HMO and PIHP Member Grievances and Appeals Guide

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Managed Care Team – BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and Wraparound Milwaukee

Contents

Document Revision History

Document Version	Update Date	Modified By	Comments
2.0	1/14/2020	Mitchell Running	Final Draft
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Reference Documents

This guide contains specific references to the following documents:

- The Code of Federal Regulations, Title 42
- Wisconsin State Statute, Chapter 49
- The Wisconsin Contract for BadgerCare Plus and/or Medicaid SSI HMO Services (referred to in this guide as the HMO Contract)
- The Care4Kids PIHP Contract
- The Children Come First and Wraparound Milwaukee PIHP contracts
- The HMO & PIHP Communication, Outreach, and Marketing Guide

1 PURPOSE

All Wisconsin Medicaid Health Plans are required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F, as contained herein.

This guide provides contractual requirements for member grievance and appeal systems, including notice timing and content requirements, and grievance and appeal resolution timeframes for the following contracts:

- BadgerCare Plus, Medicaid SSI Health Maintenance Organization (HMO)
- Prepaid Inpatient Health Plan (PIHPs)
    - Care4Kids, Foster Care Medical Home Contract
    - Children Come First, Contract for Services Between Department of Health Services and Dane County
    - Wraparound Milwaukee, Department of Health Services and Milwaukee County

Long Term Managed Care Organizations are out of scope for this guide.

The Member Grievances and Appeals guide should be reviewed by Health Plans prior to submitting grievance and appeal notification documents to the Department for review. Materials that do not meet standards defined in this document will not be approved by the Department.

Health Plans must distribute this guide to their gatekeepers, providers, subcontractors, and Independent Practice Associations (IPAs) at the time the contract is entered.

2 FEDERAL AND STATE POLICY

2.1 Federal Policy

The federal regulations detailing the requirements for managed care grievance and appeals systems are found in 42 CFR 438 Subpart F. This guide mirrors the structure of Subpart F. The table below provides a list of relevant federal citations with the corresponding sections of this guide.

CFR Citation	CFR Title	Relevant Guide Section
§ 438.400	Statutory basis, definitions, and applicability	Section 3
§ 438.402	General requirements	Section 4
§ 438.404	Timely and adequate notice of adverse benefit determination	Section 5
§ 438.406	Handling of grievances and appeals	Section 6
§ 438.408	Resolution and notification: Grievances and appeals	Section 7
§ 438.410	Expedited resolution of appeals	Section 8
§ 438.414	Information about the grievance and appeal system to providers and contractors	Section 13
§ 438.416	Recordkeeping requirements	Section 11
§ 438.420	Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending	Section 9
§ 438.424	Effectuation of reversed appeal resolutions	Section 10

2.2 State Policy

Wisconsin Statute 49.45(5) largely adopts the 42 CFR Part 438 Subpart F language regarding the circumstances under which an HMO member may file for a State fair hearing, and the time limits to request that hearing. The full Wis. Stat. § 49.45(5) language can be found below. The single addition to the 42 CFR § 438.400 definition of an adverse benefit determination is highlighted in red.

Wis. Stat. § 49.45 Medical assistance; administration

(5) APPEAL.

(a) Any person whose application for medical assistance is denied or is not acted upon promptly or who believes that the payments made in the person's behalf have not been properly determined or that his or her eligibility has not been properly determined may file an appeal with the department pursuant to par. (b). Review is unavailable if the decision or failure to act arose more than 45 days before submission of the petition for a hearing, except as provided in par. (ag) or (ar).

(ag) A person shall request a hearing within 90 days of the date of receipt of a notice from a care management organization or managed care organization upholding its adverse benefit determination relating to any of the following or within 90 days of the date the care management organization or managed care organization failed to act on the contested matter within the time specified by the department:

1. Denial or limited authorization of a requested services, including a determination based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

2. Reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

3. Denial, in whole or in part, of payment for a service. 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" under 42 CFR § 447.45(b) is not an adverse benefit determination.

4. Failure to provide services in a timely manner.

5. Failure of a care management organization or managed care organization to act within the time frames provided in 42 CFR 438.408 (b) (1) and (2) regarding the standard resolution of grievances and appeals.

6. Denial of an enrollee's request to dispute financial liability, including copayments, premiums, deductibles, coinsurance, other cost sharing, and other member financial liabilities.

7. Denial of an enrollee, who is a resident of a rural area with only one care management organization or managed care organization, to obtain services outside the organization's network of contracted providers.

(ar) If a federal regulation specifies a different time limit to request a hearing than par. (a) or (ag), the time limit in the federal regulation shall apply.

3 DEFINITIONS

As used in this guide, the following terms have the indicated meanings:

Adverse benefit determination means any of the following:

3.1 The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

3.2 The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

3.3 The denial, in whole or in part, of payment for a service. 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" under 42 CFR § 447.45(b) is not an adverse benefit determination.

3.4 The failure to provide services in a timely manner.

3.5 The failure of the Health Plan to act within the timeframes provided in 7.2.1 and 7.2.2 regarding the standard resolution of grievances and appeals.

3.6 For a resident of a rural area with only one Health Plan, the denial of a member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.

3.7 The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal means a review by the Health Plan of an adverse benefit determination.

Authorized Representative means an individual appointed by the member, including a provider or estate representative, who may serve as an authorized representative with documented consent of the member.

Grievance means 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, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Health Plan to make an authorization decision. The member or authorized representative may file a grievance either orally or in writing.

Grievance and appeal system means the processes the Health Plan implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

Health Plan(s) means any HMO or PIHP contracted to provide Medicaid managed care to Wisconsin BadgerCare Plus, Medicaid SSI, Care4Kids, Children Come First, and Wraparound Milwaukee members

Member means a BadgerCare Plus and/or Medicaid SSI member who has been certified by the State as eligible to enroll under the relevant Contract (HMO, Care4Kids, Children Come First, or Wraparound Milwaukee), and whose name appears on the Health Plan Enrollment Rosters that the Department transmits to the Health Plan according to an established notification schedule.

State fair hearing means the process used by the Wisconsin Division of Hearing and Appeals to adjudicate member appeals of Health Plan adverse benefit determinations.

4 GENERAL REQUIREMENTS

4.1 Grievance and Appeal System

The Health Plan must:

4.1.1 Have a grievance and appeal system in place for members. Non-emergency medical transportation PAHPs are not subject to this requirement. The grievance and appeal system must:

4.1.1.1 Ensure that members have the option to grieve or appeal any negative response to the Board of Directors of the HMO. The HMO Board of Directors may delegate the authority to review grievances and appeals to the HMO grievance appeal committee, but the delegation must be in writing.

4.1.1.1.1 If a grievance and appeal committee is established, the BadgerCare Plus and/or Medicaid SSI HMO Advocate must be a member of the committee.

4.1.1.2 Ensure that individuals with the authority to require corrective actions are involved in the grievance process.

4.1.2 Have written policies and procedures that detail what the grievance and appeal system is and how it operates.

4.1.3 Identify a contact person in the Health Plan to receive grievances and appeals and be responsible for routing and processing.

4.1.4 Inform members about the existence of the grievance and appeal processes and how to use them.

4.1.5 Attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a member presents a grievance or appeal, the HMO Advocate must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.

4.2 Level of Appeals

The Health Plan may have only one level of appeal for members.

4.3 Filing Requirements

4.3.1 A member may file a grievance and request an appeal with the Health Plan. A member may request a State fair hearing only after receiving notice that the adverse benefit determination has been upheld by the Health Plan (see Section 7).

4.3.2 If the Health Plan fails to adhere to the notice and timing requirements in Section 7, the member is deemed to have exhausted the Health Plan's appeals process, and the member may initiate a State fair hearing.

4.3.3 A provider or an authorized representative may request an appeal, file a grievance, or request a State fair hearing on behalf of a member, provided there is documented consent from the member. For the purposes

of this guide, when the term "member" is used, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request the continuation of benefits as specified in Section 9.2.5.

4.4 Member Filing Timeframes

4.4.1 *Grievance*

A member may file a grievance with the Health Plan at any time.

4.4.2 *Appeal*

A member has 60 calendar days from the date on the adverse benefit determination notice to file a request for an appeal to the Health Plan.

4.5 Procedures

4.5.1 *Grievance*

The member may file a grievance either orally or in writing. The member may file a grievance with either the Department or with the Health Plan. The date of the Health Plan's receipt of the member's oral or written grievance request is the start date of the acknowledgement and decision timeframes described under 7.2.1.

