MANAGED CARE PROGRAM ANNUAL REPORT (MCPAR) TECHNICAL GUIDANCE TOPIC: APPEALS AND GRIEVANCES

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Contents

Purpose

This technical guidance was created to assist state Medicaid agencies (States) and their contracted managed care plans in collecting data to be used by States to complete the appeal and grievance sections of the Managed Care Program Annual Report (MCPAR). Appeals and grievances tracking and reporting are required pursuant to 42 CFR §§ 438.416 and 438.66(e), respectively, for all managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). This technical guidance refers to these plan types collectively as "managed care plans" (MCPs).[1]

The MCPAR collects MCP-level information about appeals and grievances, including the type of service and the setting where the service occurred. This reporting facilitates the monitoring and oversight of service delivery and tracks the responsiveness of MCPs. For example, high numbers of appeals and grievances could reflect a robust appeal and grievance system or that an MCP has challenges ensuring timely access to covered services. Low numbers of appeals and grievances could mean that an MCP did not make many adverse benefit determinations, that access to care meets enrollees' needs, or that an MCP does not adequately categorize and track appeals and grievances.

In all cases, reporting robust appeals and grievances data provides States the opportunity to identify issues or problematic trends that warrant further investigation to ensure that MCPs' appeals and grievances systems work effectively and efficiently for managed care enrollees.

This technical guidance provides definitions related to appeals and grievances for the purpose of completing MCPAR, outlines processes and requirements for appeal and grievance reporting, and provides information for states on how to improve their MCPAR reporting, including addressing key questions that states have raised. This guidance may also be used to assist MCPs in reporting timely and accurate data to states to facilitate accurate MCPAR submissions.

Appeal and Grievance Regulations, Definitions, and Processes

Appeals and grievances in Medicaid managed care are addressed in Title 42 of the Code of Federal Regulations (CFR) Part 438 Subpart F (42 CFR §§ 438.400 – 483.424). These regulations drive the content and structure of MCPAR reporting on appeals and grievances.

Appeal is defined as a request by an enrollee, their representative, or a provider on behalf of an enrollee to review an **adverse benefit determination** made by an MCP.[2]

Adverse benefit determination is defined as any of the following actions:

1. An authorization for a requested service is denied or limited.
2. A previously authorized service is reduced, suspended, or terminated.

[1] States are not required to complete appeal and grievance questions in MCPAR for managed care programs that utilize primary care case management entities only.

[2] See 42 CFR 438.402(c)(1)(ii)

3. Payment is denied in whole or part for a service already rendered.[3]
4. A service is not provided in a timely manner.
5. A decision is not rendered on a requested service within the established timeframes.
6. An out-of-network service is denied for a resident of a rural area with only one MCP.
7. A request is denied disputing enrollee financial liability, such as co-payments or premiums.

Appeal: a review of an adverse benefit determination

An **expedited appeal** is a request for a quicker review based on the determination by the MCP, enrollee, or the provider that taking the time for standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

An appeal is **resolved** when the MCP has issued a decision. The appeal is considered resolved regardless of whether the decision was wholly or partially favorable or adverse to the enrollee or former enrollee, and regardless of whether the enrollee or their representative files a request for a state fair hearing or external medical review.

When an appeal results in an adverse benefit determination being upheld, the enrollee, their representative, or a provider on behalf of an enrollee may request a **state fair hearing** and, for states that offer it, an **external medical review.**

Grievance: any complaint or dispute expressing dissatisfaction about any matter except an adverse benefit determination

Separate from an appeal, a **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or MCP employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievances include an enrollee's right to dispute the amount of time an MCP takes to make an authorization decision. Grievances may include what some states or MCPs refer to as "complaints." Grievances typically do not include customer service inquiries, such as a request for assistance finding a provider or to ask whether a service is covered, unless during that request, the enrollee or their representative also expressed dissatisfaction.

[3] A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination.

Exhibit 1. Processes for Appeals v. Grievances
Appeals and grievances involve similar but distinct processes based on the actions taken by the enrollee and MCP. The following is a high-level illustration of key differences between the appeal and grievance processes.

