



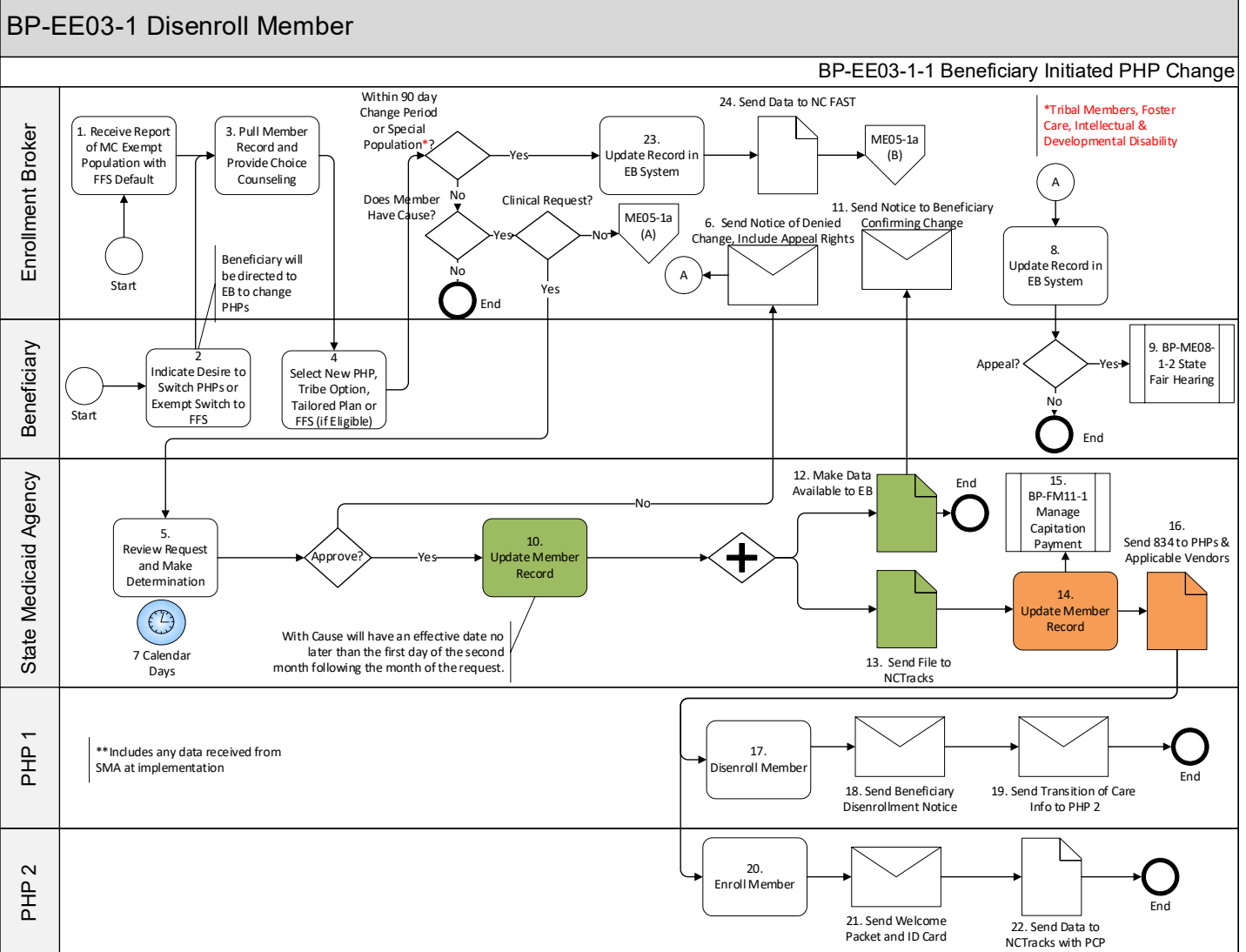
Feb. 4, 2019

Grievance and Appeals Process for Disenrollment Determinations

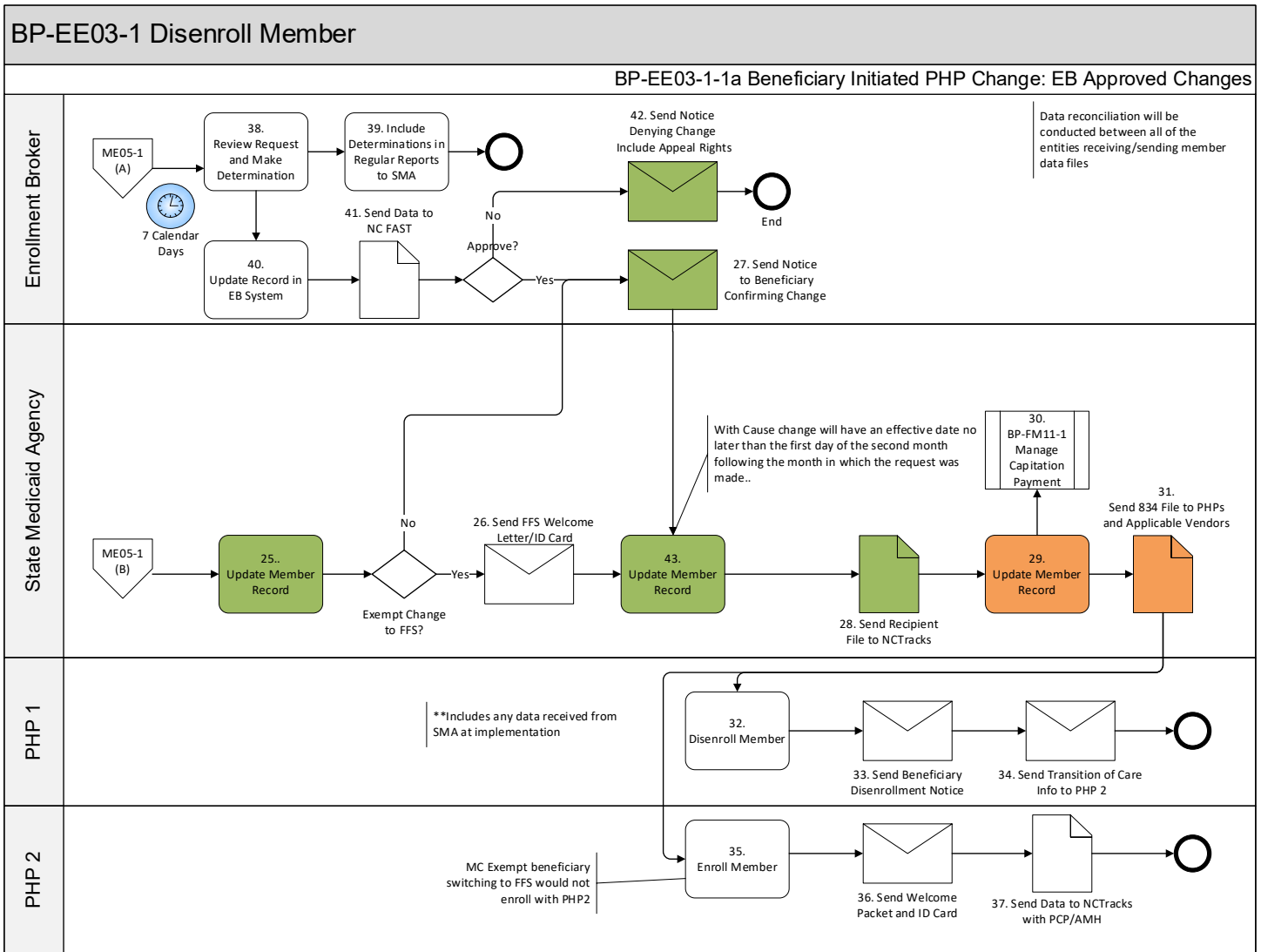
Section VII.M.1.g.

This document details the Member Grievance and Appeals Process for Disenrollment Determinations in accordance with 42 C.F.R. § 438.56(f), "Members, or an authorized representative, may appeal disenrollment determinations made by the Enrollment Broker or the Department through an appeals process defined by the Department." The first four process flows detail the Disenroll Member business processes, which are responsible for the termination of a member's enrollment in a health plan or health benefit. An enrollment termination may occur for a variety of reasons including loss of eligibility, change of residence or a request to terminate coverage. These processes are a predecessor to the Member Grievance and Appeals for disenrollment determinations.