4.5.2 *Appeal*

The member may request an appeal either orally or in writing. The date of the Health Plan's receipt of the member's oral or written appeal request is the start date of the acknowledgement and decision timeframes described under 7.2.2.

5 NOTICE OF ADVERSE BENEFIT DETERMINATIONS

5.1 Notice Requirement

5.1.1 The Health Plan must give members timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in the *HMO& PIHP Communication Outreach and Marketing Guide*. This includes adverse benefit determinations made by the Health Plan, its gatekeepers, providers, subcontractors, or its IPAs. It also includes:

5.1.1.1 Determinations on services that were authorized by the Health Plan the member was previously enrolled in.

5.1.2 This notice requirement does not apply when the Health Plan, its gatekeeper, provider, subcontractor, or its IPA triages a member to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

5.2 Content of Notice

5.2.1 The Department must review and approve all notice language prior to its use by the Health Plan. Department review and approval will occur during the BadgerCare Plus and/or Medicaid SSI certification process of the Health Plan and prior to any change of the notice language by the Health Plan.

The Department has provided template letters and mandatory language to be included in member letters. This content can be found in *Appendix B: Member Letter Templates and Mandatory Language for Member Letters* of this guide.

5.2.2 The initial notice must explain the following:

5.2.2.1 The adverse benefit determination the Health Plan has made or intends to make.

5.2.2.2 The reasons for the adverse benefit determination and the right of the member to be provided reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination free of charge. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

5.2.2.3 The member's right to request an appeal of the Health Plan's adverse benefit determination, including information on exhausting the Health Plan's one level of appeal described in Section 4.2 and the right to request a State fair hearing consistent with Section 4.3.

5.2.2.4 The procedures for exercising the rights specified in this section (5.2).

5.2.2.5 The circumstances under which an appeal process can be expedited and how to request it, including the fact that an expedited timeframe requires a medical provider or the Health Plan to verify that delay can be a health risk.

5.2.2.6 The member's right to have benefits continue while the appeal resolution is pending, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services (see Section 9.4).

5.2.2.7 The right of the member to have a representative assist him or her at any point in the grievance or appeal process including reviews or hearings, and how to request that assistance.

5.2.2.8 The right of the member to present "new" information before or during the grievance and appeal process including reviews or hearings.

5.2.2.9 The fact that punitive action will not be taken against a member who appeals the Health Plan's decision.

5.2.2.10 The fact that the member can receive help filing a grievance or appeal by calling the HMO Advocate, the Ombudsmen, or the SSI External Advocate at 1-800-928-8778.

5.2.2.11 The address and telephone number of the HMO Advocate, the Ombudsmen, and the External Advocate. (The External Advocate is for Medicaid SSI only.)

5.3 Timing of Notice

The Health Plan must mail the notice within the following timeframes:

5.3.1 For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified below (found in 42 CFR §§ 431.211, 431.213, and 431.214).

5.3.1.1 The Health Plan must send a notice at least 10 days before the date of action, except as permitted under Sections 5.3.1.1 and 5.3.1.2 below.

5.3.1.2 The Health Plan may send a notice not later than the date of action (as defined in 42 CFR § 431.201) if any of the following occur:

5.3.1.2.1 The Health Plan has factual information confirming the death of a member.

5.3.1.2.2 The Health Plan receives a clear written statement signed by a member that he or she no longer wishes services, or gives information that requires termination or reduction of services and indicates the he or she understands that this must be the result of supplying that information.

5.3.1.2.3 The member has been admitted to an institution where he is ineligible under the plan for further services.

5.3.1.2.4 The member's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See 42 CFR § 431.231 (d) for procedure if the beneficiary's whereabouts become known).

5.3.1.2.5 The Health Plan establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

5.3.1.2.6 A change in the level of medical care is prescribed by the member's physician.

5.3.1.2.7 The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act.

5.3.1.2.8 The member will be transferred or discharged in less than 10 days as a result of any of the following:

- The safety or health of individuals in the facility would be endangered.
- The resident's health improves sufficiently to allow a more immediate transfer or discharge.
- An immediate transfer or discharge is required by the resident's urgent medical needs.
- A resident has not resided in the nursing facility for 30 days (applies only to adverse actions for NF transfers).

5.3.1.3 The agency may shorten the period of advance notice to 5 days before the date of action if both of the following conditions are met:

5.3.1.3.1 The agency has facts indicating that action should be taken because of probable fraud by the member.

5.3.1.3.2 The facts have been verified, if possible, through secondary sources.

5.3.2 For denial of payment, at the time of any action affecting the claim.

5.3.3 For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service.

5.3.3.1 One extension of up to 14 days may be allowed if either of the following conditions are met:

5.3.3.1.1 The member or the provider requests an extension.

5.3.3.1.2 The Health Plan justifies the need for additional information and how the extension is in the member's interest. Determinations must be made within the timeframe specified in 5.3.3 and will be available to the Department upon request.

5.3.4 If the Health Plan meets the criteria in 5.3.3.1.2 for extending the timeframe for standard service authorization decisions it must do both of the following:

5.3.4.1 Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

5.3.4.2 Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

5.3.5 For expedited service authorization decisions, as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

5.3.5.1 The expedited timeframe may be extended by up to 14 calendar days if the criteria under 5.3.3.1 are met.

5.3.6 Service authorization decisions not reached within the timeframes specified in Sections 5.3.3 and 5.3.5 are considered an adverse benefit determination. In these situations, notice must be mailed no later than the date that the timeframes expire.

The standard service authorization timeframes detailed in Sections 5.3.3 and 5.3.5 can also be found in the Article X G (4) of the HMO Contract.

6 HANDLING OF GRIEVANCES AND APPEALS

6.1 General Requirements

6.1.1 In handling grievances and appeals, the Health Plan must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

6.1.2 When members submit a grievance directly to the Department, the Department will consider input from the member and the Health Plan when coming to a resolution.
6.1.2.1 If the Department determines that it needs additional information or documentation from the HMO, the Department will request that information/documentation from the HMO.

6.1.2.2 The Health Plan shall provide the requested information/documentation to the Department within 5 business days of the date of receipt of the request.

6.2 Requirements for Adverse Benefit Determinations

The Health Plan's process for handling member grievances and appeals of adverse benefit determinations must:

6.2.1 Acknowledge in writing receipt of each grievance and appeal.

6.2.2 Ensure that the individuals who make decisions on grievances and appeals are individuals:

6.2.2.1 Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

6.2.2.2 Who are health care professionals with appropriate clinical expertise, if deciding any of the following:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

6.2.2.3 Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

6.2.4 Provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Health Plan must inform the member orally of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in Sections 7.2 and 7.3.

6.2.4.1 If the member is presenting evidence in person, the Health Plan must inform the member in writing of the time and place of the meeting at least seven days before the meeting. In expedited appeals, the Health Plan must also notify the member orally.

6.2.5 Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Health Plan (or at the direction of the Health Plan) in connection with the appeal. This includes information or documentation generated by the Health Plan's gatekeepers, providers, subcontractors, and Independent Practice Associations (IPAs). The information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in Sections 7.2 and 7.3.

6.2.6 Include, as parties to the appeal, the member and his or her representative, or the legal representative of a deceased member's estate.

7 RESOLUTION AND NOTIFICATION

7.1 Basic Rule

The Health Plan must resolve and provide notice for each grievance and appeal as expeditiously as the member's health condition requires, and within the timeframes specified in this section.

7.2 Acknowledgement and Resolution Timeframes

7.2.1 ***Standard Resolution of Grievances***

For standard resolution of a grievance, the Health Plan must send a written acknowledgement of receipt of the grievance to the member within 10 business days of receipt of the grievance (oral or written) and a final written decision resolving the grievance within 30 calendar days of receiving the grievance (oral or written).

7.2.2 ***Standard Resolution of Appeals***

For standard resolution of an appeal, the Health Plan must send a written acknowledgement of receipt of the appeal to the member within 10 business days of receipt of the appeal (oral or written) and a final written decision resolving the appeal within 30 calendar days of receiving the appeal (oral or written). This timeframe may be extended under the conditions outlined in Section 7.3.

7.2.3 ***Expedited Resolution of Appeals***

For expedited resolution of an appeal, the Health Plan must make reasonable effort to provide oral notice and issue a written disposition of an expedited hearing decision within 72 hours of receiving the verbal or written request for an expedited resolution. This timeframe may be extended under the conditions outlined in Section 7.3.

7.2.4 ***Grievances and Appeals Submitted by Individuals Purporting to be an Authorized Representative***

If a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the Health Plan does not have the documented consent of the member for the individual to act as the member's representative on file, then the Health Plan must do the following:

7.2.4.1 Upon receipt of the grievance or appeal request, attempt to follow-up with the member to confirm the member's desire for the grievance or appeal to proceed.

