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Medicaid Managed Care
Grievance and Appeals Guidance for Providers

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The purpose of this guidance is to provide an overview of the grievance and appeals process in Medicaid Managed Care. Please review the enrollee member handbook and/or the plan's provider manual for full information regarding these rights.

New York State is expanding the behavioral health benefits administered by Medicaid Managed Care plans to include the majority of mental health and Substance Use Disorder benefits available in the Medicaid program. Providers, enrollees, and enrollees' authorized representatives may now file complaints and appeals related to these expanded behavioral health benefits with their Medicaid Managed Care plans and with the State.

Medicaid Managed Care Complaints Overview

There may be times when a Medicaid Managed Care enrollee or a provider is not satisfied with the care or services that a Medicaid Managed Care plan is providing to the enrollee. In those situations, enrollees and providers may file a formal complaint with the plan, the State, or both.

- Filing a complaint with the Medicaid Managed Care plan. A provider, enrollee, or an enrollee's authorized representative can file a complaint with the plan. The Medicaid Managed Care plan will review the complaint and notify the person who made the complaint about the decision that is made. If the person who made the complaint disagrees with the plan's decision, that person can file a "complaint appeal" with the Medicaid Managed Care plan.

- Filing a Complaint with New York State. A provider, enrollee, or an enrollee's authorized representative can file a complaint with the State at any time. A complaint does not have to be filed with the plan before it can be filed with the State. Depending on the type of Medicaid Managed Care plan and the kind of complaint, there are different agencies that can help. Please see chart below for further information.

NYS Medicaid Managed Care Enrollee and Provider Contacts for Questions/Complaints	
Type of Question/ Complaint	**How to file/ Get more information**
• Concerns about the delivery of care • Termination issues • Access and availability • Dissatisfaction with quality of care • Denied referrals • Difficulty getting appointments, health care or type of doctor needed • Billing concerns or plan's refusal to pay for a covered service	NYS Department of Health Bureau of Consumer Services Complaint Unit One Commerce Plaza, Room 1609 Albany, NY 12210 Phone: 1-800-206-8125 Email: managedcarecomplaint@health.ny.gov Information About Complaints and Appeals
• Late payments by a plan • Prompt payment law	NYS Department of Financial Services One Commerce Plaza Albany, NY 12257 Department of Financial Services Website
• Consumer health-related complaints • Consumer health care rights • Fraudulent, misleading or deceptive practices	NYS Office of the Attorney General - Health Care Bureau The Capitol Albany, NY 12224-0341 Phone: 1-800-428-9071 Attorney General's Office Health Care Bureau Website
• Eligibility questions • Enrollment issues	New York Medicaid Choice Phone: 1-844-HARP-999 (1-844-427-7999) -or- Local Department of Social Service (Medicaid Office) List of Local Departments of Social Services (Medicaid Offices)
• Questions or complaints related to Mental Health programs or services	NYS Office of Mental Health Phone: 1-800-597-8481 E-mail: For questions or comments related to behavioral health managed care: OMH-managed-care@omh.ny.gov NYS OMH Managed Care Website
• Questions or complaints related to Substance Use Disorder programs or services	NYS Office of Alcoholism and Substance Abuse Services Phone: 518-473-3460 E-mail: picm@oasas.ny.gov NYS OASAS Managed Care Website

Medicaid Managed Care Appeals Overview

Enrollees and providers have the right to appeal a Medicaid Managed Care plan's decision regarding payment or approval of treatment and services. The expansion of behavioral health services into Medicaid Managed Care gives these behavioral health providers the right to file an independent appeal for services that were denied to a Medicaid Managed Care enrollee.

A provider, enrollee, or an enrollee's authorized representative has the right to file an **internal appeal** with the Medicaid Managed Care plan and an **external appeal** with NYS Department of Financial Services (DFS). Additionally, an enrollee or his or her authorized representative has the right to a **fair hearing.**

- When a plan denies a service under utilization review, and has not discussed the request with the provider, the provider also has the right to request a "reconsideration." Reconsideration is a peer-to-peer consultation with the plan's clinical peer reviewer, is not an appeal, and does not hinder enrollee or provider from filing an appeal. If the plan upholds its denial after reconsideration, it will re-issue the initial adverse determination notice.

"AID TO CONTINUE": Continuation of Services During an Appeal

In some cases, an enrollee may be able to continue to receive services that are scheduled to end or be reduced while he or she waits for the plan appeal or fair hearing to be decided. To qualify for this, the enrollee **must request a fair hearing within 10 days** from the date of the denial notice or by the date the change in services is scheduled to occur, whichever is later. If the fair hearing upholds the denial, the enrollee may have to pay for the cost of any continued benefits that he or she received.