Appeal Process

1. Enrollee receives notice of an adverse benefit determination of MCP fails to timely act on a benefit determination
2. Enrollee files an appeal with the MCP
3. MCP renders a decision on the appeal and notifies the enrollee
4. If the decision is adverse to the enrollee, in whole or in part, the enrollee can file for a state fair hearing and/or an external medical review if offered by the state

Grievance Process

1. Enrollee expresses dissatisfaction about any matter other than an adverse benefit determination
2. MCP resolves the grievance
3. MCP notifies the enrollee

How States can Improve MCPAR Appeals and Grievances Reporting

This section provides instruction on key areas about which States have had questions or where MCPAR data has had reporting errors. For some MCPAR data fields, it is possible to check the data by comparing it to data reported in other data fields to determine if the numbers are reasonable. Math tips are denoted by the calculator icon.


Math Tip

Reporting Reason and Service Types for Appeals & Grievances

The MCPAR captures detail on the reason for grievances or appeals and the service type. How the reason and service type is captured in the MCPAR varies and is summarized below:

Reason:

- Appeals: can only have ONE reason (i.e., the primary reason).
- Grievances: can have MORE THAN ONE reason.

Service Type:

- Appeals and Grievances: can apply to MORE THAN ONE service type.

This section provides more detailed information and examples on how to report reasons and service types for appeals and grievances.

Reporting Primary Reason Only for Appeals

Questions D1.IV.6a-6g in the MCPAR list seven reasons why an enrollee can file an appeal after receiving an adverse benefit determination in accordance with 42 CFR § 438.400(b). In the MCPAR, these reasons are meant to be mutually exclusive. That is, only one reason can be assigned to each appeal, so states should report only the primary reason for the appeal. With only one reason assigned, states and CMS can pinpoint potential problems at a plan level.

Math Tip: Adding up the number of reasons for appeals in Questions 6a-6g should equal the total number of Appeals Resolved (D1.IV.1) because each appeal can only be assigned one reason.

Example: John Doe files an appeal after being denied coverage of care from an out-of-network provider for mental health services that he could not otherwise reasonably access in the rural community he resides in where there is only one choice of MCP. In the MCPAR, the state would report that the reason for the appeal is due to denial of coverage of care from an out-of-network provider and no other reason.

Reporting All Reasons for Grievances

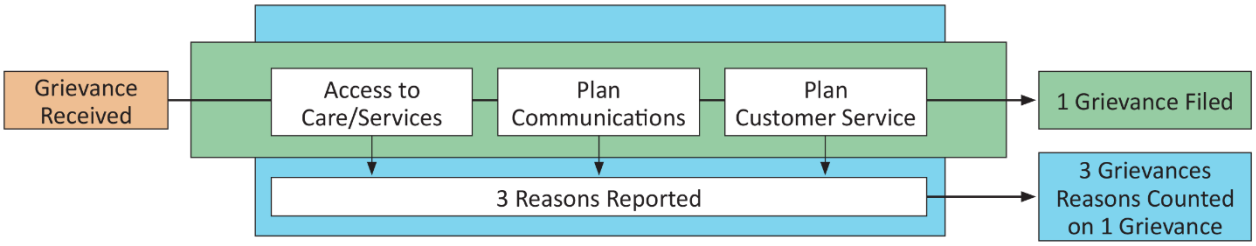
The MCPAR lists eleven reasons for grievances (**D1.IV.16a-k**). The "Grievances resolved" question (**D1.IV.10**) should be completed with the total number of grievances resolved by the MCP in the reporting year.

Math Tip: The sum of grievance reasons (D1.IV.16 a-k) can exceed the total grievances resolved (D1.IV.10). Please note that this is different than an appeal, which can only have one reason.

Example: Sarah Smith calls her MCP because she called several ear, nose, and throat doctors in the network directory to get an appointment for her son. None of the doctors were taking new

patients despite being listed in the directory as accepting new patients. During the call, Sarah felt the customer service representative was dismissive of her concerns and unhelpful. Sarah filed a grievance, which was then coded with the following reasons: access to care/services (reason D1.IV.16c), plan communications related to the incorrect network directory (reason D1.IV.16e), and plan customer service (reason D1.IV.16a). **Exhibit 2** below illustrates that this would be counted as one grievance with three reasons.