7.2.4.2 If contact is made with the member and the member confirms, either verbally or in writing, that they desire the grievance or appeal to proceed, inform the member of the need to provide written consent for an individual to act as the member's authorized representative in the grievance or appeal and that, in the absence of such documented consent, the grievance or appeal will be processed as a request from the member.

7.2.4.2.1 Initiate the appeal or grievance resolution process as of the date the member confirms that they wish to proceed with the appeal or grievance.

7.2.4.2.2 Send the written acknowledgement letter to the member (and, if the member's documented consent is obtained prior to the acknowledgment letter being sent out, to the member's authorized representative) within the timeframes described under 7.2.1, 7.2.2

or 7.2.3. The HMO's receipt of the member's grievance or appeal with respect to these timeframes is the date of the member's confirmation that they wish to proceed with the grievance or appeal.

7.2.4.2.3 Complete the appeal or grievance resolution process and issue a written resolution decision within the timeframes described under 7.2.1, 7.2.2 or 7.2.3. The HMO's receipt of the member's grievance or appeal with respect to these timeframes is the date of the member's confirmation that they wish to proceed with the grievance or appeal.

7.2.4.2.4 If the Health Plan does not receive documented consent from the member for the purported authorized representative to act as the member's representative prior to the appeal or grievance resolution decision deadline, send the written decision resolving the grievance or appeal to the member.

7.2.4.2.5 If the Health Plan receives documented consent from the member for the purported authorized representative to act as the member's representative prior to the appeal or grievance resolution decision deadline, send the written decision resolving the grievance or appeal to the representative and the member.

7.2.4.3 If contact is made with the member and the member does not wish to proceed with the grievance or appeal, dismiss the grievance or appeal and send a written notice to that effect to the member.

7.2.4.4 If no contact is made with the member within 30 calendar days of receipt of the grievance or appeal from the purported representative, dismiss the grievance or appeal and send a written notice to that effect to the member.

7.3 Extension of Timeframes

7.3.1 The Health Plan may extend the timeframes from Section 7.2 by up to 14 calendar days if any of the following occur:

7.3.1.1 The member requests the extension.

7.3.1.2 The Health Plan shows that there is need for additional information and how the delay is in the enrollee's interest. Documentation regarding this determination must be available to the Department upon request.

7.3.2 The total timeline for the Health Plan to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt.

7.4 Requirements Following Extension

If the Health Plan extends the timeframes not at the request of the member, it must complete all of the following:

7.4.1 Make reasonable efforts to give the member prompt oral notice of the delay.

7.4.2 Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

7.4.3 Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

7.5 Deemed Exhaustion of Appeals Processes

If the Health Plan fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Health Plan's appeals process and the member may initiate a State fair hearing.

7.6 Format of Notices

7.6.1 ***Grievances***

The Health Plan must provide written notice of resolution of a grievance in a format and language that, at a minimum, meet the standards described in the *HMO & PIHP Communication, Outreach, and Marketing Guide.*

7.6.2 ***Appeals***

7.6.2.1 For all appeals, the Health Plan must provide written notice of resolution in a format and language that, at a minimum, meet the standards described in the *HMO& PIHP Communication, Outreach, and Marketing Guide.*

7.6.2.2 The Health Plan must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. For example, if two adverse benefit determinations are made by the Health Plan at the same time, the Health Plan must send out two separate adverse benefit determinations to the member. If the member appeals both adverse benefit determinations, the Health Plan must issue two separate notices of appeal resolution.

7.6.2.3 For notice of an expedited resolution, the Health Plan must also make reasonable efforts to provide oral notice.

7.7 Content of Notice for Appeal Resolution

7.7.1 The Department must review and approve all notice language prior to its use by the Health Plan. Department review and approval will occur during the BadgerCare Plus and/or Medicaid SSI certification process of the Health Plan and prior to any change of the notice language by the Health Plan.

The Department has provided template letters and mandatory language to be included in member letters. This content can be found in *Appendix B: Member Letter Templates and Mandatory Language for Member Letters* of this guide.

7.7.2 The written notice of the resolution must include the following:

7.7.2.1 The results of the resolution process and the date it was completed.

7.7.2.2 For appeals not resolved wholly in favor of the member:

7.7.2.2.1 The right to request a fair hearing with the Division of Hearing and Appeals (DHA), and how to do so.

7.7.2.2.2 The right to request and receive benefits while the hearing is pending, and how to make the request.

7.7.2.2.3 That the member maybe held liable for the cost of those benefits if the hearing decision upholds the Health Plan's adverse benefit determination (see Section 9.4).

7.8 Requirements for State Fair Hearings

7.8.1 A member may request a State fair hearing with the DHA only after receiving notice that the Health Plan is upholding the adverse benefit determination.

7.8.2 If the Health Plan fails to adhere to the notice and timing requirements in this section (7.2, 7.3, 7.4, and 7.5), the member is deemed to have exhausted the Health Plan's appeals process and the member may initiate a State fair hearing.

7.8.3 The member must request a State fair hearing no later than 90 calendar days from the date of receipt of the Health Plan's notice of resolution. Receipt of notice is presumed within 5 calendar days of the date the notice was mailed.

7.8.4 The parties to the State fair hearing include the Department, the Health Plan, and the member and his or her representative, or the representative of a deceased member's estate.

7.8.5 Upon request for information regarding a State fair hearing, the Health Plan must provide all relevant materials to appropriate party (the Department, the state's fiscal agent, or DHA) within 5 business days, or sooner if possible. This includes:

7.8.5.1 The Health Plan denial letter.

7.8.5.2 All pertinent medical or dental records.

7.8.5.3 Any other pertinent documentation, as determined by the Department.

7.8.6 Per 42 CFR § 431.244, State fair hearing decisions will be reached within the specified timeframes:

7.8.6.1 ***Standard Resolution***
Within 90 calendar days of the date the member filed the appeal with the Health Plan, not including the number of days the enrollee took to subsequently file for a State fair hearing.

7.8.6.2 ***Expedited Resolution***

Within three (3) working days from Department receipt of a hearing request for a denial of a service that:

- Meets the criteria for an expedited appeal process but was not resolved using the Health Plan's appeal timeframes, or
- Was resolved wholly or partially adversely to the member using the Health Plan's expedited appeal timeframes.

8 EXPEDITED RESOLUTION OF APPEALS

8.1 General Rule

The Health Plan must establish and maintain an expedited review process for appeals, when the Health Plan determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

8.2 Punitive Action

The Health Plan and its contracted providers must ensure that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal.

8.3 Action following denial of a request for expedited resolution

If the Health Plan denies a request for expedited resolution of an appeal, it must:

8.3.1 Transfer the appeal to the timeframe for standard resolution in accordance with Section 7.2.2.

8.3.2 Follow the requirements in Section 7.4.

9 CONTINUATION OF BENEFITS DURING THE APPEAL AND STATE FAIR HEARING PROCESS

9.1 Definition of Timely Filing

As used in this section -

Timely filing means the member has filed for continuation of benefits on or before the later of the following:

9.1.1 Within 10 calendar days of the Health Plan sending the notice of adverse benefit determination.

9.1.2 The intended effective date of the Health Plan's proposed adverse benefit determination.

9.2 Continuation of Benefits

The Health Plan must continue the member's benefits if all of the following occur:

9.2.1 The enrollee files the request for an appeal timely in accordance with Section 4.3.3 and 4.4.2 of this guide.

9.2.2 The appeal involves the termination, suspension, or reduction of previously authorized services.

9.2.3 The services were ordered by an authorized provider.

9.2.4 The period covered by the original authorization has not expired.

9.2.5 The member or their authorized representative timely files for continuation of benefits. (Per Section 4.3.3 providers cannot request that benefits be continued)

9.3 Duration of Continued or Reinstated Benefits

If, at the member's request, the Health Plan continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:

9.3.1 The member withdraws the appeal or request for state fair hearing.

9.3.2 The member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the Health Plan sends the notice of an adverse resolution to the member's appeal under Section 7.6.2.

9.3.3 The DHA issues a hearing decision adverse to the member.

9.4 Member Responsibility for Services Provided

If the DHA upholds the Health Plan's adverse benefit determination, the Health Plan may pursue reimbursement from the member for the cost of services provided to the member while the Health Plan appeal and state fair hearing was pending, to the extent that they were provided solely because of the requirements of this section.

10 REVERSED APPEAL RESOLUTIONS

10.1 Services not provided while the appeal is pending

If the Health Plan or the DHA reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Health Plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

10.2 Services provided while the appeal is pending.

If the Health Plan or the DHA reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Health Plan must pay for those services.

