollee.
 - Adds a standard requiring plans to make reasonable efforts to give the enrollee **prompt oral notice** of the delay and requires that managed care plans provide enrollees **written notice of the delay within two calendar days**.
 - Adds a provision requiring that grievance notices (**as established by the state**) and appeal notices (as directed in the regulation) meet the standards of the plans to ensure meaningful access for people with disabilities and people with limited English proficiency.
- (3) Deemed exhaustion of appeals process.** In the case of an MCO, PIHP or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the managed care entities appeals process. The enrollee may initiate a State Fair Hearing (SFH).

(2) Appeals. For all appeals the MCO, PIHP or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards.

- **Expedited appeals**—For notices of an expedited resolution, the managed care entity must also make reasonable efforts to provide oral notice.
- (e) Content of notice of appeal resolution.** The written notice of the resolution must include the following:
 - The written notice of the resolution process and the date it was completed.
 - For appeals not resolved wholly in favor of the enrollees—
 - i. The right to request a SFH, and how to do so.
 - ii. The right to request and receive benefits while the hearing is pending, and how to make the request.
 - iii. That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the managed care entity’s benefit determination.

Requirements for State fair hearings (SFH).

- **Availability**—An enrollee may request a SFH only after receiving notice that the managed care entity is upholding the adverse benefit determination. The final rule modified the appeals process by requiring an enrollee to exhaust the managed care entity’s appeal process prior to requesting a SFH. It also lengthens the timeframe for enrollees to request a State fair hearing from a maximum of 90 days to **120 calendar days**.
- (ii) External medical review.** The state may offer and arrange for an external medical review if the following conditions are met:
 - The review must be at the enrollee’s option and must not be required before or used as a deterrent to proceeding to the SFH.
 - The review must be offered without any cost to the enrollee.
 - The review must not extend any of the timeframes in the standards and must not disrupt the continuation of benefits.

Financial liability for services furnished while appeal is pending—CMS is declining to assign, at the federal level, the financial liability to the enrollee or the managed care plan for services furnished while the appeal is pending, including in the context of the 14 calendar day extension.

- Enrollees may be held responsible or may be required to pay the costs of these services, consistent with state policy.
- Requirements must be consistently applied within the state under both managed care and FFS.

§438.410 Expedited resolution of appeals.

- (a) **General Rule.** Each MCO, PIHP and PAHP must establish and maintain an expedited review process for appeals when the managed care entity determines (at the request of an 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, physical or mental health, or ability to attain, maintain, or regain maximum function.
- States determine whether an MCO, PCCM or PCCM entity has violated any regulations or requirements and whether to impose corresponding sanctions.
 - CMS may also impose sanctions for certain failures or lack of compliance by an MCO. States have discretion under state law to develop enforcement authority and impose sanctions or take corrective action.

This section as proposed will be finalized with a modification to include both physical and mental health.

- (b) **Punitive action.** The managed care entity must ensure that punitive action is not 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 a request for an expedited appeal is denied the managed care entity must:
- Transfer the appeal to the timeframe for standard resolution in accordance with the standards, and
 - Follow the requirements as if operating under and extension of the timeframes had occurred.

§438.414 Information about the grievance and appeal system to providers and subcontractors.

The MCO, PIHP or PAHP must provide information specified in the rule about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

§438.416 Information about the grievance and appeal system to providers and subcontractors.

- (a) The state must require MCOs, PIHPs and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy.

Content of records—The current record-keeping provisions do not set standards for the type of appeals and grievance information to be collected, and only stipulate that states must review that information.

- The final rule sets minimum standards for the types of information that must be collected to create consistency across states:
 - A general description of the reason for the appeal or grievance.
 - The date received.
 - The date of each review or review meeting if applicable.
 - The resolution at each level and the date of resolution.
 - The name of the enrollee involved.
- This provision adds language and information that the state must review as part of its monitoring of their managed care programs, and for updating and revising its comprehensive quality strategy.

State Assessment Report—States are required to address the performance of their appeal and grievance system in the managed care program assessment report required in §436.66ⁱ of the final rule. States are also required to post this program report on their state public website for public viewing.

§438.420 Continuation of benefits while the MCO, PIHP or PAHP appeal and the State fair hearing (SFH) are pending.

Definitions.

- **Timely files**—Files for continuation of benefits on or before the later of the following:
 - Within 10 calendar days of the managed care entity sending the notice of adverse benefit determination.
 - The intended effective date of the managed care entity’s proposed adverse benefit determination.
- (b) Continuation of benefits.** The MCO, PIHP or PAHP must continue the enrollee’s benefits if all of the following occur:
 - The enrollee files the request for an appeal in a timely manner, and in accordance with the final rule.
 - The appeal involves the termination, suspension or reduction of previously authorized services.
 - The services were ordered by an authorized provider.
 - The period covered by the original authorization has not expired.
 - The enrollee files for continuation of benefits in a timely manner.
- (c) Duration of continued or reinstated benefits.** If benefits are continued or reinstated while the appeal or SFH is pending, the benefits must be continued until one of the following occurs:
 - The enrollee withdraws the appeal.
 - The enrollee fails to **request a SFH** and continuation of benefits within **10 calendar days** after receiving notice of adverse resolution to the enrollee’s appeal.
 - A SFH office issues a hearing decision adverse to the enrollee.
- (d) Enrollee responsibility for services furnished while the appeal or SFH is pending.** If the final resolution of the appeal or SFH is adverse to the enrollee (upholding the MCOs, PIHPs or PAHP’s finding), he or she may consistent with the state’s usual policy on recoveries and as specified in the managed care entities contract, recover the cost of services furnished to the enrollee while the appeal and SFH were pending, to the extent that they were furnished solely because of the requirements of the final rule.

§438.424 Effectuation of reversed appeal resolution.

(a) Services furnished while the appeal is pending.

Revises the current rule so that a managed care entity must effectuate a reversal of an adverse benefit determination and authorize or provide such services no later than **72 hours** from the date it receives notice of the adverse benefit determination being overturned.

- If a decision to deny authorization of services is reversed, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP or PAHP, or the state, must pay for those services, in accordance with state policy and regulations.
- If an enrollee paid for the services out-of-pocket, the enrollee must be reimbursed.

Appeal rights regarding the reversal of adverse benefit determinations. CMS is not including requirements to establish appeal rights regarding the reversal of adverse benefit determinations. This is a state-specific issue and should be addressed between the state and managed care plan.

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ⁱ § 438.66 Monitoring procedures. The State agency must have in effect procedures for monitoring the MCO’s, PIHP’s or PAHP’s operations, including, at a minimum, operations related to the following: (a) beneficiary enrollment and disenrollment, (b) Processing of grievances and appeals, (c) Violations subject to intermediate sanctions, as set forth in subpart I of this part. (d) Violations of the conditions for FFP, as set forth in subpart J of this part, (e) All other provisions of the contract, as appropriate.