

## ME Manage Member Grievance and Appeal

Manage Member Grievance and Appeal		
Item	Details	VA "As-Is" Details
Description	<p>The <b>Manage Member Grievance and Appeal</b> business process handles applicant or member (or their advocate's) appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the <b>Manage Applicant and Member Communication</b> process via the <b>Receive Inbound Transaction</b> process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the <b>Send Outbound Transaction</b> Process.</p> <p>This process supports the <b>Program Quality Management</b> Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.</p> <p>In some states, if the applicant or member does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited.</p> <p><b>NOTE:</b> States may define "grievance" and "appeal" differently, perhaps because of state laws. States must enforce the Balance Budget Act requirements for grievance and appeals processes in their MCO contracts at 42 CFR Part 438.400. They may adopt these for non-MCO programs.</p>	<ol style="list-style-type: none"> <li><b>2010 MITA:</b> DMAS primarily handles appeals for the Fee For Service program. The Managed Care Program handles both grievances and appeals. The MCO member can appeal to the MCO only, the MCO and DMAS simultaneously, or to DMAS instead of the MCO; at any time in the process, the member (Medicaid recipient) can waive the MCO process and request an appeal directly to DMAS.</li> </ol> <p>DMAS allows appeals to be expedited if they meet certain criteria.</p> <ol style="list-style-type: none"> <li>Program Quality Management process is not supported on the Fee For Service side for Member appeals; however, the Fee For Service Provider appeal process does support the Program Quality Management process. The Managed Care Program supports the Program Quality Management process by including monitoring of enrollee grievances and appeals in the MCOs Quality Improvement Program (QIP).</li> <li>The second appeal for the Fee For Service program goes directly to the circuit court, it is not handled internally by DMAS. If a Managed Care program appeal results in an unfavorable decision, the member can file an appeal with DMAS. The decision of the DMAS hearing officer is final is the final administrative ruling. It can be appealed to circuit court.</li> <li>DMAS currently defines "grievance" and "appeal" differently. Grievances are only used by the Managed Care program.</li> </ol>

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<b>Trigger Event</b>	Receipt of grievance or appeal of adverse decision data set from <b>Receive Inbound Transaction</b> process.	<b>2010 MITA:</b> Receipt of an appeal must be within 30 calendar days of an adverse decision from a Fee For Service or Managed Care program member. Receipt of a grievance from a Managed Care member can be by phone in addition to the other stated methods, but must be followed up in writing.
<b>Result</b>	Final disposition of grievance or appeal sent to the applicant or member via the <b>Send Outbound Transaction</b> process.	<b>2010 MITA:</b> The Fee For Service appeals business process steps differ somewhat from the MITA steps. For DMAS Step 4 in the MITA process occurs prior to Step 2. There is also an additional verification step that occurs after Step 1. Each appeal must be verified for timeliness, appealable action and that it was filed by the recipient or their authorized agent. Maximus prepares a grievance log and delivers it to DMAS monthly for tracking purposes.
<b>Business Process Steps</b>	<ol style="list-style-type: none"> <li>1. Start: Receive grievance or appeal via <b>Receive Inbound Transaction</b> Process</li> <li>2. Situational: Request additional documentation</li> <li>3. Determine status as initial, second, or expedited.</li> <li>4. Triage to appropriate personnel for review.</li> <li>5. Schedule review or hearing within required time.</li> <li>6. Conduct review or hearing within required time.</li> <li>7. Determine disposition.</li> <li>8. End: Request that the <b>Manage Applicant and Member Communication</b> process prepare a formal disposition to be sent to the applicant or member via <b>Send Outbound Transaction</b> process.</li> </ol>	<b>2010 MITA:</b> In the Fee For Service appeals process, additional information can be requested during and after the hearing as long as all parties are copied on the information requested.

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<b>Shared Data</b>	<ol style="list-style-type: none"> <li>Benefit data store: Services and provider types covered; program policy; and health plan contractor information</li> <li>Member data store: Member demographics, benefit package, enrollment data; applicant/member financial, social, functional and clinical data. Updated enrollment data is loaded</li> <li>Contractor data store: Contracted service areas, MCO provider network and other provider data</li> <li>Provider data store: Provider data, such as type, location, availability, gender and linguistic and cultural competence</li> <li>Policy data store: Based on the appeal process, if a member wins an appeal that could impact or clarify a policy, that information would be shared to a process that would change or modify policy and or the state plan,</li> </ol>	<b>2010 MITA:</b> No updates
<b>Predecessor</b>	Receipt of grievance or appeal data set from <b>Receive Inbound Transaction</b> process.	<b>2010 MITA:</b> No updates
<b>Successor</b>	Formally notify applicant or member via <b>Send Outbound Transaction</b> process.	<b>2010 MITA:</b> No updates
<b>Constraints</b>	In addition to general rights of Medicaid and Medicare beneficiaries under federal law, state policy and state law constrain the legal issues about which applicants and members may file grievances and appeals, provide additional rights, e.g., for second or expedited appeal, and set time limits for disposing of the appeal.	<b>2010 MITA:</b> DMAS provides provisions for MCO enrollees that do not exist for Fee-for-service enrollees. MCO enrollees have a grievance process that is not available to fee-for-service members. As a result the grievance process may help to limit the number of appeals that are actually bought forward and provides an opportunity to resolve an issue at the lowest level before or instead of it becoming an appeal.
<b>Failures</b>	<ol style="list-style-type: none"> <li>Applicant, member, or advocate withdraws grievance/appeal.</li> <li>Grievances and appeals fail to be processed according to federal or state law.</li> </ol>	<b>2010 MITA:</b> Administrative cessation of appeals process within the confines of State and Federal laws.

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Performance Measures	<p>Examples of Measures –</p> <ol style="list-style-type: none"> <li>1. Time to complete process: normal grievance/appeal = __days; second appeal = __days; expedited appeal = __hours</li> <li>2. Accuracy of decisions = __%</li> <li>3. Consistency of decisions and disposition = __%</li> </ol>	<p><b>2010 MITA:</b> Performance measures are to meet the stated time deadlines.</p> <p>Time to complete normal appeals - 90 days</p> <p>Time to complete expedited appeals - 72 hours. Expedited appeals are primarily on the medical side.</p> <p>Accuracy and Consistency of decisions are not applicable to this process.</p>