11 RECORDKEEPING REQUIREMENTS

11.1 Recordkeeping System

11.1.1 The Health Plan must maintain records of grievances and appeals and must submit them in accordance with requirements detailed in Section 12 of this guide.

11.1.2 The recordkeeping system must include a copy of the original grievance or appeal, the response, and the resolution.

11.2 Record Information Requirements

11.2.1 Records must distinguish BadgerCare Plus or Medicaid SSI members from commercial members.

11.2.1.1 If the Health Plan serves both BadgerCare Plus and Medicaid SSI members, the records must distinguish between the two populations.

11.2.2 The record of each grievance or appeal must contain, at a minimum, all of the following information:

11.2.2.1 A general description of the reason for the appeal or grievance.

11.2.2.2 The date received.

11.2.2.3 The date of each review or, if applicable, review meeting.

11.2.2.4 Resolution at each level of the appeal or grievance, if applicable.

11.2.2.5 Date of resolution at each level, if applicable.

11.2.2.6 Name of the covered person for whom the appeal or grievance was filed.

11.3 Record Maintenance

The record must be accurately maintained in a manner accessible to the Department and available upon request to CMS.

12 MONITORING OF GRIEVANCES AND APPEALS

12.1 Department Review of Timely Notification

Per 42 CFR § 438.228(b), the Department will conduct random reviews of the Health Plan and its gatekeepers, providers, subcontractors, and IPAs to ensure that they are adhering to the timely notice requirements detailed in this guide.

12.2 Submission of Reports

The Health Plan must submit quarterly reports to the Department of all grievances and appeals. The Health Plan must forward all reports under section 12.3 to the Department within 30 days of the end of the quarter in the format specified. Failure on the part of the Health Plan to submit the quarterly grievance and appeal reports in the required format within five days of the due date may result in any or all sanctions available under the Contract.

12.3 Member Grievance and Appeal Reporting Form

The Health Plan must summarize each BadgerCare Plus and/or Medicaid SSI grievance reviewed in the past quarter. The report must distinguish between the BadgerCare Plus and Medicaid SSI members, if the Health Plan serves both populations.

Health Plans should report in sections 12.3.1 through 12.3.3 below only those members that grieved or appealed to the Health Plan's grievance and appeal committee.

12.3.1 *Grievances Report*

The Grievances Report shall be submitted quarterly, in Excel format, and contain, at a minimum, the fields listed below.

Field Name	Field Description
Member Name	The individual's name (formatted <Last>, <First>, <MI>)
Member ID	The individual's Member ID
Date Received	The date the Health Plan received the request for the grievance
Description	A general description of the reason for the grievance
Date Resolved	The date the Health Plan resolved the grievance
Summary of Resolution	Summary of the grievance resolution
Administrative Changes	High-level description of any administrative changes that occurred as a result of the grievance resolution process

12.3.2 *Appeals Report*

The Appeals Report shall be submitted quarterly, in Excel format, and contain, at a minimum, the fields listed below.

Field Name	Field Description
Member Name	The individual's name (formatted <Last>, <First>, <MI>)
Member ID	The individual's Member ID
Date Received	The date the Health Plan received the request for the appeal

Appeal Type	The appeal type, as defined in Section 12.3.3 below
Services Continued?	If appeal type selected is "Reductions and Terminations," <Yes> / <No> field indicating whether or not services were continued pending the outcome of the appeal.
	If <No>, indication of why services were not continued: • Member did not request continuation of services; • Member requested continuation of services but request was not timely; • Services requested to be continued were not ordered by an authorized provider; • The period covered by the original service authorization had expired.
	If <Yes>, but continued services ultimately ended, indication of reason for continued services ending: • Member withdrew appeal or subsequent request for state fair hearing; • Member did not timely request a state fair hearing and continuation of benefits after receiving an adverse resolution to his or her HMO appeal; • DHA issued a hearing decision adverse to the enrollee.
Description	A general description of the reason for the appeal
Date Resolved	The date the Health Plan resolved the appeal
ABD Overturned?	Indication of whether or not the initial adverse benefit decision was overturned by the Health Plan. It is suggested that the Health Plan use <Yes> / <No> / <Partial> for this field.
Summary of Resolution	Summary of the appeal resolution
State Fair Hearing?	<Yes> / <No> field indicating whether or not the member filed for a fair hearing
Appeal Resolution Overturned?	Indication of whether or not Health Plan's appeal decision was overturned by DHA. It is suggested that the Health Plan use <Yes> / <No> / <Partial> for this field.
Administrative Changes	High-level description of any administrative changes that occurred as a result of the appeal resolution process

12.3.3 ***Appeal Type Definitions***

The appeal types defined below are based on the adverse benefit determination definitions, which can be found in Section 3 of this guide.

Appeal Type Name	**Appeal Type Definition**

Authorizations	The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
Reductions and Terminations	The reduction, suspension, or termination of a previously authorized service.
Denial of Payment	The denial, in whole or in part, of payment for a service.
Timely Service	The failure to provide services in a timely manner
Standard Resolution Violation	The failure of the HMO to act within the timeframes regarding the resolution of appeals.
Rural Services	For a resident of a rural area with only one HMO, the denial of an enrollee's request to exercise his or her right to obtain services outside the network.
Financial Liability	The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

12.4 Changes to Appeal and Grievance Reporting Requirements

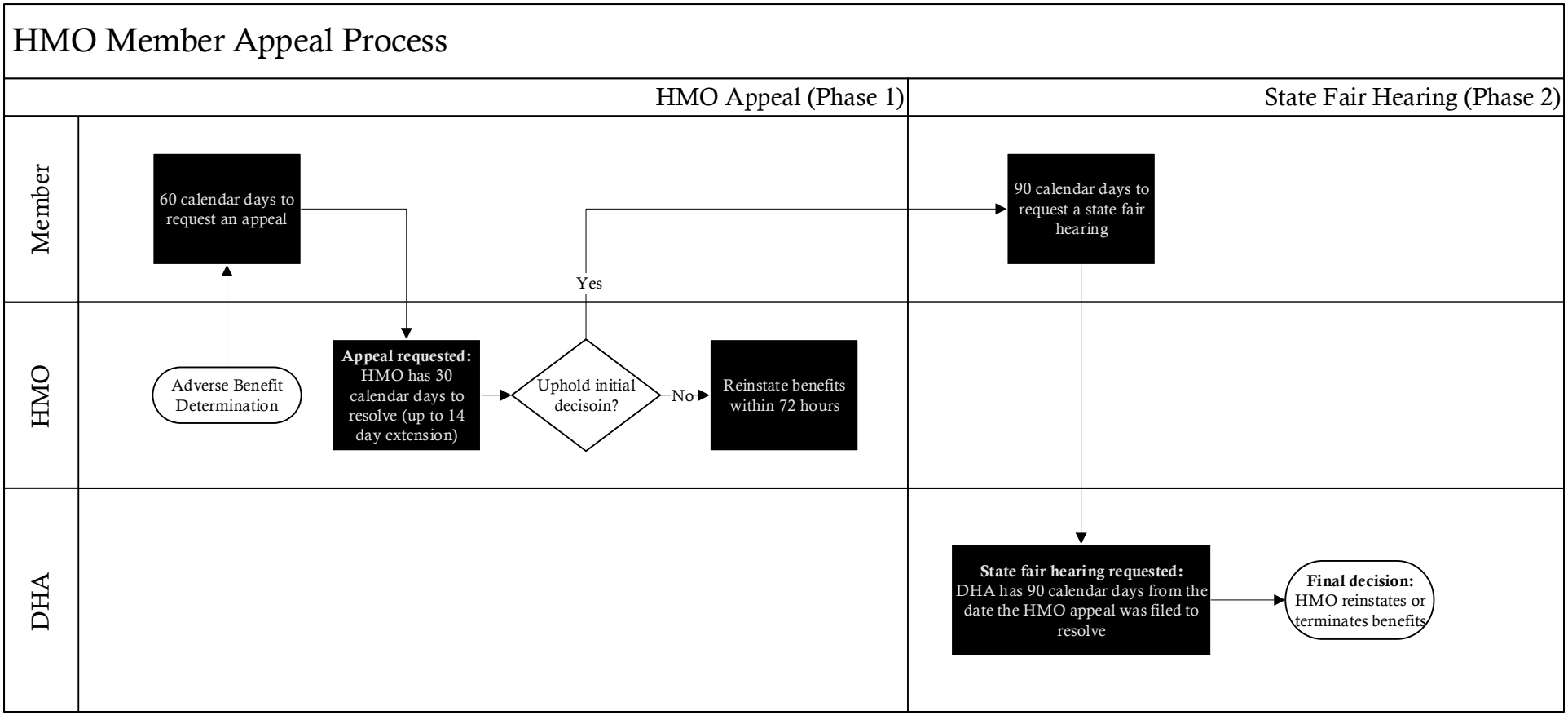
The Department may revise elements to be included in the quarterly appeal report or grievance report and shall give the HMO notice of new elements to include in the report consistent with Article XIV.D.4.k of the HMO Contract.

