Medicaid Managed Care Final Rule
Beneficiary Protections: Subpart F - Grievance & Appeals System

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CMS Overview of Subpart F: The CMS final rule for Subpart F – Grievance and Appeal System – aligns definitions and timeframes for grievances and appeals with the private market and Medicare Advantage. Plans must have only one level of internal appeals, which beneficiaries must exhaust before requesting a State Fair Hearing. States may offer beneficiaries external reviews so long as the process does not extend the timeframes for the appeals process.[i]

Existing Mental Health Plan (MHP) Requirements: County MHP contracts currently align with the requirements of the former Medicaid managed care rule. MHP contractual requirements related to beneficiary problem resolution processes are found in Exhibit A, Attachment I of the MHP contract (pp. 30-44 of the MHP contract boilerplate).[ii]

Overview of Key Sections and Changes from Previous Rule: The implementation dates for each of the following sections is July 1, 2017.

Subpart F - Grievance & Appeals System[iii]		
Section	***New Requirement***	***Previous Requirement***
§438.402 General Requirements	Each MHP may have only **one level of appeal for enrollees** (§438.402(b)).	Previous regulations do not provide guidance on levels of appeals.
	The State may offer and arrange for an external medical review if the following conditions are met (§438.402(c)).	
	Following receipt of a notification of an adverse benefit determination by a MHP, **an enrollee has 60 calendar days from the date on the adverse benefit determination notice** in which to file a request for an appeal ((§438.402(c)).	Previous regulations allowed states to specify a reasonable timeframe for a beneficiary to file an appeal which should be no less than 20 days and not to exceed 90 days from the date of the notice of action provided to the beneficiary.
§438.406 Handling of Grievances and Appeals	Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MHP in connection with the appeal of the adverse benefit determination. This information must be provided **free of charge and sufficiently in advance of the resolution timeframe for appeals** as specified in §438.408(b) and (c) (§438.406(b)).	Previous regulation did not include the clause regarding providing evidence to enrollees free of charge and sufficiently in advance of the resolution timeframes for appeals.
§438.408 Resolution and Notification of Grievances and	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** from the day the MHP receives the appeal.	For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MHP receives the appeal. This timeframe

Subpart F - Grievance & Appeals System[iii]		
Section	***New Requirement***	***Previous Requirement***
Appeals	This timeframe may be extended under certain circumstances as described in paragraph (c) of this section (§438.408(b)(2)).	may be extended under certain circumstances as described under paragraph (c) of this section.
	For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is **no longer than 72 hours after the MHP receives the appeal**. This timeframe may be extended under certain circumstances as described in paragraph (c) of this section (§438.408(b)(3)).	For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MHP receives the appeal. This timeframe may be extended under certain circumstances as described under paragraph (c) of this section.
	An enrollee may request a State fair hearing only after receiving notice that the MHP is upholding the adverse benefit determination. In the case of an MHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MHP's appeals process. The enrollee may initiate a State fair hearing (§438.408(f)).	The previous regulation permitted states to decide whether a beneficiary is required to exhaust the internal appeals process prior to requesting a State Fair Hearing.
	The State may offer and arrange for an external medical review if conditions in paragraph (f)(ii) are met (§438.408(f)(ii)).	The previous regulation did not address external medical reviews.
	The **enrollee must request a State fair hearing no later than 120 calendar days** from the date of the MCO's, PIHP's, or PAHP's notice of resolution (§438.408(f)).	The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days.

Other Related Sections

- Grievance and Appeals Systems (§438.228)
  - The State must ensure that each MHP has in effect a grievance and appeal system that meets the requirements of subpart F.
  - The State must conduct random reviews of each MHP and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner.
- Definitions (§438.400)
  - This section defines the following terms: adverse benefit determination, appeal, grievance, grievance and appeal system, and state fair hearing.
  - Implementation date: 7/1/17
- Contents of a Notice of Adverse Benefit Determination (§438.404)
  - Implementation date: 7/1/17
- Recordkeeping requirements (§438.416)
  - Implementation date: 7/1/17
- Effectuation of reversals (§438.424)
  - Implementation date: 7/1/17

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[i] Medicaid and CHIP Managed Care Final Rule (CMS-2390-F). *Beneficiary Experience and Provisions Unique to Managed Long Term Services and Supports (MLTSS).* Accessed via: https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-webinar.pdf

[ii] MHP Contract Boilerplate. 2013-2018. Accessed via: http://www.dhcs.ca.gov/services/MH/Documents/2013-2018_MHP_Contract.pdf

[iii] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability (CMS-2390-P). Accessed via the Federal Register: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf