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This model complaint procedure supercedes earlier versions from August 1998, October 1997 and March 1997. This process is intended for use in state-based managed care programs, particularly Medicaid and child health insurance programs. But, it can be adapted to other managed care situations as well. Many of the provisions are taken from existing state managed care rules and contracts or were developed out of our work with advocates and individual clients.

NHeLP Model

Definitions

A. Definitions:

1. Complaint -- Any clear expression by an applicant or recipient, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority. A complaint may be brought at the Plan level, through the grievance process, or at the state level, through a State fair hearing.

2. Grievance -- a complaint at the Plan level.

3. State fair hearing -- a complaint to the State Medicaid agency to be heard by an impartial hearing officer.

[Note: States are using a number of terms to label complaint processes, such as: informal in-plan grievance, formal in-plan grievance, internal grievance, reconsideration, complaint, fair hearing. Clients, advocates, plans, and states have remarked to us that there is, in fact, a confusion of terms that hampers dispute resolution. See National Health Law Program, Making the Consumers' Voice Heard in Medicaid Managed Care: Increasing Participation, Protection and Satisfaction -- Report on Legal and Voluntary Mechanisms (Dec. 1996).]

Consumer relations office

B. Each Plan will maintain an adequately staffed consumer relations office which can receive telephone calls and meet personally with members and which members can use to ask questions and get problems resolved informally. Although these consumer relations activities will operate through verbal, as well as written, communications, consumer relations staff will document all communications. Consumer relations staff will receive regular training on the complaint process and appropriate referral procedures. The consumer relations office will maintain records that include the name of the member (or member identification number), a short summary of each question or problem, date of contact, the resolution, and date of resolution. If the Plan does not have a separate log for Medicaid recipients, the log shall distinguish Medicaid recipients from other Plan members. This information will be available to the State Medicaid agency.

The in-plan grievance process

C. The Plan shall have a timely and organized grievance system.

[Note: This process is required for Medicaid recipients by 42 C.F.R. § 434.32].

1. The grievance process will be available for disputes between the Plan and the member concerning, among other things, denial, reduction, delay, suspension, or termination of services; requests for services that are not acted upon in a timely manner; dissatisfaction with providers; appropriateness of services rendered; availability of services; the inability to obtain culturally and linguistically appropriate care; or disputes concerning disenrollment. A denial includes any instance in which a request for a medical service has been made in which a member has been told "no" for all or part of the service.

2. The Plan's grievance procedures are neither a substitute for nor a prerequisite of a fair hearing before an impartial hearing officer. The recipient may request a fair hearing before, during, or after a Plan grievance procedure. The agency will provide a hearing and a final written decision within 90 days of the initial request unless the matter is resolved in favor of the

recipient or involves urgent matters. Urgent matters will be resolved on an expedited basis described in section K, below.

[Note: This provision can also note other state-based hearing processes that are available, by law, to the member, including hearing procedures set forth in the state's Administrative Procedures Act or state Insurance Code. These procedures may supplement, but cannot substitute for, federally required grievance and fair hearing procedures.]

3. The Plan will develop written policies and procedures for its grievance process, which at minimum must comply with the following:

a. The procedure will be approved by the Plan's governing body and be the direct responsibility of the governing body, and it will be approved in writing by the State Medicaid agency prior to implementation.

[Note: Optimally, the Plan's governing body will include consumer representatives.]

b. The procedure will name specific individuals in the Plan who have responsibility for the proper functioning of the grievance process and authority to require corrective action.

c. The procedure will allow members to complain to the Plan's governing body. The governing body may delegate this authority to a grievance committee, but the delegation must be in writing.

[Additional suggestion: The grievance committee will include at least one Plan administrator with authority to require corrective action; at least two Medicaid consumers; at least two providers with expertise in the area in dispute; and at least one State Medicaid agency representative. The Plan must demonstrate that the Plan administrator has education and experience in necessary specialized areas such as mental health, substance abuse, and pediatric care.]

d. Grievances will be filed by the member or member's representative, on a form to be developed by the State Medicaid agency. All grievances will be mailed to a single address within the State Medicaid agency. Unless the dispute involves a request for expedited review (described in section K below), the State Medicaid agency will log in the request and return it to the Plan within 72 hours of receipt.