13 INFORMATION TO PROVIDERS AND CONTRACTORS

13.1 The Health Plan must distribute to its gatekeepers, providers, subcontractors, and Independent Practice Associations (IPAs) the informational flyer on member grievance and appeal rights (the Ombudsmen Brochure) and this guide, at the time the contract is entered. When a new brochure is available or this guide is updated, the Health Plan must distribute copies to its gatekeepers, providers, subcontractors, and IPAs within three weeks of receipt of the new brochure.

13.2 The Health Plan must ensure that its gatekeepers, providers, subcontractors, and IPAs have written procedures for describing how members are informed of denied services. The Health Plan will make copies of the gatekeepers', providers', subcontractors', and IPAs' grievance procedures available for review upon request by the Department.

APPENDIX A: HMO and PIHP MEMBER APPEAL PROCESS FLOW



APPENDIX B: Member Letter Templates and Mandatory Language for Member Letters

1. Notice of Adverse Benefit Determination Template

This notice is intended to notify members when the HMO has made an adverse benefit determination (see Section 3 of the *HMO and PIHP Member Grievances and Appeals Guide* or 42 CFR 438.400 for definitions). All notices of adverse benefit determination must be sent to members according to the timelines found in Section 5 of the *HMO and PIHP Member Grievances and Appeals Guide* (also outlined in 42 CFR 438.404).

Guidance for Implementation

- Health plans may modify the format of this letter as needed to ensure readability and accessibility for members. However, all information presented here must remain in the letter.
- When sending the Notice of Adverse Benefit Determination letter to members, include only one of the adverse benefit determination types in the letter. For example, if a prior authorization was denied, only include **Option 1: "Deny your request for this service"**. Do not include the full list of options 2 through 11.
- If multiple adverse benefit determinations have been made for the same individual, the member should receive different notices for each determination.
- Under the section **Your Appeal Rights**, the health plan may modify the Grievance and Appeal Committee language to align with internal processes. Currently the text reads, "we will schedule a meeting for you with <Health Plan Name>'s Grievance and Appeal Committee." Some health plans automatically schedule committee meetings for members, while others will only schedule if a member requests a meeting. If this text is changed for the latter situation, the resulting letter must make clear that: 1) members do have the option to request a meeting; and 2) detail the process for requesting a meeting.
- Only include the **Continuing Your Services During An Appeal** section if the adverse benefit determination is a is a termination, suspension, or reduction of previously authorized services.
- Option 6, Denial of Payment (member request), should be selected when a member purchases an item or service and is requesting reimbursement for the item or service from the HMO.
- Option 7, Denial of Payment (provider claim) should be selected when a provider's claim remains unpaid, in whole or in part, after the provider has completed the provider appeals process with the MCO and Department and the unpaid claim is a clean claim as defined under 42 CFR § 447.45(b): https://www.law.cornell.edu/cfr/text/42/447.45
  When Option 7 is selected:
    a. Replace the following text under the salutation:
       "We have important information about <insert service or benefit in question>. Based on our guidelines, we have decided to <include one per notice>"

       with:

       "<Provider name> asked us to pay for a service or support that you received from them. This is called a "claim." The Wisconsin Department of Health Services determined that <Provider name> cannot be paid for its claim. **It's not your fault the claim wasn't covered and you aren't responsible for paying any amount to us, <Provider name>, or anyone else**. The details about this denial are as follows:"

    b. Add the following text immediately under "Your Appeal Rights": "**You have the right to appeal the denial of <Provider name>'s claim but you are not required to do so. Whether you appeal or**

not, you are not responsible for paying any amount for this claim to us, <Provider name> or anyone else."

- Option 9 applies only to situations in which the member is a resident of a rural area with only one HMO.

When sending the notice because the health plan failed to follow the grievance or appeal timeframe (option 11), remove the heading "How to Appeal This Decision" and all of the language that follows for the remainder of the notice and replace it with the heading "How To Ask for a State Fair Hearing" and all of the language that follows from the "Appeal Resolution Letter Template (HMO Adverse Benefit Determination Upheld)" notice.

Notice of Denial, Change, or Delay in Your Services

Mailing Date

Member's Name
Member/Authorized Representative's Address

Member MAID Number

Dear <Mr./Ms./Mrs.> <Last Name>,

ACTION MAY BE NEEDED
See Page X for more information on actions you may want to take today.

We have important information about <insert service or benefit in question>. Based on our guidelines, we have decided to <include one per notice>:

(1) Deny your request for this service.

Date of request: <Date>

(2) Limit your request for this service.

Date of request: <Date>
Description of requested level of service: <insert description>
Approved level of service: <insert description>

(3) End this service.

Effective date of intended action: <Date>

(4) Reduce this service.

Effective date of intended action: <Date>
Description of current level of service: <insert description>
New level of service: <insert description>

(5) Suspend this service.

Effective date of intended action: <Date>
Expected date service will resume: <Date>

(6) Deny payment for this service (member request).

Date of request: <Date>
Date(s) service provided: <Date(s)>
Provider/Supplier: <insert provider/supplier>
Payment amount being denied: <$ amount>

(7) Deny payment for this service (provider claim).

Service or support: <List the name(s) of the service(s) and/or support(s) for which payment is being denied>

Date(s) of denial(s): <Enter the date of the Department's appeal decision denying the provider's claim(s), in whole or in part>
Date(s) of claim(s): <Enter the date(s) of the claim(s) for which payment was denied by the MCO>
Provider/Supplier: <List the name of the provider/supplier of the service or support for which the payment is being denied>

(8) Deny your request to dispute a financial liability.

Date of request: <Date>

(9) Deny your request to obtain a service outside of our provider network.

Date of request: <Date>

(10) Tell you about a failure to provide services in a timely manner.

Date of service request: <Date>

(11) Tell you about our failure to follow grievance and appeal timeframes.

Date grievance or appeal received: <Date>

The reason for our decision is: <explanation of decision for the member. HMO/PIHP must include specific rationale used to make the decision and any recommended alternatives.>

This decision is based on: <Cite specific contract language, federal provisions, state laws, FH topics, clinical guidelines, etc.>

Your provider can talk to the individual(s) who made the decision by calling the <title/department> at <phone number>.

How To Appeal This Decision

If you disagree with this decision, you have the right to file an appeal. An appeal is chance for <Health Plan Name> to take a second look at the decision, and you are an important part of that process. If you file an appeal, your health care benefits will not be affected, and you will not be treated differently than other members. To file an appeal, you can call <Health Plan Member Advocate phone number> to start the process immediately or write to the following address by <**appeal filing deadline – 60 calendar days from mailing date**>:

<Health Plan Mailing Address>

Your authorized representative, including an attorney, can also file an appeal for you, if you have given them written consent to do so.

Once your appeal is filed, <Health Plan Name> will have 30 calendar days to give you a decision. If you or your doctor think that waiting 30 days could seriously harm your health or ability to perform your daily activities, you can request a fast appeal. You can find more information on fast appeals below.

Your Appeal Rights

When you file an appeal, we will schedule a meeting for you with <Health Plan Name>'s Grievance and Appeal Committee. You may call in to this meeting, but you have the right to appear in person if you choose. You have the right to be represented at the hearing by anyone you choose, including an attorney. You may also bring a friend or family member. You may also bring new evidence and witnesses to this meeting.

You have the right to a free copy of all documents, records, and other information related to this decision. This includes medical information needed, and any processes, policies, or standards used in making the decision. You have a right to

this information whether or not you file an appeal. If you do file an appeal, you also have the right to a free copy of any new or additional information <Health Plan Name> gathers during your appeal.

