

## Memorandum

### Re: Final Medicaid Managed Care Rules - Grievance Systems (Subpart F)

From: Jane Perkins

Date: Mar. 29, 2001

The Health Care Financing Administration proposed Medicaid managed care rules, including grievance rules, on September 29, 1999. 63 Fed. Reg. 52021 *et seq.*. Below is a summary of changes contained in the grievance system provisions of the final Medicaid managed care regulations that were published in the Federal Register on January 19, 2001.

See

66 Fed. Reg. 6228. With little explanation and no opportunity for the public to provide notice and comment through the Administrative Procedure Act, these regulations have been delayed by the Bush Administration until June 18, 2001.

See

66 Fed. Reg. 11546 (Feb. 26, 2001).

The following summary does not present a full discussion of the statute and proposed regulations. For fuller explanation of the proposed rule and NHeLP's reaction/suggestions concerning each proposed rule, see Health Advocate No. 194 (Fall 1998); for similar discussion of the statute, see Health Advocate No. 190 (Fall 1997).

### Statutory authorization and background

The Medicaid Act requires states to implement beneficiary protections for enrollees in Medicaid managed care organizations. See 42 U.S.C. § 1396u-2. One such protection states:

Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this subchapter, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such services.

*Id.* at § 1396u-2(b)(4).

The Medicaid Act also requires fair hearings:

A state plan for medical assistance must ... provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness. *Id.* at § 1396a(a)(3).

The fair hearing statute has been implemented through a set of detailed and explicit regulations that address all aspects of the fair hearing process, including: when an action occurs, content of the required notice, timing of the notice, conduct of the fair hearing, timing of the fair hearing decision, corrective payments and appeals. See 42 C.F.R. §§ 431.200 - 431.250.

### Discussion of the January 19<sup>th</sup> Final Regulations

## Section 438.400 - Statutory Basis, Definitions, General Requirements

***Statutory basis and definitions - 42 C.F.R. §438.400.***

***General Requirements - 42 C.F.R. §438.402.***

Proposed rules:

At the MCO level, the proposed regulations defined two levels of disputes: complaints and grievances. A "complaint" was broadly defined as any *oral or written* communication by or on behalf of an enrollee that expresses dissatisfaction with any aspect of the MCO's or provider's operations, activities, or behavior. A "grievance" was a *written* communication by or on behalf of the enrollee expressing dissatisfaction with any aspect of the MCO's or provider's operations, activities, or behavior that pertains to:

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the availability, delivery, or quality of health care services (including utilization review decisions);

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payment, treatment or reimbursement claims for services;

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issues unresolved through the complaint process.

The preamble noted that the MCO grievance process must "[n]ot substitute for the State's fair hearing system." "The State must either permit the enrollee to request a State fair hearing on a grievance at any time, or provide for a State fair hearing following an MCO adverse decision on the grievance." 63 Fed. Reg. at 52086. According to the preamble, if the state was going to require exhaustion of the MCO grievance process, then it had to assure that the MCO-level activities were completed in a time frame to allow the beneficiary to receive final administrative action from the state fair hearing process within 90 days of the date of the initial grievance. *Id.*

Changes in final rule regarding definitions:

(1) Drops the concept of "complaint." Adds definition of the word "grievance." A grievance is an expression of dissatisfaction about any matter other than an "action." This includes, for example, concerns regarding quality or interpersonal relationships. There is also a separate "quality of care grievance."

(2) Adds a new definition of the word "appeal." An appeal is a request for review of an "action."

(3) Adds definition of the word "action." An action includes the following actions by an MCO or PHP or any of its providers: (a) the denial or limited authorization of a requested service; (b) the reduction, suspension, or termination of previously authorized services; (c) the denial of payment, in whole or in part for a service; (d) for a resident of a rural area with only one MCO or PHP, denial of an enrollee's request to exercise the right to obtain services out of network; (e) the failure to either furnish, arrange, or provide for payment of services in a timely manner, and (f) the failure of an MCO or PHP to resolve an appeal within the time frames provided in the regulations (§ 438.408). The denial by the state agency of a request to disenroll is also an action.

(4) The types of activities that are now considered grievances and appeals do not overlap, a revision which clarifies the process. However, grievances are not subject to state fair hearings. They are subject to an undefined further state review, at enrollee request.

Changes in final rule regarding general requirements:

(1) Postpones major changes to the fair hearing regulations.

(2) Allows appeal to be filed "whenever the entity has delayed access to the service to the point where there is a substantial risk that further delay will adversely affect the enrollee's health condition." For all other actions, requires States to allow beneficiaries "up to" 90 days to file an appeal and requires beneficiaries be given a minimum of 20 days to file an appeal.

