GRIEVANCE AND APPEALS PROCESS FOR MEDICAID MANAGED CARE MEMBERS
2016

GRIEVANCE AND APPEALS PROCESS
FOR MEDICAID MANAGED CARE MEMBERS

Medicaid managed care (MCO) member problems can be resolved through three channels:

- The Health Plan's customer or member services department's informal complaints process
- The Health Plan's formal grievance and appeals process
- The existing Fair Hearing process of the Executive Office of Health & Human Services (EOHHS)

1. Health Plans

MCO members are encouraged to use the customer or member services department to help solve their problems. When this cannot be done to the member's satisfaction, then the member can file a formal grievance or appeal with the Health Plan. The Health Plans, as part of their contractual agreement with the State are required to inform members about the complaint, grievance and appeal process available within the Health Plans and at the State level.

The Health Plans maintain internal policies and procedures to conform to the State reporting rules and policies. Medicaid managed care members must exhaust the internal Health Plan appeal process before requesting an External Review (3rd level review) through the Health Plan and/or EOHHS Fair Hearing. Members may choose to initiate a third level appeal or external appeal, per the Department of Health Rules and Regulations for Utilization Review of Health Care Services (R23-17.12-UR). A member does not have to exhaust the third level (external) appeal before accessing the EOHHS Administrative Fair Hearing.

As listed in Patient's Rights and Protections (Section 1311.16, 1311.22, and 1311.24 of the EOHHS Manual), appeals filed with a Health Plan fall into three areas:

- **Medical emergency (Expedited/Urgent) —** A Health Plan must decide the appeal within two (2) business days when a treating provider such as a doctor who takes care of the member determines the care to be an *emergency* and all necessary information has been received by the Health Plan.

- **Other medical care —** There are two levels of a non-emergency medical care appeal. For the initial level of appeal, the Health Plan must decide the appeal within fifteen (15) calendar days of all necessary information being received by the Health Plan. If the initial decision is against the member, then the Health Plan must offer the second level of appeal. For the second level of appeal, the Health Plan must decide on the grievance within fifteen (15) calendar days of all necessary information being received by the Health Plan.

- **Non-medical care —** If the grievance involves a problem other than medical care, the Health Plan must decide the grievance within thirty (30) calendar days and all necessary information has been received by the Health Plan.

A MCO member may also contact the Rhode Island Department of Health at (401) 277-4905 as well as the Office of the Health Insurance Commissioner (OHIC) at 401-462-9517 to register complaints.

2. EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

As is also listed in the MCO member Patient's Rights and Protections, members have a right to a timely EOHHS State Fair Hearing after the Health Plan internal appeals process has been exhausted. The member may file a formal grievance or appeal by obtaining the proper form from any local Department of Human Services (DHS) office. Both Health Plans and DHS staff are responsible for advising the clients of the steps necessary to file a grievance and appeal external to the Health Plans with DHS.

It is important to note that MCO members, like all Medical Assistance (MA) recipients, have the right to a formal hearing if they are dissatisfied with EOHHS decision or if the EOHHS delays in making a decision. If a hearing is requested, the appeal will be heard promptly. An MA applicant/recipient may be represented by a lawyer or any other person the applicant/recipient selects. Hearing forms for filing a formal complaint through the Fair Hearing Process are available at every Rhode Island Department of Human Services field office or on line at www.dhs.ri.gov, select "Quick Links" then "Request for a Hearing".

The entire Fair Hearing process, including the reporting of an action required to make the decision effective, must be completed whenever possible within thirty (30) days of receipt of a request, but in no case is it to exceed a maximum of ninety (90) days, unless the individual requests in writing a delay to prepare his or her case. A MCO member may request an expedited decision. EOHHS will inform the MCO member of their right to judicial review in the event their appeals to these agencies are unsuccessful.

3. REFERRAL TO RHODE ISLAND LEGAL SERVICES

Notices to applicants will include the information that an applicant/member may represent herself/himself or be represented by someone else such as a lawyer, relative, or another person. Notices will also include information regarding free legal help being available by

calling Rhode Island Legal Services at (401) 274-2652 and, outside the Providence calling area, by calling toll-free at 1-800-662-5034.