If <Health Plan Name>'s Grievance and Appeal Committee decides against your appeal OR if we do not come to a decision within 30 days of receiving your appeal, you will have the option to file for a state fair hearing with the Wisconsin Division of Hearing and Appeals. If <Health Plan Name>'s Grievance and Appeal Committee decides against your appeal, you will receive a decision letter with more information on how to file for a state fair hearing. **You must finish your appeal with <Health Plan> before filing for a state fair hearing.**

Continuing Your Services During An Appeal

You have the right to request that < insert service or benefit in question> continue until a decision on your appeal has been made. If you want to keep your benefits during your appeal, you can call <Health Plan Member Advocate phone number> or send in a written request at the mailing address above. **To continue this service, this request must be made on or before <insert appropriate date – the later of 10 days from the mailing date or the effective date of the action>.**

If <Health Plan Name>'s Grievance and Appeal Committee decides against your appeal, you may need to repay the cost of the services you received while your appeal was being processed.

Getting Help With Your Appeal

We can help you complete forms and take other steps to process your appeal. If you have any questions about the process or need help submitting an appeal or obtaining records, you can contact the <Health Plan Name> Member Advocate at <Health Plan Member Advocate phone number>.

If you want to talk to someone outside of <Health Plan Name>, you can call the BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>. If you are enrolled in a Medicaid SSI Program, you can also call the SSI Managed Care External Advocacy Project at 1-800-928-8778for help with your appeal.

Asking For A Fast Appeal

You can ask for a faster decision on your appeal if you or your doctor think that waiting 30 days could seriously harm your health or ability to perform your daily activities. This is called an "expedited" or fast appeal. If <Health Plan Name> agrees that you need a fast appeal, you will get a decision within 72 hours. If <Health Plan Name> decides you do not need a fast appeal, you will get a letter letting you know why the request was denied, and your appeal will be decided within 30 days. To ask for a fast appeal call <title/department> at <phone number>.

Asking For More Time

<Health Plan Name> will always try to decide your appeal within 30 days of receiving it. However, it may take more time to complete the appeal. If you need more time to resolve the appeal, you can ask <Health Plan> for a 14-day extension. If <Health Plan Name> needs more time, they will call you and send you a letter to let you know the decision deadline has been extended. The appeal decision deadline can only be extended for up to 14 days.

2. Mandatory Language for Appeal Acknowledgement Letter

Health Plans are required to send out acknowledgement of receipt letters when they receive an appeal from a member. The Department does not have template letters for these notices. Consequently, to comply with 42 CFR § 438.406, the Department is requiring that health plans include the following language in their notice to members acknowledging receipt of the member's appeal.

Guidance for Implementation

- Health plans may modify the format of this letter and add additional content as needed to ensure readability and accessibility for members. However, all information presented here must be included in the letter.
- Under the section **Your Appeal Rights**, the health plan may modify the Grievance and Appeal Committee language to align with internal processes. Currently the text reads, "we will schedule a meeting for you with <Health Plan Name>'s Grievance and Appeal Committee." Some health plans automatically schedule committee meetings for members, while others will only schedule if a member requests a meeting. If this text is changed for the latter situation, the resulting letter must make clear that: 1) members do have the option to request a meeting; and 2) detail the process for requesting a meeting.
- The health plan should include a copy of the Wisconsin Division of Hearings and Appeals (DHA) fair hearing request form with the letter to the member. PDFs of this form can be found at the Wisconsin DHA "Requesting a Hearing" webpage.

Beginning of Letter:

We Received Your Request for an Appeal

<Health Plan name> received your request for an appeal on <date – use date of receipt of oral, mailed or faxed request>. We have up to 30 calendar days to make a decision on your appeal, and we will send you our decision by <*date the HMO received the appeal + 30 calendar days*>. If we need more than 30 days to make a decision, we will inform you in writing. If we did not give you a decision by <*date the HMO received the appeal + 30 calendar days*>, or if you did not get a notice from us telling you we need more time, you can request a state fair hearing. Instructions about how to ask for a state fair hearing are at the end of this letter.

End of Letter:

Getting Assistance With Your Appeal

We can help you complete forms and take other steps needed to process your appeal. If you have any questions about the process or need help submitting an appeal or getting records, you can contact the <Health Plan Name> Member Advocate at <Health Plan Member Advocate phone number>.

If you want to talk to someone outside of <Health Plan Name> you can call the BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>. If you are enrolled in a Medicaid SSI Program, you can also call the SSI External Advocate at 1-800-928-8778for help with filing your fair hearing.

Your Appeal Rights

When you file an appeal, we will schedule a meeting for you with <Health Plan Name>'s Grievance and Appeal Committee. You may call in to this meeting, but you have the right to appear in person if you choose. You have the right

to be represented at the hearing, and you can bring a friend or family member. You may also bring new evidence and witnesses to this meeting.

You have the right to a free copy of all documents, records, and other information related to this decision. This includes medical information needed, and any processes, policies, or standards used in making the decision. You have a right to this information whether or not you file an appeal. If you do file an appeal, you also have the right to a free copy of any new or additional information <Health Plan Name> gathers during your appeal.

If <Health Plan Name>'s Grievance and Appeal Committee decides against your appeal **OR** if we do not come to a decision within 30 days of getting your appeal, you will have the option to file for a state fair hearing with the Wisconsin Division of Hearing and Appeals. If <Health Plan Name>'s Grievance and Appeal Committee decides against your appeal, you will get a decision letter with more information on how to file for a state fair hearing. **You must finish your appeal with <Health Plan> before filing for a state fair hearing.**

Asking For More Time

<Health Plan Name> will always try to make a decision on your appeal within 30 days of getting it. However, it may take more time to complete the appeal. If you need more time to complete the appeal, you can ask <Health Plan> for a 14 day extension. If <Health Plan Name> needs more time, they will call you and send you a letter to let you know the decision deadline has been extended. The appeal decision deadline can only be extended for up to 14 days.

Asking For A State Fair Hearing

If we do not give you a written decision on your appeal or a notice telling you we need more time by <*date the HMO received the appeal + 30 calendar days*>, you can ask for a state fair hearing starting on <*date the HMO received the appeal + 31 calendar days*>. Your health care benefits will not be affected, and you will not be treated differently than other members if you ask for a state fair hearing. **To ask for a state fair hearing, use the form included with this letter or send a written request to the address or fax below by <date the HMO received the appeal + 30 calendar days + 90 calendar days>. Include a copy of this letter with your request.**

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
Fax: 608-264-9885

If you need a special arrangement for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (hearing impaired).

Once you have asked for a state fair hearing, the Division of Hearings and Appeals will have 90 calendar days to hold your hearing and issue a written decision, unless you requested an expedited appeal from <Health Plan Name>.

3. Appeal Resolution Letter Template (HMO Adverse Benefit Determination Upheld)

This notice is intended to notify members when the HMO has upheld the initial adverse benefit determination (see Section 3 of the *HMO and PIHP Member Grievances and Appeals Guide* or 42 CFR 438.400 for definitions). The notice of appeal resolution must be postmarked on or before the 30th calendar day after receiving the appeal, or 44th if there has been an extension (see Section 7 of the *HMO and PIHP Member Grievances and Appeals Guide* or 42 CFR 438.408 for timelines).

Guidance for Implementation

- Health plans may modify the format of this letter as needed to ensure readability and accessibility for members. However, all information presented here must remain in the letter.
- When sending the Appeal Resolution letter health plans should include **Option 1** if the member had requested benefits continue during the appeal and **Option 2** if the member did not request that benefits continue during the appeal.
- Only include the **Continuing Your Services During A State Fair Hearing** section if the member had requested benefits continue during the appeal.
- The health plan should include a copy of the Wisconsin Division of Hearings and Appeals (DHA) fair hearing request form with the letter to the member. PDFs of this form can be found at the Wisconsin DHA "Requesting a Hearing" webpage.

Notice of Decision on Your Appeal

Mailing Date

Member's Name
Member/Authorized Representative's Address

Member MA ID Number

Dear <Mr./Ms./Mrs.> <Last Name>,

ACTION MAY BE NEEDED
See Page X for more information on actions you may want to take today.

The <Health Plan Name>'s Grievance and Appeal Committee has made a decision on your appeal about <insert service or benefit in question>. Our meeting was held on <date>, where you <you participated/you and your representative participated/your representative participated/you chose not to participate>. After reviewing your case, the <Health Plan Name>'s Grievance and Appeal Committee has decided to <description of the decision>.

The reason for this decision is <Must include specific explanation for why the original decision was upheld>.

If you disagree with this decision, you can ask for a state fair hearing with the Wisconsin Division of Hearings and Appeals. You can find more information on how to ask for a state fair hearing below.

<CHOOSE ONE>
(Option 1. Standard continued benefits)

At your request, we continued your <describe continued services> during the appeal process. **Based on the <Health Plan Name>'s Grievance and Appeal Committee's decision, we will <reduce/terminate/etc.> your <describe continued services> on <effective date of intended action – no earlier than 10 calendar days after the mailing date of this letter>.** If you choose to ask for a state fair hearing, you can ask to have your benefits continue during the process. You can find more information on how to ask for your benefits continue below.