Exhibit 2. Example of One Grievance with Three Reasons



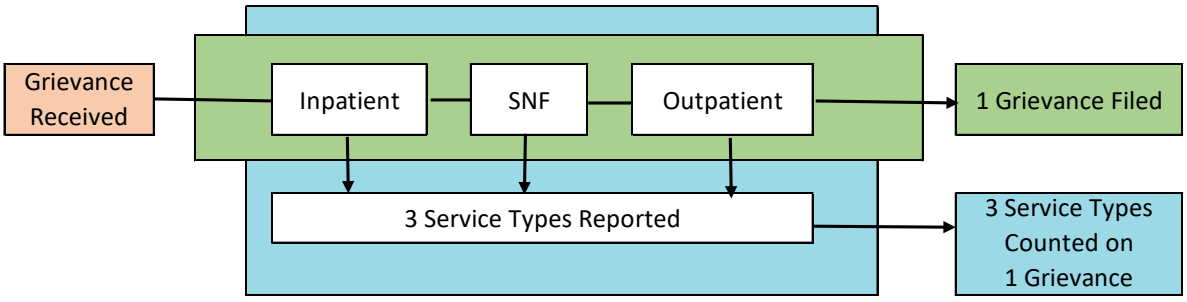
Reporting Appeals and Grievances by Service Types

The number of resolved appeals (**D1.IV.7a-7j**) or resolved grievances (**D1.IV.15a-15j**) by service type can be greater than the number of resolved appeals or resolved grievances, respectively. This is because a single appeal or grievance can be related to more than one service type.

Math Tip: The sum of appeals or grievances across all service types should always be equal to or greater than total resolved appeals or grievances because all resolved appeals or grievances would be assigned to at least one service type.

Example: Jane Doe fractured her hip. After waiting ten hours in the emergency room, she was admitted to the hospital and had surgery four days later. Jane was then transferred to a skilled nursing facility (SNF) for 21 days. After being discharged, she was supposed to be seen by a home health nurse within one day, but the nurse did not visit until five days post-discharge. Jane filed a grievance that named the hospital, the SNF, and the home health agency. **Exhibit 3** below illustrates that although this is filed as one grievance it should be reported on the MCPAR as three separate service types.

Exhibit 3. Example of One Grievance with Three Service Types



Use of "Other" Category for Grievance Reason and Service Type

Resolved grievances must be categorized by the **service type** and **reason** to which they relate. There is an "other" category for service types (**D1.IV.15j**) and for reason (**D1.IV.16k**). We encourage states to avoid selecting "other" unless no categories available are sufficiently similar and to use the category that most closely aligns with type of service or reason for the grievance whenever possible.

Timeliness of Resolved Appeals

MCPAR not only requires the reason for the appeal, but also whether the appeal was resolved timely.

Appeals that are resolved in a timely manner are reported by whether they are standard or expedited (**D1.IV.5a** and **D1.IV.5b**).

Math Tip: If the number of timely appeals resolved (D1.IV.5a and D1.IV.5b) is greater than the number of resolved appeals (D.1.IV.1), then there is a problem with the numbers.

The total number of timely resolved appeals (i.e., the sum of standard and expedited appeals) **should be less than or equal to the number of resolved appeals.** This is because the total number of resolved appeals includes those that were resolved on time and those that were not resolved on time (either standard or expedited). **Exhibit 4** on the next page illustrates how this works using correct and incorrect examples.

Exhibit 4: Formula and Examples of Calculations for Timely Resolved Appeals

This is the formula states should follow when reporting Timely Resolved Appeals

Standard appeals for which timely resolution was provided D1.IV.5a	+	**Expedited appeals** for which timely resolution was provided D1.IV.5b	≤	Number of **appeals resolved** D1.IV.1

These examples are correct	This example is incorrect
This example is correct because the number of timely standard and expedited appeals is less than the number of resolved appeals. In this case, 100 resolved appeals were not timely. $800 + 100 \leq 1{,}000$ *800: **standard appeals** for which timely resolution was provided (D1.IV.5a)* *100: **expedited appeals** for which timely resolution was provided (D1.IV.5b)* *1,000: **resolved appeals** (D1.IV.1)* This example is correct because the number of timely standard and expedited appeals is equal to the number of resolved appeals. In this case, all appeals were resolved timely. $800 + 200 = 1{,}000$ *800: **standard appeals** for which timely resolution was provided (D1.IV.5a)* *200: **expedited appeals** for which timely resolution was provided (D1.IV.5b)* *1,000: **resolved appeals** (D1.IV.1)*	This example is incorrect because the sum of timely standard and expedited appeals can never be greater than the total number of resolved appeals. $1{,}200 + 200 > 1{,}000$ *1,200: **standard appeals** for which timely resolution was provided (D1.IV.5a)* *200: **expedited appeals** for which timely resolution was provided (D1.IV.5b)* *1,000: **resolved appeals** (D1.IV.1)*