[Note: By filing all grievances, first, with the state Medicaid agency, the process is simplified for recipients. In many cases, recipients do not know where in their plan to complain -- or even know the name of their plan. Central logging also makes the process more accountable to consumers. Once the request is logged in, the time frame for a final decision will begin to run. The state will have a record of the grievance and can hold the plans accountable for resolving it. Finally, central logging enhances the program's ability to use complaint information in quality monitoring. Tennessee's Medicaid program is using a central log-in system.]

4. Benefits must be continued pending final resolution, in accordance with section L.

D. The Plan will provide information about its grievance process to members and applicants, to all subcontractors at time of subcontracting, and to non-contracting providers within ten (10) days of the date of receipt of a claim.

1. Members will be informed of the grievance process orally and in writing, through a state-developed [or state-approved] description of the grievance process, posted at no less than one conspicuous location of each reception area of each provider within the Plan; and provided to the member at:

a. the time of initial enrollment;

b. each time a service is denied, reduced, suspended, delayed, or terminated, and/or whenever a Plan or provider does not take a course of action or treatment normally taken for the member's medical problem;

c. when the member initially contacts the Plan regarding a problem or complaint;

d. at every eligibility recertification;

e. each time the recipient enrolls in a Plan;

f. at completion of the grievance procedure;

g. at the request of the member or member's representative; and

h. in the member handbook.

2. The oral information and written notice will explain:

a. how to file both grievance and state fair hearing requests;

b. time frames for filing and resolving grievances and state fair hearing, including expedited time frames;

c. availability of free assistance with a grievance and/or state fair hearing; and

d. a statement that filing a grievance or state fair hearing request will not affect eligibility, benefits, or the way the member is treated by the provider/Plan or the state Medicaid agency.

3. If service or eligibility is denied, reduced, suspended, terminated or delayed, a written notice will be hand-delivered or mailed to the member (or the member's authorized representative)

explaining:

- a. what action the Plan intends to take;
- b. the reasons for the intended action;
- c. the specific laws and rules that support the action;
- d. an explanation of the individual's right to file a grievance with the Plan or to request a fair hearing before the state Medicaid agency;
- e. an explanation of the circumstances under which benefits will continue pending resolution of the problem (described below);
- f. that the member has a right to a second opinion, at the Plan's expense and how to exercise that right;
- g. that if the member decides to file a grievance, that the member has the option of an in-person hearing before the Plan personnel who will decide the grievance;
- h. how to contact the consumer relations office;
- i. how to request a grievance and/or fair hearing;
- j. that filing or resolving a complaint through the Plan's grievance mechanism is not a prerequisite to obtaining a fair hearing with the state Medicaid agency;

k. that a state fair hearing will be held before an impartial decision-maker;

l. the circumstances that will cause an expedited review and how to request an expedited review;

m. an explanation of how members can obtain copies of their managed care Plan records, not to be limited to medical records. Members are entitled to receive copies of their records at no cost to the member.

n. the right to be advised or represented by a lay advocate or attorney and of the potential availability of free legal services. The notice will provide the phone number and address of legal services organizations.

4. The Plan will maintain copies of all notices sent for a one year period and will make these available to the State Medicaid agency.

5. At each visit to a participating provider, the patient should receive an explanation that if they feel that they did not receive the services they need, they have the right to request an in-plan grievance or a state fair hearing. This explanation may be included as part of the information provided to the patient upon check-out.

E. A trained Plan investigator will send a letter of notification to the member within two days of receipt of the grievance form from the state. The letter will either: (1) immediately resolve the grievance in the member's favor or (2) indicate that the matter will be further investigated and set a date for the hearing. The letter will summarize the investigator's understanding of the grievance. The investigator will investigate the claim by questioning concerned parties and conducting on-site visits, if necessary.

F. Upon completion of the investigation, the entire record of the grievance will be forwarded to the grievance committee. The decision on the grievance will be based upon the record of the

case, including the hearing, if any, and relevant program laws and policies and will be made in writing. The decision will be sent to the member by certified mail. The decision will include:

1. the name and address of the member;
2. the name of staff investigator;
3. the date the investigation was completed;
4. the results of the investigation;
5. a summary of the steps taken on behalf of the member to resolve the issue;
6. the action taken; and
7. a clear explanation of the right to a state fair hearing.

G. Except in cases involving expedited review (described in section K), the grievance must be resolved and the member notified in writing of the decision as soon as possible but, in any event, no later than 30 days from the date the form was filed with the state Medicaid agency.