- Internal Appeal. An enrollee, or enrollee's authorized representative can file an internal appeal with the Medicaid Managed Care plan in certain circumstances, including when:

  - The plan issues an initial adverse determination notice denying a requested service;
  - The plan authorizes a service at an amount, duration, or scope that is less than requested;
  - The plan denies, in whole or in part, payment for a service;
  - The plan fails to adhere to appointment availability standards;
  - The plan fails to make a timely determination regarding a request for services;
  - The plan fails to adhere to timeframes for resolution and notification of grievances and appeals;
  - The plan restricts an enrollee to specific providers.

The plan's initial adverse determination notice will contain the specific reason for denial and the enrollee's rights for appeal. There is an option for an expedited internal appeal in certain circumstances.
A provider has an independent right to an internal appeal when the plan makes a retrospective utilization review (medical necessity) determination, or denies payment for a claim. The provider rights are described in the plan's provider manual.

Upon receiving a request for an internal appeal, the Medicaid Managed Care plan will review its initial adverse determination. If the denial is upheld or only partially reversed, the plan will then issue a final adverse determination within a specific timeframe.

- External Appeal. External appeals are administered by the NYS Department of Financial Services (DFS). There is an option for an expedited appeal in certain circumstances. External appeals may only be filed when the services are included in the plan's benefit package, and the plan has denied authorization or payment because the plan determined the services were:

  - not medically necessary;
  - experimental/investigational;
  - not different from a service available in-network; or
  - available from a participating provider who has the appropriate training and experience to meet the enrollee's needs.

  Providers may only request an external appeal for concurrent and retrospective decisions.

  An external appeal may be requested:
  - After an internal appeal has been filed, and the plan has issued a Final Adverse Determination; or
  - After the plan and enrollee has jointly agreed to waive the internal appeal process and go directly to external appeal: or
  - When an expedited internal appeal is filed.

  An expedited external appeal may also be filed at the same time as an external appeal.

  DFS contracts with independent organizations to review external appeals. Medicaid Managed Care plans may charge providers a $50.00 fee per appeal requested; however, the fee will be returned if the denial is overturned. If a provider requests an external appeal of a concurrent denial on their own behalf, and the decision is not in the provider's favor, the provider will be charged for part or all of the cost of the external appeal.

- Fair Hearing**.** An enrollee or his or her authorized representative can request a Fair Hearing with the NYS Office of Temporary and Disability Assistance (OTDA). A Fair Hearing provides an opportunity for the enrollee or his or her representative to tell an Administrative Law Judge from OTDA why he or she disagrees with the Medicaid Managed Care plan's decision. An enrollee does not need to file an Internal Appeal or External Appeal before he or she can request a fair hearing.
  - Providers do not have an independent right to ask for a Fair Hearing.
  - The hearing decision takes precedence over internal and external appeals.
  - In addition to decisions regarding denials of coverage or payment, a Fair Hearing is also available to appeal decisions about Medicaid enrollment, disenrollment, and eligibility determinations.
  - A fair hearing is also available to appeal decisions about eligibility for Behavioral Health Home and Community Based Services (BHHCBS).

These requests must be filed within the timeframes outlined in the chart below.

NYS Medicaid Managed Care Timeframes to File Appeals		
	Enrollee	**Provider**
Internal Appeal	Check member handbook for plan's specific timeframe. The enrollee must be allowed at least 60 business days (but no more than 90 calendar days) from initial adverse determination to file an appeal.	Check the plan's provider manual for the plan's specific timeframe. The provider must be allowed at least 45 days to file a utilization review appeal.
External Appeal	Within 4 months of the final adverse determination notice or agreement to waive the internal appeal process.	Within 60 days of final adverse determination notice.
Fair Hearing	60 days of adverse determination notice. Aid to Continue request must be made within 10 days (as explained above).	Providers do not have the right to a fair hearing.

NYS Medicaid Managed Care Enrollee and Provider Appeal Contacts		
Type of Appeal	**Who Can File**	**Where to file/Get More Information**
Internal Appeal	Enrollee, Provider	Contact enrollee's MCO plan. This information can be found in member handbook or by calling the member services telephone number on the insurance card
External Appeal	Enrollee, Provider	Submit a NYS external appeal application to: Department of Financial Services, PO BOX 7209 Albany NY 12224 Phone: (800) 400-8882

		Fax: (800) 332-2729 www.dfs.ny.gov/ExternalAppeal
Fair Hearing	Enrollee Only	NYS Office of Temporary and Disability Assistance Managed Care Hearing Unit PO Box 22023 Albany, NY 12201-2023 Phone: 1-800-342-3334 Fax: (518) 473-6735 www.otda.ny.gov/hearings/