(Option 2. Benefits were not continued)
Your services were not continued during the <Health Plan Name> appeal; therefore, they cannot be provided if you choose to ask for a state fair hearing.

Thank you for using <Health Plan Name>'s grievance and appeals process. If you have any questions or would like help to ask for a state fair hearing, contact the <Health Plan Name> Member Advocate at <Health Plan Member Advocate phone number> or one of the organizations listed on the following page.

Sincerely,
<Signature lines>

Asking For A State Fair Hearing

If you disagree with this decision, you have the right to ask for a state fair hearing with the Wisconsin Division of Hearings and Appeals. Your health care benefits will not be affected, and you will not be treated differently than other members if you ask for a state fair hearing. **To ask for a state fair hearing, use the form included with this letter or send a written request to the address or fax below no later than 90 calendar days from the date you receive this notice. Include a copy of this letter with your request.**

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
Fax: 608-264-9885

If you need a special arrangement for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (hearing impaired).

Once you have asked for a state fair hearing, the Division of Hearings and Appeals will have 90 calendar days to hold your hearing and issue a written decision, unless you asked for an expedited appeal from <Health Plan Name>.

Your Fair Hearing Rights

The hearing will be held by an independent administrative law judge. These hearings are usually done by telephone. You have the right to be represented at the hearing, and you can bring a friend or family member. You can also ask the judge to include witnesses and send new evidence for the judge to consider when reviewing your case.

You have the right to a free copy of all documents, records, and other information related to this decision. This includes medical information needed, and any processes, policies, or standards used in making the decision. You have a right to this information whether or not you filed an appeal. If you did file an appeal, you also have the right to a free copy of any new or additional information <Health Plan Name> gathered during your appeal.

Continuing Your Services During A State Fair Hearing

You have the right to request that <insert service or benefit in question> continue until a decision has been made on the state fair hearing. **To continue this service while you submit a state fair hearing, you must send a request for a state fair hearing *and* continuation of your benefits to the Division of Hearings and Appeals by <insert appropriate date – 10 calendar days from the mailing date or the intended effective date, whichever is later>.**

If the administrative law judge decides that the <Health Plan Name>'s Grievance and Appeal Committee is correct, you may need to repay the cost of the services you received while your appeal was being processed.

Getting Help With Your State Fair Hearing

We will complete forms and take other steps needed to process your appeal. If you have any questions about the process or need help asking for a state fair hearing or getting records, you can contact the <Health Plan Name> Member Advocate at <Health Plan Member Advocate phone number>.

If you want to talk to someone outside of <Health Plan Name>, you can call the BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>. If you are enrolled in a Medicaid SSI Program, you can also call the SSI Managed Care External Advocate at 1-800-928-8778 for help with asking for your state fair hearing.

How Did We Make Our Decision?

The decision outlined in this letter is based on the following: <Cite specific contract language, federal provisions, state laws, FH topics, clinical guidelines, etc.>.

4. Appeal Resolution Letter Template (HMO Adverse Benefit Determination Reversed)

This notice is intended to notify members when the HMO has reversed the initial adverse benefit determination (see Section 3 of the *HMO and PIHP Member Grievances and Appeals Guide* or 42 CFR 438.400 for definitions). The notice of appeal resolution must be postmarked on or before the 30th calendar day after receiving the appeal, or 44th if there has been an extension (see Section 7 of the *HMO and PIHP Member Grievances and Appeals Guide* or 42 CFR 438.408 for timelines).

Guidance for Implementation

- Health plans may modify the format of this letter as needed to ensure readability and accessibility for members. However, all information presented here must remain in the letter.

Notice of Decision on Your Appeal

Mailing Date

Member's Name Member MA ID Number
Member/Authorized Representative's Address

Dear <Mr./Ms./Mrs.> <Last Name>,

The <Health Plan Name>'s Grievance and Appeal Committee has made a decision on your appeal about <insert service or benefit in question>. Our meeting was held on <date>, where you <you participated/you and your representative participated/your representative participated/you chose not to participate>. After reviewing your case, the <Health Plan Name>'s Grievance and Appeal Committee has decided to <description of the decision>.

The reason for this decision is <Must include specific explanation for why the original decision was reversed>.

Thank you for using our appeals process. <Health Plan Name> care management staff will be contacting you within 72 hours to implement this decision. If you have any follow up questions, contact your <<Health Plan Member Advocate>> at <<telephone number>>.

Sincerely,

<<Staff Name>>
<<Title>>
<<Telephone Number>>

5. Notice of Extension of Time to Decide an Appeal Template

Health Plans are required to send out notices to members when they determine that they need more than the standard amount of time (30 calendar days) to make a decision on the member's appeal.

Guidance for Implementation

- Health plans may modify the format of this letter as needed to ensure readability and accessibility for members. However, all information presented here must be included in the letter.
- When sending the Extension notice health plans should include **Option 1** when the health plan is requesting additional time and **Option 2** when the member is requesting additional time.
- Only include the **Continuing Your Services During A State Fair Hearing** section if the member had requested benefits continue during the appeal.
- The health plan should include a copy of the Wisconsin Division of Hearings and Appeals (DHA) fair hearing request form with the letter to the member. PDFs of this form can be found at the Wisconsin DHA "Requesting a Hearing" webpage.

More Time Is Needed to Make A Decision On Your Appeal

Mailing Date

Member's Name Member MA ID Number
Member/Authorized Representative's Address

Dear <Mr./Ms./Mrs.> <Last Name>,

(Option 1. Health plan requests additional time)

On <date>, we contacted you because we need additional time to make a decision on your appeal of our decision to <adverse benefit determination>.
(Option 2. Member requests additional time)

On <date>, you contacted <Health Plan Name> to ask for more time before we make a decision on your appeal of <adverse benefit determination>. We have extended the deadline for a decision on this appeal by <*XX days – no more than 14 days*>.

If you do not get our decision on your appeal by <*date the health plan received the appeal + 30 calendar days + up to 14 extension days*>, you can ask for a state fair hearing. Instructions about how to ask for a state fair hearing are at the end of this letter.

If you do not agree with our decision to extend the deadline for making a decision on your appeal, you have the right to file a grievance.

Submitting a grievance to <<insert HMO name>>

You may file a grievance by <<insert process and/or contact person for requesting a grievance with HMO>>.

Submitting a grievance to ForwardHealth

You can also send your grievance to ForwardHealth. To do this you can call the BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>, or you can send a letter to the following address:

BadgerCare Plus and Medicaid SSI
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

Getting Assistance With Your Grievance

You can get help or ask questions about the grievance process by contacting the <<insert HMO name>> Member Advocate at <<HMOAdvocate phone number>> or one of the organizations listed below:

- The BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>

- If you are enrolled in a Medicaid SSI Program, you can also call the SSI Managed Care External Advocacy Project at 1-800-928 for help with submitting a grievance.

State Fair Hearing:

If we do not provide you with a written decision on your appeal on or before <*date the HMO received the appeal + 30 calendar days + number of additional extension days*>, you can request a state fair hearing starting on <*date the HMO received the appeal + 30 calendar days + number of additional extension days +1 calendar day*>. Your request for a state fair hearing must be mailed or faxed to DHA **on or before <*date the health plan received the appeal + 30 calendar days + number of additional extension days + 90 calendar days*>**.

Asking For A State Fair Hearing

If we do not provide you with a decision by the deadline and you want to ask for a state fair hearing, you must send your request to the Wisconsin Division of Hearings and Appeals. Your health care benefits will not be affected, and you will not be treated differently than other members if you request a state fair hearing. **To ask for a state fair hearing, you must send a written request to the address or fax below by <*date the health plan received the appeal + 30 calendar days + number of additional extension days + 90 calendar days*>. Include a copy of this letter with your request.**

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
Fax: 608-264-9885

If you need a special arrangement for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (hearing impaired).

Once you have asked for a state fair hearing, the Division of Hearings and Appeals will have 90 calendar days to hold your hearing and issue a written decision, unless you asked for a faster appeal from <Health Plan Name>.

Your Fair Hearing Rights

The hearing will be held by an independent administrative law judge. These hearings are usually done by telephone. You have the right to be represented at the hearing, and you can bring a friend or family member. You can also ask the judge to include witnesses and send new evidence for the judge to consider when reviewing your case.