H. The Plan will retain grievance documents for five (5) years following a final decision or close of a grievance. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later.

State Fair Hearings

I. If the member requests a state fair hearing, all documents supporting the Plan's actions must be received by the state Medicaid agency no later than five (5) working days from the date the Plan receives notice from the state that a fair hearing request has been filed.

J. The State Medicaid agency will provide members with a fair hearing process that has the following characteristics:

1. The state fair hearing process shall adhere to 42 C.F.R. § 431.200 et seq., which is incorporated herein by reference;
2. When an ongoing course of treatment is at issue, services must continue pending a final decision on the complaint;
3. Any Plan policy or procedure that impedes a member from obtaining supporting evidence, including medical records and affidavits from health care providers, is prohibited;
4. Before the hearing, the member has the right to review the case file and all records that will be used at the hearing in support of the adverse decision;
5. The individual has the right to an in-person hearing. At the hearing, the individual can present and cross-examine witnesses. The person can represent himself or herself at the hearing or be assisted by a representative. An in-person hearing can be waived at the request of the individual;
6. The hearing officer must be impartial and cannot engage in ex parte communications with either side;

7. The hearing decision must be based solely on the evidence produced at the hearing and the record of the case, which shall include the official transcript or report of the testimony at the hearing and all papers filed in the proceeding;

8. In cases other than expedited reviews (described in section K), a final written decision must be issued by the hearing officer within 90 days from the date the complaint was initially filed with the Plan, or if the member appeals directly to the state Medicaid agency, within 90 days of the date the fair hearing request was filed. If the individual is dissatisfied with the final decision of the hearing officer, he or she can appeal to a court of law as set forth in state law.

K. The State Medicaid agency will make an expedited review process available.

1. An expedited review will occur when the member attests that services are urgently needed and the failure to provide them promptly or to continue them may cause deterioration or impair improvement in condition, including but not limited to termination or denial of: inpatient services, home health care, pharmaceuticals, therapy services, or surgery;

[Alternative: An expedited review will occur when the member attests that the concern is urgent. An urgent concern is one in which a reasonable lay person could believe that delay could prevent a consumer from realizing the full benefit of a decision in her or his favor.]

2. Requests for expedited review will be filed with the State Medicaid agency. The agency will notify the Plan of the request. The Plan will forward case records and documentation supporting its decision immediately to the state. An expedited decision by the state Medicaid agency must be issued within 2 days of the request, unless the member requests additional time to obtain evidence;

3. The member's Plan can reverse its decision at any time prior to decision on expedited review by the state Medicaid agency;

4. Benefits will be continued pending final resolution, in accordance with section L.

5. The decision by the state Medicaid agency on expedited review will include the information contained in section F, above.

Continued benefits

L. The Plan and State Medicaid agency must provide for benefits to continue pending resolution of the complaint, as follows:

1. If a member files a grievance, a request for expedited review, or a state fair hearing on or before the tenth day after a decision is communicated in writing to the member to reduce, suspend, or terminate services that the member has been receiving, or before the date of the proposed action, whichever is later, the Plan will continue to provide services at a level equal to the level ordered by the Plan physician until a final decision is made by the Plan and, if a state fair hearing is requested, by the state Medicaid agency.

2. If the resolution by the Plan is adverse, in whole or part, to the member, the member must be notified again of his or her rights to a state fair hearing and to continued benefits pending the final decision. If the member appeals a Plan's written resolution within ten days after it is issued, or before the date of the proposed action, whichever is later, services must be continued pending a final state fair hearing decision. A resolution is made or issued on the date it is postmarked.

3. Members will be notified that, if the final decision is adverse to them, they may be required to repay the costs of services provided to them during the pendency of the dispute, as allowed by 42 C.F.R. § 431.230(b).

Accessibility of the complaint process

M. All written and oral materials regarding the complaint process, including posted notices, descriptions of the complaint processes, complaint forms, and decisions, must be made

available orally and in writing in the recipient's primary language and in alternative formats, including TTY and telecommunication devices for the hearing impaired, braille, large print, and cassette.

N. In-person hearings must be held at locations that meet the requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1974. Trained interpreters must be used at hearings when the member's primary language is not English.

O. The Plan and/or State must provide transportation to and from the grievance or state fair hearing for the recipient, his or her representative, and witnesses.