Reporting All Grievances

When an enrollee expresses dissatisfaction with an aspect of their Medicaid managed care coverage that is not related to an adverse benefit determination, it is a grievance. The MCP must track all grievances and report them to the state, even if they are resolved quickly. An enrollee inquiry alone is not a grievance, but if there is any expression of dissatisfaction during the inquiry, it qualifies as a grievance and must be reported.

Example: If a member contacts the MCP to receive help finding a specialist near them, that should be considered an inquiry and does not need to be reported in MCPAR. However, if during the call, the member expresses frustration that they contacted all specialists in the network directory and none of them are taking new patients, that would be an expression of dissatisfaction. This should be categorized as a grievance and reported as such in MCPAR.

Timeframe for Appeal and Grievance Reporting

Count resolved appeals or grievances based on when they were resolved, even if they were filed in a previous reporting period. If an appeal or grievance was **filed** in a previous MCPAR reporting year, but **resolved** within the current MCPAR reporting year, it would have been counted in the **previous reporting year** as an active or pending appeal (i.e., not yet resolved) (**D1.IV.2**) or grievance (**D1.IV.11**) **and** as a resolved appeal (**D1.IV.1**) or grievance (**D1.IV.10**) in the **current reporting year**. **Exhibit 5** below illustrates how to report appeals that are active in 2022 but resolved in 2023 in a Calendar Year (CY) reporting state. Although the example relates to an appeal, this also applies to grievances.

Exhibit 5. Example of Timeline for Appeal (or Grievance) Reporting

2022						2023					
Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
-	-	-	♦	-	♠	♣	-	-	-	-	-

- ♦ **October 2022:** Adverse benefit determination occurred 10/6/22
- ♠ **December 2022:** Appeal received 12/5/22 – Reported as **active** in MCPAR submitted for CY 2022
- ♣ **January 2023:** Appeal resolved 1/3/23 – Reported as **resolved** in MCPAR for CY23

Use of "Not Applicable" (N/A) for Appeals and Grievances

When reporting appeals and grievances by service type (**D1.IV.7a-j and D1.IV.15a-j**), states should only enter "N/A" when the MCP does not cover the service type. Otherwise, a number should be used in these responses. Enter a "0" (zero) when the service is covered but there are no grievances or appeals for the reporting year. See Appendix A for a list of MCPAR appeal and grievance questions where N/A is appropriate. For all other questions, N/A is not a valid response.

Reporting for Long-Term Services and Supports (LTSS) Plans

There are MCPAR questions that apply only to MCPs that cover LTSS benefits and/or have LTSS users (Appendix A identifies LTSS-specific questions.) For states that do not cover LTSS in an MCP contract, it is appropriate to enter "N/A" for LTSS-related questions. States that cover LTSS in an MCP contract should include appeals and grievances filed by or on behalf of enrollees who use LTSS in response to MCPAR questions in Section D1.IV.

For questions that require LTSS-specific reporting, the first step is to identify if the program covers LTSS. If the answer is yes, proceed with answering each LTSS question:

- Report the total number of appeals **filed** within the reporting year for enrollees who received at least one LTSS service during the year (**D1.IV.3**). There is a similar question for grievance reporting (**D1.IV.12**).
- Report the number of critical incidents that occurred during the reporting year involving an LTSS user that also filed an appeal. To develop this number, determine if the enrollees associated with critical incidents also filed an appeal within the reporting year **for any reason** (**D1.IV.4**). There is a similar question for grievance reporting (**D1.IV.13**).

- Report the number of resolved appeals that were related to LTSS institutional care or home and community-based services (**D1.IV.7g**). There is a similar question for grievance reporting (**D1.IV.15g**). These two questions should only capture appeals or grievances specifically related to LTSS.

Appendix A. When "Not Applicable" (N/A) is Appropriate

This appendix lists each MCPAR appeal or grievance-related question in an abbreviated form and describes if a response of "N/A" is allowable.

Note: Questions that only apply to LTSS enrollees or services are noted.