You have the right to a free copy of all documents, records, and other information related to this decision. This includes medical information needed, and any processes, policies, or standards used in making the decision. You have a right to this information whether or not you file an appeal. If you do file an appeal, you also have the right to a free copy of any new or additional information <Health Plan Name> gathered during your appeal.

Continuing Your Services During State Fair Hearing

If you asked for a service to continue while waiting for a decision from us, you can also ask for it to continue until the state fair hearing is resolved. **To continue this service while you appeal, you must send a request for a state fair hearing *and* continuation of your benefits to the Division of Hearings and Appeals by <*date the MCO received the appeal + 30 calendar days + number of additional extension days + 90 calendar days*>.**

If the administrative law judge decides that the <Health Plan Name>'s Grievance and Appeal Committee is correct, you may need to repay the cost of the services you received while your appeal was being processed.

Getting Help With Your State Fair Hearing

We can help you complete forms and take other steps to process your appeal. If you have any questions about the process or need help asking for a state fair hearing or getting records, you can contact the <Health Plan Name> Member Advocate at <Health Plan Member Advocate phone number>.

If you want to talk to someone outside of <Health Plan Name>, you can call the BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>. If you are enrolled in a Medicaid SSI Program, you can also call the SSI Managed Care External Advocacy Project at 1-800-928-8778 for help with requesting your state fair hearing.

Sincerely,
<<Staff Name>>
<<Title>>
<<Telephone Number>>

6. Denial of Request for Expedited Appeal Decision Template

This notice is intended to notify a member when the member has requested an expedited appeal determination and the HMO is denying that request (see Section 8 of the *HMO and PIHP Member Grievances and Appeals Guide* or 42 CFR 438.410).

Guidance for Implementation

- Health plans may modify the format of this letter as needed to ensure readability and accessibility for members. However, all information presented here must remain in the letter.

Notice of Denial of Request for Expedited Appeal Decision

Date mailed

Member's Name
Member/Authorized Representative's Address

Member MAID Number

Member's Name
Member/Representative's Street Address
City, State, Zip Code

Dear <Mr./Ms./Mrs.> <Last Name>,

On <<insert date>> you requested that <<Health Plan Name>> make an expedited decision on your appeal. An appeal decision can be expedited when it is determined that <<Health Plan Name>> taking the standard amount of time to make a decision could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function.

This letter is to notify you that << Health Plan Name>> will not be making an expedited decision on your appeal. We will complete the process and reach a decision no later than <<insert date Health Plan received appeal + 30 calendar days>>.

If you do not agree with our decision not to expedite your appeal, you have the right to file a grievance.

Submitting a grievance to <<Health Plan Name>>

You may file a grievance by <<insert process and/or contact person for requesting a grievance with the Health Plan>>.

Submitting a grievance to ForwardHealth

You can also send your grievance to ForwardHealth. To do this you can call the BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>, or you can send a letter to the following address:

BadgerCare Plus and Medicaid SSI
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

Getting Assistance With Your Grievance

You can get help or ask questions about the grievance process by contacting the <<Health Plan Name>> Member Advocate at <<Health Plan Advocate phone number>> or one of the organizations listed below:

- The BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>

- If you are enrolled in a Medicaid SSI Program, you can also call the SSI Managed Care External Advocacy Project at 1-800-928-8778 for help with submitting a grievance.

Sincerely,

<<Staff Name>>
<<Title>>
<<Telephone Number>>

7. Mandatory Language for Acknowledgement of Grievance Letter

Health plans are required to send out acknowledgement of receipt letters when they receive a grievance from a member. The Department does not have template letters for these notices. Consequently, to comply with 42 CFR § 438.406, the Department is mandating that health plans include the following language in their notice to members acknowledging receipt of the member's grievance

Guidance for Implementation

- Health plans may modify the format of this letter and add additional content as needed to ensure readability and accessibility for members. However, all information presented here must be included in the letter.
- Health plans must also notify members of grievance resolution. At this time, the Department does not have a template letter or mandatory language for inclusion in a letter to the member. Health plans may use their existing grievance resolution letters, but need to submit them to the Department for review.

Beginning of Letter:

We Received Your Grievance

<Health Plan name> received your grievance on <date>. A grievance is any complaint about your health plan or health care provider that is not related to a denial, change, or delay in your benefits. We have up to 30 days to make a decision on your grievance, and we will send you our decision by *<date the health plan received the grievance + 30 calendar days>*. If we need more than 30 days to make a decision, we will notify you in writing.

Submitting a grievance to ForwardHealth

You can also send your grievance to ForwardHealth. To do this you can call the BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>, or you can send a letter to the following address:

BadgerCare Plus and Medicaid SSI
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

Getting Assistance With Your Grievance

You can get help or ask questions about the grievance process by contacting the <Health Plan Name> Member Advocate at <Health Plan Member Advocate phone number> or one of the organizations listed below:

- The BadgerCare Plus and Medicaid SSI Ombuds at <ForwardHealth Ombuds Phone #>
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- If you are enrolled in a Medicaid SSI Program, you can also call the SSI Managed Care External Advocacy Project at 1-800-928-8778 for help with submitting a grievance.

APPENDIX C: CHANGE LOG

Citation	Date	Analyst	Description of Change
Appendix A	4/10/2020	Mitchell Running	Modified fair hearing filing timeframe in the visual from 120 days to 90 days to align with DHS programs
Version 3.0	4/10/2020	Makalah Wagner	Removed watermark and tracked changes to create final for distribution.
Table of Contents	5/20/2020	Mitchell Running	Updated table of contents to reflect correct page numbers and headings
Table of Contents	12/13/2021	Nate Vercauteren	Updated table of contents to reflect correct page numbers and headings
Sections 2.2 & 3	12/13/2021	Nate Vercauteren	Updated definition of denial of payment adverse benefit determination to include denial of a provider's claim.
Sections 4.5; 6.2.3; 7.2.1 and 7.2.2	12/13/2021	Nate Vercauteren	Removed text and template language requiring an oral appeal to be followed up with a written appeal. Clarified that appeal and grievance resolution timeframe begins with receipt of grievance/appeal (whether filed orally or in writing).
Section 6.1	12/13/2021	Nate Vercauteren	Added language indicating that Department will request additional information from HMO as needed and that HMO will have 5 business days to provide requested information.
Section 7.4	12/13/2021	Nate Vercauteren	Added process HMO must follow when individual purporting to be member's representative files an appeal or grievance on the member's behalf.
Section 7.6.2.2	12/13/2021	Nate Vercauteren	Added clarification that HMO must send a separate appeal decision for each adverse benefit determination appealed by a member.
Section 7.8.3	12/13/2021	Nate Vercauteren	Added clarification that 5 day mailing presumption applies to member's receipt of HMO's appeal decision when determining the start date of the member's 90 day timeframe to request a fair hearing.
Section 9.3.4	12/13/2021	Nate Vercauteren	Deleted expiration of service authorization timeframe as reason for discontinuing benefits while appeal is pending.
Sections 12.3.1 & 12.3.2	12/13/2021	Nate Vercauteren	Clarified that quarterly appeal and grievance data must be reported in excel format and added additional appeal information that must be reported.
Section 12.4	12/13/2021	Nate Vercauteren	Added reference to DHS-MCO contract with respect to notice provided to HMOs regarding DHS changes to appeal and grievance related reporting requirements.
Appendix B	12/13/2021	Nate Vercauteren	Updated NOA template with additional instructions re: rural areas with one HMO and instances in which the HMO fails to render an appeal or grievance decision within the required amount of time.
Appendix B	12/13/2021	Nate Vercauteren	Deleted contact info for HMO Enrollment Specialist on all templates.
Appendix B	12/13/2021	Nate Vercauteren	Updated NOA template with (1) clarification that attorney can act as member representative and request appeal on the member's behalf; (2) contact information for provider to call to discuss NOA; (3) contact information for requesting a fast appeal.
Appendix B	12/13/2021	Nate Vercauteren	Added new template: Appeal Resolution Letter Template (HMO Adverse Benefit Determination Reversed)
Appendix B	12/13/2021	Nate Vercauteren	Modified existing mandatory template language into new template: Notice of Extension of Time to Decide an Appeal Template
Appendix B	12/13/2021	Nate Vercauteren	Added new template: Denial of Request for Expedited Appeal Decision Template
Appendix B	12/13/2021	Nate Vercauteren	Updated template letters to include DRW 1-800 number as opposed to placeholder for the HMO to enter the regional office number.
Appendix B	12/13/2021	Nate Vercauteren	Removed language from templates requiring an oral appeal to be followed up with a written appeal.
Appendix B	12/13/2021	Nate Vercauteren	Updated NOA template notice to implement MCR denial of provider claim requirements.