P. The Plan and the state Medicaid agency will include toll-free numbers for a member to use to communicate a complaint and/or complete a grievance form by telephone. These toll-free services will have adequate TTY and language interpreter capabilities.

Q. Members will be informed of these accessibility provisions in the written and oral materials describing the complaint processes and on posted notices.

Monitoring and Quality Assurance

R. Failure of a plan to comply with the complaint process requirements of state and federal Medicaid law and these provisions with respect to a particular service or payment for a member will result in an automatic ruling in favor of the member.

S. The State Medicaid agency must monitor and investigate the compliance of plans with the foregoing hearing requirements. If it learns that a contracting entity has failed to meet these requirements, the State Medicaid agency is prohibited from renewing or entering into a subsequent contract with the entity.

T. Information regarding the nature of grievances and their resolution must be publicly disclosed

by the state Medicaid agency. Such disclosure will maintain member confidentiality.

U. The state Medicaid agency will collect and analyze data, including data on complaints. This information will be collected quarterly and as part of annual reports made by the Plan to the state Medicaid agency. This information is to be used as an ongoing indicator of plan performance which may identify the need for targeted monitoring and special investigations. The data to be reported will be broken out by plan, to include:

1. number and nature of complaints reported orally and in writing;
2. time frame for resolution and outcome of resolution of complaints;
3. listing of all grievances which have not been resolved to the satisfaction of the provider or subscriber who filed the grievance;
4. number, nature, and resolution of expedited proceedings.

V. When repeated grievances are filed against a Plan or provider, an in-depth review, including on-site visits, will be conducted by the state Medicaid agency. When a provider or a member files repeated complaints, a review will also be conducted by the state Medicaid agency.

W. The information described in this subsection will be used for quality improvement, credentialing, and will be provided to the Consumer Advisory Board on a quarterly basis.

X. This complaint procedure should incorporate the following definition of medical necessity:

The health plan must provide all medically necessary care, including services, equipment, and pharmaceutical supplies. Medically necessary care is the care which, in the opinion of the

treating physician, is reasonably needed to do one or more of the following:

- prevent or delay the onset or worsening of an illness, condition, or disability;
- assess or screen for an illness, condition, or disability;
- establish a diagnosis;
- provide palliative, curative or restorative treatment for physical and/or mental health conditions;
- prolong life;
- promote physical and mental health and efficiency;
- assist the individual to achieve or maintain maximum functional capacity.

Each service must be performed in accordance with national standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration and scope may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness or condition (42 CFR 440.230). Children's medical necessity decisions will be governed by the EPSDT coverage rules (42 USC § 1396(r)(5) and 42 USC § 1396d(a)). The health plan should affirmatively ensure access to care. The definition will be applied and interpreted consistent with the best interests of the enrollee.

Kentucky

Kentucky Request for Application

Kentucky Medicaid Partnership, Request for Application (1997) [Effective Date: Varies according to region]

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7.8.8 Complaints, Grievances and Appeals

Any Partnership Member has the right to file a complaint or grievance with their Partnership or with the Department for Medicaid Services if they are dissatisfied with the actions taken with respect to their care. Complaints/grievances filed with the Partnership shall relate to actions of

The Partnership and its Subcontract providers, including dissatisfaction with direct service providers, appropriateness of services rendered, timeliness of services, denial, reduction or termination of services, or any other performance that is considered unsatisfactory. In addition, Members may appeal actions of The Partnership and its Subcontract providers described above to the Department for Medicaid Services.

Complaints/grievances related to eligibility determination for Medicaid are required to be filed with the Department for Social Insurance.

Required Response: The Partnership shall indicate agreement with these conditions.

7.8.8.1 Department for Medicaid Services Complaint, Grievance and Appeal Process

In accordance with 42 CFR 434.32, 907 KAR 1:560 and 907 KAR 1:705 Section 9 recipients of medical assistance may appeal to either The Partnership or the Department any actions taken with respect to health services or other actions of The Partnership or provider.

Required Response: The Partnership shall indicate agreement with these requirements.