(3) Allows enrollee to start the appeal time clock with an oral request but requires follow up in writing (except in expedited situations where written appeal is not required).

(4) Makes regulatory the requirement for final administrative action within 90 days and provides for counting to be tolled between the time the MCO issues its notice of decision and the time the beneficiary files for a state fair hearing (§ 431.244). This applies whether or not in-plan exhaustion is required.

(5) Restricts the scope of state fair hearings from what was proposed. State fair hearings are limited to appeals to review an action, as defined above.

(6) Permits provider to file a grievance or appeal or request a state fair hearing on behalf of an enrollee, with the enrollee's written permission.

## Section 438.404 - Notice of Intended Action

Proposed rule:

If an MCO is going to "deny, limit, reduce, delay, or terminate a service" or deny payment for a service, it must give the enrollee a timely written notice. The notice must explain: (a) the action the MCO intends to take; (b) the reasons for the intended action; (c) any laws and rules that support the action; (d) the enrollee's right to file a complaint or grievance with the MCO and to request a state fair hearing; (e) the circumstances for an expedited grievance and how to get it; (f) how to file complaint, grievance, and state fair hearing requests; (g) that the grievant can appear in person before the grievance or fair hearing; (i) how to contact the grievance body; and (j) how to obtain copies of the enrollee's records, not limited to medical records.

Changes in final rule:

(1) Requires notice to be sent, even if the MCO or PHP believes the contract does not require that it provide the service.

(2) Deletes the word "delay" in service from the requirement for notice.

NOTE: 42 U.S.C. §1396a(a)(3), requires notice when there is an unreasonable "delay," so this change is not supported by the statute. HCFA says that the delay problem is taken care of with its requirement that authorization decisions occur within 14 days or there is deemed denial and notice must be provided (§ 438.210).

(3) Allows providers to give only a general notice, to be followed up by MCO or PHP with specific notice. MCOs/PHPs will need to have systems in place to find out from their providers when an action has been taken.

(4) Adds specificity to information that must be included in the notice of action; information

about right to appeal, that the enrollee can represent himself or use legal counsel or other representative, and that filing will not negatively affect the person in any way (§ 438.404(b)).

(5) Deletes requirement that notice inform enrollee of the opportunity to present their case in person to the in-plan decision maker.

### **Handling of grievances - Section 436.406**

Proposed rule:

Each MCO must have a designated complaint and grievance office that is adequately staffed. Each state is allowed to establish its own approach to how enrollees obtain assistance with problems, and the regulations only require that the MCOs provide assistance in completing forms "or taking other steps necessary to obtain resolution of the complaint or grievance at the MCO level."

The MCO must hear the grievance using an "impartial" individual who was not previously involved in review of decision-making on the claim. Reviews of denials based on medical necessity must be performed by "a physician with appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease."

Changes in final rule:

(1) Requires MCOs/PHPs to track the date of acknowledgment that an appeal has been filed and report it to the state annually. The rule did not include a suggestion that MCOs/PHPs be required to acknowledge receipt of an appeal in writing to the beneficiary.

(2) Changes requirement that MCOs/PHPs provide "any assistance" to "reasonable assistance" with the completion of forms and other procedural steps in the grievance process.

(3) Requires MCOs/PHPs to make interpreter services available, as well as to have adequate TTY/TTD and interpreter capability.

(4) Removes description of MCO/PHP decision maker as "impartial."

NOTE: The preamble (p. 6347) acknowledges that independent external review processes are no substitute for the state fair hearing. If a beneficiary uses the external process, then the state fair hearing decision would be controlling over an inconsistent determination made by this body.

(5) Requires grievances and appeals to be reviewed by a health professional with appropriate clinical expertise in treating the enrollee's condition if the appeal concerns a denial based on lack of medical necessity, grievance regarding denial of expedited appeal, and grievance and appeals regarding clinical issues. (Proposed rule was limited to review by a physician.)

## **Grievance Resolution and Notification - Section 438.408**

### **Proposed Rule**

The proposal requires the MCO to investigate the grievance, reach a decision based on the case record and the law, and provide a written notice of decision.

Time frames are established for two types of grievances: standard and expedited. Standard



grievances must be resolved by the MCO "as expeditiously as the enrollee's health condition requires, within time frames established by the State, but no later than 30 calendar days after it receives the grievance." Expedited grievances must be resolved by the MCO "as expeditiously as the enrollee's health condition requires, within time frames established by the State, but no later than 72 hours after it receives the grievance." Both the standard and expedited time frames may be extended up to 14 days if the enrollee requests an extension or the MCO (on request to the State agency) justifies the need for additional information and explains how the delay is in the interest of the enrollee.

