MEDICAID HEALTH PLAN GRIEVANCE AND APPEAL PROCESS

What is the Medicaid Health Plan Grievance and Appeal Process?

- All Statewide Medicaid Managed Care (SMMC) health plans must have a grievance and appeal system for handling enrollee complaints, grievances, and appeals.
- In 2016, the Centers for Medicare & Medicaid Services published a final rule on Medicaid managed care that changed some of the requirements around the grievance and appeal system.
- The Florida Legislature passed a law to designate responsibility to the Agency for Health Care Administration (Agency) for conducting Medicaid fair hearings for services related to Medicaid programs (including managed care) administered by the Agency, beginning March 1, 2017.
- The Department of Children and Families (DCF) is responsible for fair hearings related to iBudget waiver services, Medicaid financial eligibility determinations made by DCF, fair hearings arising out of the Pre-admission Screening and Resident Review (PASRR), and all fair hearings resulting from resident transfers or discharges from nursing facilities or related health care facilities.

Types of Requests:

- A **complaint** is when an enrollee submits an oral or written expression of dissatisfaction to the health plan or a state agency that is resolved by close of business the **next business day**.
- A **grievance** is an expression of dissatisfaction about any matter other than a service decision. When a complaint has not been resolved within one business day, the complaint becomes a grievance. The health plan must resolve a grievance within **90 days**.
- An **adverse benefit determination** is a health plan's denial, reduction, suspension, or termination of a service, or when the health plan has not responded to an enrollee's grievance within 90 days. The health plan must also send the enrollee a letter, called a **notice of adverse benefit determination**. This notice tells the enrollee what the health plan decided and why, and gives directions on how the enrollee may ask for a plan appeal. An adverse benefit determination must be made within **7 days** and may be **appealed by the enrollee within 60 days**.
- A **plan appeal** is when the enrollee disagrees with the health plan's adverse benefit determination and wants to seek a review. The health plan must resolve a plan appeal within **30 days**. If the plan upholds any part of its decision, the enrollee may ask for a Medicaid fair hearing.
- An **expedited appeal** is a "fast" plan appeal. An enrollee can ask for an expedited appeal when waiting for a standard response for 30 days may be harmful to the enrollee. The health plan must resolve an expedited appeal within **72 hours**.

Medicaid Fair Hearings:

The enrollee must complete the plan appeal process before asking for a Medicaid fair hearing. The enrollee may **ask an Agency hearing officer to have a Medicaid fair hearing within 120 days** after any part of the plan's decision is upheld, to challenge the health plan's appeal decision. The Agency hearing officer will make a **final decision on the enrollee's fair hearing in about 90 days**.

Continuation of Benefits during Appeals and Fair Hearings:

While the plan appeal or the Medicaid fair hearing are taking place, the enrollee can ask to have his or her services continue. This is called continuation of benefits. To do this, the request for an appeal or fair hearing must be filed no later than 10 days after the unfavorable notice was mailed OR on or before the first day that the enrollee's services are scheduled to be reduced, terminated or suspended. If services are continued and

the plan's decision is upheld, the enrollee may be asked to pay for the cost of continued services. However, Medicaid benefits cannot be taken away and the enrollee's family or legal representative cannot be asked to pay.

To learn more about SMMC:

Access the Agency's SMMC Program website at: www.ahca.myflorida.com/SMMC