7.8.8.2 Partnership Complaint and Grievance Process

The Partnership shall have a timely and organized system with written policies and procedures for resolving complaints and formal grievances filed by Members, which shall conform to the requirements as promulgated by HCFA and the Department for Medicaid Services and shall include the following:

A. Establish written policies and procedures for the receipt, handling, and disposition of complaints and grievances. These policies and procedures shall:

- be approved by The Partnership's governing body or board of directors;
- be approved in writing by the Department for Medicaid Services prior to implementation and to be conducted in accordance with 907 KAR 1:560 and 907 KAR 1:705;
- provide for individuals with authority to require corrective action to participate in the process;
- include a routine process for evaluating patterns of complaints and grievances for impact on the formulation of policy and procedures;
- establish procedures for maintenance of records of complaints, grievances and appeals separate from patient medical records and in a manner which protects the confidentiality of Members who complain or file formal grievance or appeals;
- name specific individuals designated by The Partnership's governance body who have responsibility for the proper functioning of the grievance process;
- include a method for obtaining Member and Provider advice for resolution of individual grievances;
- inform Members, both verbally and in writing, about Partnership and state agency complaint, grievance and appeal processes when The Partnership or its subcontract providers deny, reduce or terminate a Member's request for services, and by making information readily available at each Partnership facility including facilities of Subcontract providers; and by distribution to all members upon enrollment and to all Subcontractors at the time of Subcontract, and at eligibility recertification, or any change in eligibility status;
- provide Members with assistance in making complaints or filing grievances, if the Member wants assistance;
- include assurance that there will be no discrimination against a Member solely on the basis that the Member filed a grievance or made a complaint;
- provide an explanation regarding the continuation of services pending resolution of a complaint, grievance or appeal;
- include provisions for notifying members that they have the right to appeal The Partnership's disposition of a complaint or grievance to the Department for Medicaid Services' state fair hearing process, including expedited time frames;
- include notification of the grievance procedure anytime at the request of the Member or the Member's representative; and
- include notification to Members regarding the availability of free legal aid assistance with a grievance and/or state fair hearing.

B. Informal Complaints

The Partnership shall have an informal complaint process which consists of verbal complaints. The Partnership shall include an adequately staffed member services function which can receive telephone calls and meet with members face-to-face to answer questions and attempt to resolve complaints. Every complaint received in person or by telephone shall be logged into The Partnership's management information system or documented in the complaint log book. Log forms must be pre-approved by the Department for Medicaid Services with the following

information included: name of Member or Member identification number, Member's telephone number, complaint, date of complaint, Member's Primary Care Provider, Member's Primary Care Provider's telephone number, Member's county of residence, resolution, date of resolution, corrective action required and person recording complaint.

If complaints cannot be resolved at this level, The Partnership's member services staff shall be trained on referring complaints on to the formal grievance procedure.

C. Formal Grievances

The Partnership shall have a timely and organized formal grievance system in place to resolve members' grievances with health care services provided to them. The grievance process will be available for disputes between The Partnership and the Member concerning, among other things, denial, reduction, or termination of services; requests for services that are not acted upon in a timely manner; dissatisfaction with Providers; appropriateness of services rendered; availability of services; the inability to obtain culturally and linguistically appropriate care; or disputes regarding disenrollment. A denial includes any instance in which a request for a medical service or Medicaid eligibility has been made in which a member has been told "no".

The Partnership's grievance procedure must comply, at a minimum, with the following:

- The grievance procedure will be approved by The Partnership's governance body, and will be approved in writing by the Department for Medicaid Services prior to implementation.
- All grievances will be in writing preferably within 30 days of the aggrieved occurrence, either by the Member or the Member's representative, stating the reason for the grievance and submitted to the Member's Partnership.
- Grievances shall be logged into The Partnership's management information system or documented in the complaint log book. Log forms must be pre-approved by the Department for Medicaid Services with the following information included: name of Member or Member identification number, Member's telephone number, complaint, date of complaint, Member's Primary Care Provider, Member's Primary Care Provider's telephone number, Member's county of residence, resolution, date of resolution, corrective action required and person recording complaint.
- The Partnership shall respond within three business days to the member filing the grievance, including written acknowledgment of receipt of the grievance and the name and telephone number of the staff member who may be contacted about progress in resolving the grievance.

D. Resolution Notification to the Member

The Partnership will send a letter, notifying the Member of the grievance resolution. The letter will report the grievance decision, as well as a clear explanation of the Member's right to a state fair hearing.

