## State CHECKLIST ✓

### Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Subpart F–Grievance and Appeal System

- ✓ The amended terms as they appear in state statute comport with the amended definitions in the final rule.
- ✓ State managed care contracts are being amended to comply with grievance and appeal system requirements for all contracts beginning on or after July 1, 2017.
- ✓ **State negotiated issues with managed care entities**–States must negotiate with their managed care entities how these issues will be handled in the grievance and appeal system:
  - **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. Recoupment of costs from enrollees must be addresses between the state and the managed care entity when a final adverse benefit determination is made and there must be consistent across both the fee-for-service (FFS) and the managed care delivery systems within the Medicaid program.
    - 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.
    - States should consider reviewing their usual policy on recoveries and the language used in state managed care contracts.
  - **Grievance filings**–CMS is declining to add a timeframe cap that requires enrollees to file a grievance within a specific amount of time, but is encouraging states to consider how they might set standards with their managed care plans on filing and resolving grievances.
  - **Expedited resolution of appeal**–States must determine whether an MCO, primary care case manager (PCCM) or PCCM entity has violated any regulations or requirements related to resolution of an appeal and whether to impose corresponding sanctions. States have discretion under state law to develop enforcement authority and impose sanctions or take corrective action.
- ✓ **State fair hearing system**–Ensure that the state has a mechanism for Medicaid managed care enrollees to access reviews of adverse benefit determinations through a State fair hearing process once they have exhausted grievance and appeal review mechanisms available through the managed care entities internal processes. This final rule establishes a one-level internal review within the contracted managed care entity before moving an appeal forward to an impartial State fair hearing, or an external review at the enrollees' option.
- ✓ **External medical review**–If a state is considering offering state Medicaid managed care enrollees an external medical review, it must be independent of the state and the managed care entity involved. States must consider how this additional level of review may be used to the benefit of the enrollee without acting as a deterrent to proceeding to a State fair hearing or disrupting the continuation of benefits pending the appeal.
- ✓ **Authorized representative**–States must consider whether, with written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing on their behalf if such provisions do not currently exist in state law.
- ✓ **Grievance and appeal records:**
  - States must review appeal and grievance information collected by the managed care entities as part of their program monitoring and when updating and revising their comprehensive quality strategies.
  - **State assessment report**–States are required to address the performance of their appeal and grievance system in the managed care program assessment report in the final rule. States are also required to post this program report on their state public website for public viewing.
- ✓ **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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