



Statewide Medicaid Managed Care (SMMC) Program Snapshot: Process for Enrollee Grievances and Appeals

The Agency for Health Care Administration (Agency) contracts with health and dental plans to provide Medicaid services to health plan enrollees. The Agency recently entered into new contracts with health and dental plans that will greatly benefit enrollees and providers.

Under the new contracts, all Statewide Medicaid Managed Care (SMMC) health and dental plans shall be required to continue and maintain an enrollee grievance and appeal system for reviewing and resolving enrollee complaints, grievances, and appeals.

The Agency will transition to the new contracts in February of 2025.

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.

The Agency is responsible for fair hearings related to the denial, reduction, termination, or suspension of Medicaid services.

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 30 days.

An adverse benefit determination is a health plan's denial, reduction, termination, or suspension of a service, or when the health plan has not responded to an enrollee's grievance within 30 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 48 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:

If the action is related to a reduction, termination or suspension of a service, the enrollee can ask for his or her services to continue while the plan appeal or the Medicaid fair hearing is taking place. 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 the enrollee requested that services continue pending the outcome of the fair hearing and the plan's decision is upheld at the fair hearing, the enrollee may be asked to pay for the cost of the services provided during that time. However, Medicaid benefits cannot be taken away if the enrollee is unable to pay and the enrollee's family cannot be asked to pay.