Complaints or grievances of an emergency or urgent nature, would constitute an expedited review process. Denial of emergency care services shall be reviewed and resolved within three (3) hours of the denial. Urgent complaints or grievances relating to matters which could place the Member at risk or which could seriously jeopardize the Member's health or well-being shall be resolved within 48 hours or less. Non-urgent complaints and grievances shall be resolved within 30 days from the initial formal grievance filing. A written response to timely grievances shall be provided to the member filing the grievance within 30 days from the initial filing. A written response to grievances filed later than 30 days following the aggrieved occurrence shall be provided within 60 days from the initial filing.

E. Reports

The Partnership shall submit to the Department for Medicaid Services and to The Partnership's Quality and Access Recipient Advisory Committee, a quarterly summary report of all Member complaints, grievances and appeals and their disposition. The report shall be in a format approved by the Department for Medicaid Services, and shall include at least the following information: number of complaints and number of grievances; number of urgent complaints and grievances; nature of complaints and grievances; organization or provider which is the subject of complaints or grievances; resolution; time frame for resolution; and number of pending complaints and grievances. The Department for Medicaid Services may conduct reviews or site visits to follow up on repeated complaints or grievances or patterns of complaints or grievances. Any patterns of suspected fraud or abuse identified through review of complaint and grievance data shall immediately be referred to The Partnership's Program Integrity Unit.

F. State Fair Hearings For Applicants and Eligibles

A member may request a state fair hearing at any time to the Department for Medicaid Services to be heard by an impartial state hearing officer. Filing or resolving a complaint or grievance through The Partnership grievance process is not a prerequisite to obtaining a fair hearing with the Department for Medicaid Services.

All documents supporting The Partnership's actions must be received by the Department for Medicaid Services no later than five (5) working days from the date The Partnership receives notice from the state that a fair hearing process has been filed. The Department for Medicaid Services will provide Members with a fair hearing process that shall adhere to 907 KAR 1:560.

Failure of The Partnership to comply with the fair hearing requirements of the State and Federal Medicaid law in regards to a particular service or payment for the member or to appear and present evidence at a fair hearing requested by a member will result in an automatic ruling in the favor of the member.

In cases other than expedited reviews, a final written decision must be issued by the hearing officer to the Member. If the individual is dissatisfied with the final decision of the hearing officer, he or she can appeal to a court of law as set forth in state law.

Required Response (a): Provide a narrative outlining the Member's complaint and grievance procedures as well as The Partnership's implementation, tracking and record keeping plan.

Required Response (b): Submit The Partnership's Members complaint and grievance policies and procedures.

Finally, this complaint procedure provision will be strengthened by a clear definition of medical necessity.

North Carolina

North Carolina Contract

North Carolina Division of Medical Assistance, Managed Care Unit, Medicaid Managed Care Risk Contract between The State of North Carolina Division of Medical Assistance and The Wellness Plan [Effective Date: 7/1/96 - 6/30/99]

APPENDIX IX:

GRIEVANCE PROCEDURES

The Plan shall have a timely and organized internal grievance system with written policies and procedures (42 CFR 434.32). The Plan shall establish an internal grievance process to resolve complaints from Members whose claims for medical assistance are denied, terminated, reduced, inappropriate to needs, or not acted upon promptly. A denial includes any instance in which a request for a medical service has been made in which a Member has been told "no". The process will be available for disputes between the Plan and the Member concerning disenrollments.

A. Through the internal grievance process, Members can seek to resolve disputes with the Plan. The Plan's internal grievance procedures are not a substitute for the State appeal procedures, set forth in 10 North Carolina Administrative Code, Chapter 26, Subchapter I (10 NCAC 26I), which shall be available to Medicaid applicants/recipients at any time.

B. The Plan shall develop written policies and procedures which detail the operation of the internal grievance process and which shall:

1. be approved by the Plan's governing body and be the direct responsibility of the governing body;
2. be approved by the Division prior to implementation;
3. be distributed to all Members upon enrollment, to all subcontractors at time of subcontract,

and to non-contracting providers within ten (10) days of the date of receipt of claim;

4. inform Members and applicants about the internal Plan grievance process and state appeals process set forth in 10 NCAC 26I orally and in writing, through a State developed or approved description of the grievance process, at: (1) no less than one conspicuous location of each reception area of each provider within the Plan; (2) the time of initial enrollment; (3) each time a service is denied, reduced, and/or terminated, and/or whenever a Plan or provider does not take a course of action or treatment normally taken for the Member's medical problem; (4) at every eligibility recertification; (5) each time the recipient enrolls in another Plan;