The beneficiary must be given a written notice of the decision. Oral notice must also be given of expedited decisions. Final decisions wholly or partially adverse to the enrollee must be forwarded, along with all supporting documentation, to the State agency as expeditiously as the enrollee's health condition requires, but no later than:

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30 days after receipt of the grievance, for standard decisions;

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24 hours after it reaches the decision, for expedited decision

The written notice of decision must include the name of an MCO contact, results of the process and the date it was completed, a summary of the steps taken, an explanation of the right to a state fair hearing, and a statement of the circumstances under which benefits will continue if the enrollee files a fair hearing request.

Changes in final rule:

(1) Provide that, unless the enrollee has determined that an extension is in his interests and requests an extension, there should be no extensions in expedited cases. (Proposed rule had allowed the MCO/PHP to obtain a 14 day extension.)

(2) Requires that the state fair hearing decision on expedited cases be made within 72 hours (the same time frame as used in Medicare+Choice).

NOTE: This required a change in the state fair hearing regulations (§ 431.244(f)(2)) as well. Note, as well, that HCFA finds the state fair hearing process to be the Medicaid counterpart of the Center for Health Dispute Resolution review in that in both cases it is the first "independent" and "external" review of the MCO's decision (66 Fed. Reg. at. 6349).

(3) Adds a requirement that MCOs inform enrollees when they have extended time (in non-expedited situations), to include the reasons the reasons for the delay and to inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision to extend the time frames.

(4) Clarifies that the time frames for resolving appeals begin to run on the date the MCO/PHP first "receives" an oral or written appeal.

(5) Requires MCOs and PHPs to forward information to the state on adverse standard appeal decisions, within 72 hours of the state's request, and requires automatic referral in cases of adverse decisions on expedited appeals. (Proposed rule had required forwarding for all decisions in whole or in part against the beneficiary).

### **Expedited Resolution of Grievances and Appeals - Section 438.410**

Proposed rule:

Each MCO must maintain an "expedited grievance review process." The process applies when:

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an enrollee makes the request and the MCO determines that taking the time for standard resolution could "seriously jeopardize the enrollee's life or health or the enrollee's ability to regain maximum function."

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a physician makes the request or supports an enrollee's request and indicates that taking the time for standard resolution could "seriously jeopardize the enrollee's life or health or the enrollee's ability to regain maximum function."

Thus, if a physician either makes the request or supports the enrollee's request, the expedited review must occur. However, if the request comes from the enrollee alone, the MCO will decide whether to expedite. In all cases, the request must be in writing or, if oral, followed up in writing within 24 hours.

Changes in final rule:

(1) Expands the criteria for requesting an expedited appeal to include all instances for which the time needed for standard resolution could "seriously jeopardize the enrollee's life or health, or the ability to attain, maintain or regain maximum function." Specifically, this responds to comments seeking addition of "retain function" cases.

## **Information about the Grievance system - Section 438.414**

Proposed rule:

Each MCO must provide information about the grievance system to enrollees, potential enrollees as permitted by the state, and all providers at the time of subcontracting. All of the information furnished must meet the new regulatory requirements that apply to the provision of information in general.

The grievance information description must be state-developed or state-approved and include: what constitutes a grievance, complaint, fair hearing; how to file grievance and hearing requests and time frames; toll-free numbers to register a complaint or complete a grievance by telephone (including adequate TTY and interpreter capability); titles and telephone numbers of persons with MCO responsibility; assurance that filing will have no negative affect on the way the enrollee is treated; and procedures for continued benefits.

On request, the MCO must provide enrollees and potential enrollees with aggregate information on the nature of enrollee grievances and their resolution.

Changes in final rule:

(1) Clarifies that the beneficiary's state fair hearing rights must be explained, including the fact that enrollees have the right to represent themselves or be represented by legal counsel, a relative, a friend, or other spokesperson.

(2) Requires aggregate information on grievances and appeals to be provided to the general public on request.

(3) Specifies that information on the grievance system must be provided to subcontractors as well as to contractors.

## **Continuation of Benefits Pending Resolution of the State Fair Hearing - Section 438.420**

Proposed rule:

The proposed regulation provides that if an enrollee files a "timely" grievance, expedited grievance request, or request for a state fair hearing, the MCO must continue the enrollee's benefits until issuance of the final grievance decision or state fair hearing decision if:

- (1) the current level of services was ordered by the MCO treating physician or another MCO physician;
- (2) the physician is authorized to order the services under the MCO contract; and
- (3) the enrollee requests the continuation.

"Timely" means filing on or before the time limit specified by the state in the notice of intended action or before the effective date of the MCO's proposed action, whichever is later. The state-specified time limit may not be less than the 5-day or 10-day time frames specified in the fair hearing regulations. See 42 C.F.R. § 431.230.