Question Focus	Question #	Question	When a Response of N/A is Allowable
Appeal	D1.IV.1	Appeals Resolved	N/A should not be used
Appeal	D1.IV.2	Appeals Pending	N/A should not be used
Appeal	D1.IV.3	Appeals for LTSS enrollees **[Question only applies to LTSS enrollees or services]**	If specific benefit not covered
Appeal	D1.IV.4	Critical Incidents following an Appeal for LTSS enrollees **[Question only applies to LTSS enrollees or services]**	If specific benefit not covered
Appeal	D1.IV.5a	Standard appeals	N/A should not be used
Appeal	D1.IV.5b	Expedited appeals	N/A should not be used
Appeal	D1.IV.6a	Denial or limited authorization of a service	N/A should not be used
Appeal	D1.IV.6b	Reduction, suspension, or termination (previously authorized)	N/A should not be used
Appeal	D1.IV.6c	Payment denial	N/A should not be used
Appeal	D1.IV.6d	Service timeliness	N/A should not be used
Appeal	D1.IV.6e	Lack of timely plan response to an appeal or grievance	N/A should not be used
Appeal	D1.IV.6f	Denial of an enrollee's right to request out-of-network care in a rural community where there is only one MCP	If plan is not in a rural area with only one MCP.
Appeal	D1.IV.6g	Denial of an enrollee's request to dispute financial liability	N/A should not be used
Appeal	D1.IV.7a	General inpatient services	If specific benefit not covered
Appeal	D1.IV.7b	General outpatient services	If specific benefit not covered
Appeal	D1.IV.7c	Inpatient behavioral health services	If specific benefit not covered
Appeal	D1.IV.7d	Outpatient behavioral health services	If specific benefit not covered
Appeal	D1.IV.7e	Covered outpatient prescription drugs	If specific benefit not covered
Appeal	D1.IV.7f	Skilled nursing facility (SNF) services	If specific benefit not covered
Appeal	D1.IV.7g	Long-term services and supports **[Question only applies to LTSS enrollees or services]**	If specific benefit not covered
Appeal	D1.IV.7h	Dental services	If specific benefit not covered
Appeal	D1.IV.7i	Non-emergency medical transportation (NEMT)	If specific benefit not covered
Appeal	D1.IV.7j	Other service types	If specific benefit not covered

Question Focus	Question #	Question	When a Response of N/A is Allowable
Appeal	D1.IV.8a	State fair hearings filed	N/A should not be used
Appeal	D1.IV.8b	State fair hearings partially or fully favorable to enrollee	N/A should not be used
Appeal	D1.IV.8c	State fair hearings adverse to enrollee	N/A should not be used
Appeal	D1.IV.8d	State fair hearings retracted prior to decision	N/A should not be used
Appeal	D1.IV.9a	External medical review partially or fully favorable to enrollee	If external medical review not offered
Appeal	D1.IV.9b	External medical review adverse to enrollee	If external medical review is not offered
Grievance	D1.IV.10	Resolved grievances	N/A should not be used
Grievance	D1.IV.11	Active grievances	N/A should not be used
Grievance	D1.IV.12	Grievances filed by LTSS users or their representative **[Question only applies to LTSS enrollees or services]**	If specific benefit not covered
Grievance	D1.IV.13	Critical incidents filed by an LTSS user with a previous grievance **[Question only applies to LTSS enrollees or services]**	If specific benefit not covered
Grievance	D1.IV.14	Total number of grievances with timely resolution	N/A should not be used
Grievance	D1.IV.15a	General inpatient services	If specific benefit not covered
Grievance	D1.IV.15b	General outpatient services	If specific benefit not covered
Grievance	D1.IV.15c	Inpatient behavioral health services	If specific benefit not covered
Grievance	D1.IV.15d	Outpatient behavioral health services	If specific benefit not covered
Grievance	D1.IV.15e	Covered outpatient prescription drugs	If specific benefit not covered
Grievance	D1.IV.15f	Skilled nursing facility services	If specific benefit not covered
Grievance	D1.IV.15g	Long-term services and supports	If specific benefit not covered
Grievance	D1.IV.15h	Dental services	If specific benefit not covered
Grievance	D1.IV.15i	Non-emergency medical transportation	If specific benefit not covered
Grievance	D1.IV.15j	Other service types	If specific benefit not covered