5. name specific individuals in the Plan who have authority to administer the internal grievance policy;

6. include an adequately staffed consumer relations or member services office which can receive telephone calls and meet personally with Members and which members can use to ask questions and resolve problems. This aspect of the internal grievance process will be informal and operate through verbal communication. The consumer relations/member services office will maintain records that include a short, dated summary of each question or problem, name of the member, date of contact, the response, and the resolution. If the Plan does not have a separate log for Medicaid recipients, the log shall distinguish Medicaid recipients from other Plan enrollees;

7. include an internal grievance process through which Members can complain directly to the Plan's governing body. The governing body may delegate this authority to an internal grievance committee, but the delegation must be in writing. Grievances are to be filed in writing either by the Member or Member's representative, stating the reason for the grievance. The Plan will maintain records that include a copy of the original grievance, the response, and the resolution. This system shall distinguish Medicaid recipients from other Plan Members and identify the grievant and the date of complaint;

8. provide for retention of the records described in subparagraphs 6 and 7, above, for five (5) years following a final decision or close of the grievance. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later;

9. resolve all emergency (as defined in Appendix I.1.17) complaints within 24 hours and resolve all urgent (as defined in Appendix I.1.64) complaints within 48 hours. All other complaints shall be resolved by the Plan within thirty (30) days of the date of the grievance;

10. assure that Plan executives with the authority to require corrective action are involved in the internal grievance process.

C. When a Plan denies, reduces or terminates a Member's request for service or requests the Division to disenroll a Member, a written notice to the Member (or the Member's authorized representative) must explain:

1. that Member has a right to a second opinion if medically necessary, at the Plan's expense and how to exercise that right;

2. how to contact the consumer relations or member services office and how to file an internal grievance with the Plan;

3. the right to file an informal or formal appeal with the State pursuant to 10 NCAC 26I and how to obtain more information about those procedures;

4. that filing or resolving a grievance through the Plan's internal grievance mechanism is not a prerequisite to filing an informal or formal appeal with the State pursuant to 10 NCAC 26I;

5. the circumstances under which health services must be continued pending resolution of the internal grievance or state appeal (see section D, below);

6. the circumstances that will cause an expedited hearing;

7. the right to be advised or represented by a lay advocate or attorney and of the potential availability of free legal services;

8. the right to enroll in another Plan if the Member is not satisfied at the end of the internal grievance or State appeal process;

9. that the Health Benefits Manager is available to the Member/Applicant at any time, to provide assistance during the internal plan grievance process or the State appeal process under 10 NCAC 26I.

D. If a Member files an internal grievance with the Plan or appeals to the State pursuant to 10 NCAC 26I on or before the tenth day after a decision is communicated in writing to the Member to reduce, suspend, or terminate services the Member had been receiving from the Plan on an ongoing basis, or before the date of the proposed action, whichever is later, and the treating Plan physician or another Plan physician has ordered the services at the present level and is authorized by the Contract with the Plan to order the services, the Plan will continue to provide services at a level equal to the level ordered by the Plan physician until a final decision is made by the Plan and/or the State. If the resolution by the Plan is adverse, in whole or part, to the Member, the Member must be notified again of the right to a State appeal pursuant to 10 NCAC 26I and to continued services pending the appeal. If the Member appeals a Plan's written resolution within ten (10) days after it is issued, or before the date of the proposed action, whichever is later, services must be continued pending a final state-level decision. A resolution is made or issued on the date it is mailed or the date postmarked, whichever is later.

E. The Plan must make the information and notices described in this addendum readily available orally and in writing in the recipient's primary language.

F. Information regarding the nature of internal grievances and resolution may be publicly disclosed by the State in consumer information materials.

G. The Plan's final written decision upon completion of the internal grievance shall be delivered by certified mail to the Member and it will contain the information set forth in section C.3 and

C.5-9, above.

H. If the Plan's decision is appealed under 10 NCAC 26I, all supporting documentation must be received by the State no later than five (5) working days from the date the Plan receives the appeal or notice from the State that an appeal has been filed. The appeal file must include:

1. written request of the grievant asking for appeal;
2. copies of the entire file that include investigation material, medical records, the Plan's decision(s), and the Member's response;
3. any information used by the Plan to reach its decision.