Changes in final rule:

- (1) Clarifies that benefits must continue without interruption, if elected by the enrollee, through the conclusion of the state fair hearing if the case is not resolved favorably at the MCO/PHP

level.

(2) Expressly requires enrollees to request continued benefits and requires notice of action to inform enrollee of the potential for financial liability for services continued during appeal.

(3) The preamble states HCFA's position that if an enrollee requests re-authorization for services that were approved for a limited time/number and the MCO/PHP denies the request or re-authorizes the services at a lower level than requested, this is treated as a new service request and notice of denial/limitation must be sent. However, the MCO/PHP is not obligated to provide continued benefits (66 Fed. Reg. at.6354). This is a very disappointing statement because, increasingly, MCOs use the time/visit limited authorization technique.

(4) Modifies the requirement that an MCO/PHP physician with authority under the contract must have authorized the services in order for them to be continued (§ 438.420(b)). The final rule uses the term "authorized provider" rather than "MCO or PHP physician." The preamble provides examples of when the MCO/PHP must provide continued benefits: if services are covered under Medicaid, benefits must be continued, if there is a timely appeal and request, regardless of whether the beneficiary remains enrolled in the MCO/PHP. This includes instances in which services were begun by a provider under the fee-for-service system. Benefits must be continued when (1) the MCO/PHP pays for services prescribed out-of-plan; (2) services are prescribed by an outside specialist who is treating the enrollee with the MCO's consent; (3) family planning services are being received from an out-of-plan provider and the services are covered under the MCO contract; and (4) in rural areas, where individuals are, by law, allowed to seek out-of-network services. 66 Fed. Reg. at 6354.

## **Record keeping and Reporting Requirements - Section 438.416**

***Record keeping and reporting requirements - 42 C.F.R. § 438.416, proposed 63 Fed. Reg. At 52088***

***Effectuation of Reversed Grievances - Section 438.421 of proposed rule and section 438.424 of final rule***

***Monitoring of the grievance system - 42 C.F.R. §438.422, proposed 63 Fed. Reg. At 52088***

***Consequences of noncompliance - 42 C.F.R. §438.424, proposed 63 Fed. Reg. At 52088***

Proposed rules:

Proposed regulation, § 438.416, requires the MCO to collect certain information and to comply with Medicaid confidentiality requirements. Specifically, the MCO must maintain a log of all complaints and grievances and their resolution, track each grievance until its final resolution, and record any disenrollment and the reason for it. Records of complaints, grievances, and disenrollment must be maintained for a period of three years. A longer time period may apply if the record is the subject of litigation, audit, or other action.

Upon request by the state and at least annually, the MCO must analyze the collected information and send to the state a summary that includes: the number and nature of all complaints and grievances; the time frames for resolution and the decisions; a list of all grievances that have not been resolved to the satisfaction of the enrollee; the nature of grievances requiring expedited review and the decisions; and any trends relating to a particular provider or service.

Proposed regulation, § 438.422, provides that these records and summaries will form the basis for monitoring by the MCO and the state. If the summary reveals "undesirable trends" relating to a particular provider or service, the MCO must conduct an in-depth review, report to the state, and take corrective action.

Proposed regulation, § 438.424, says that if the MCO or its providers fail to comply with the grievance regulations, the state can terminate the MCO's contract, and HCFA can deny federal financial participation to the state. According to HCFA, these sanctions are being included in these regulations, "in order to emphasize the importance of the grievance and appeal requirements."

Changes in final rule:

(1) Deletes the requirement that MCOs/PHPs submit a list of all appeals not resolved to the satisfaction of the enrollee. 66 Fed. Reg. at 6352-53.

(2) Adds reporting of the number of requests for expedited review.

(3) Adds requirements that grievances, as well as appeals, be tracked and reported, including the time frames for acknowledging to the enrollee the receipt of grievances and appeals.

(4) Removes the requirements that MCOs/PHPs "record any disenrollment and the reason for it" as duplicative (see § 438.242).

(5) Eliminates the time frames for providing services that were in the proposed rules (no later than 30 calendar days where the grievance is resolved in the beneficiary's favor and no later than 60 days from the date the MCO/PHP receives notice that the state fair hearing is resolved in the beneficiary's favor).

(6) Adds a requirement that the MCO/PHP or state must pay for services denied to an enrollee when the enrollee received the services and later won an appeal of the denial.



(7) The proposed rules had required follow up for "undesirable trends." The final rules replace this phrase with the requirement that when the MCO/PHP identifies through trends in collected data that systemic changes are needed, the MCO/PHP must investigate, report the results to the State, and take corrective action.

(8) Deletes the requirement to identify trends by provider.

(9) Deletes § 438.242 regarding consequences of noncompliance.