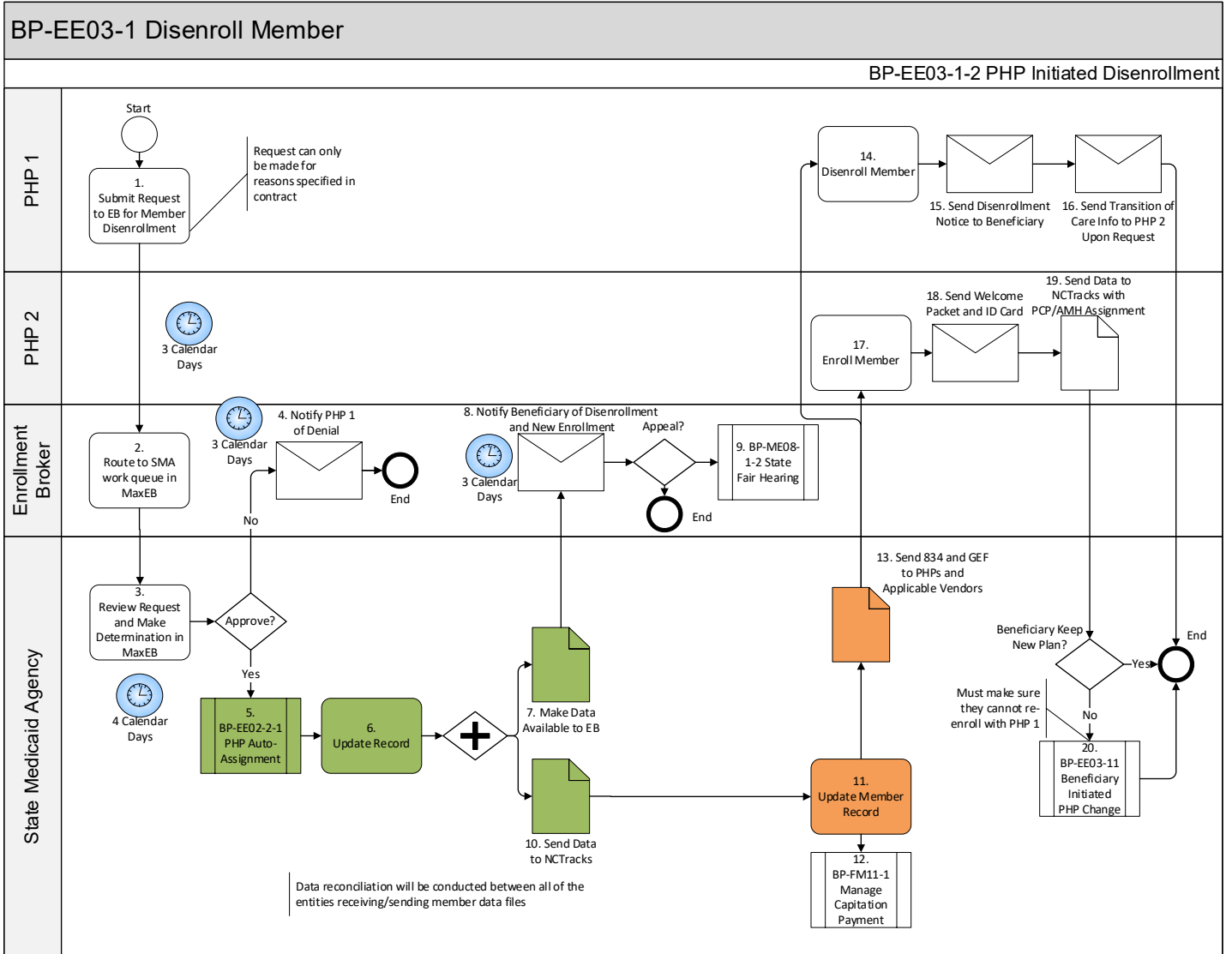
3.2.1 BP-EE03-1-1 Beneficiary Initiated PHP Change



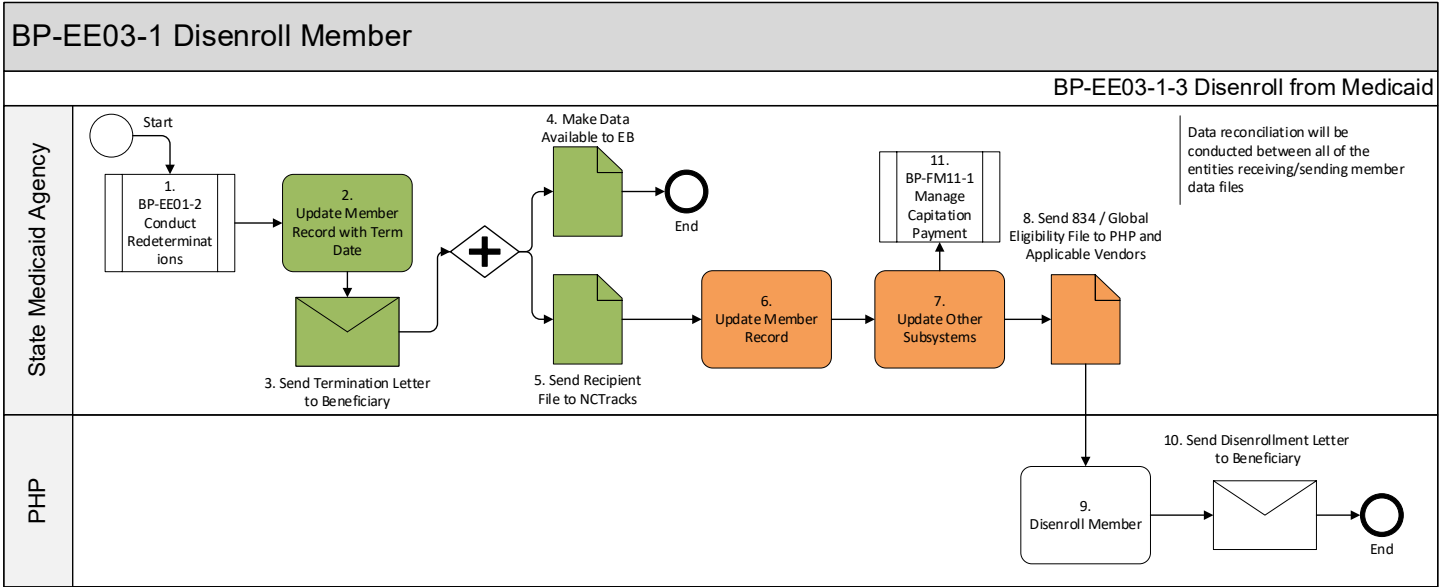
3.2.2 BP-EE03-1-1a Beneficiary Initiated PHP Change, Non-clinical Request



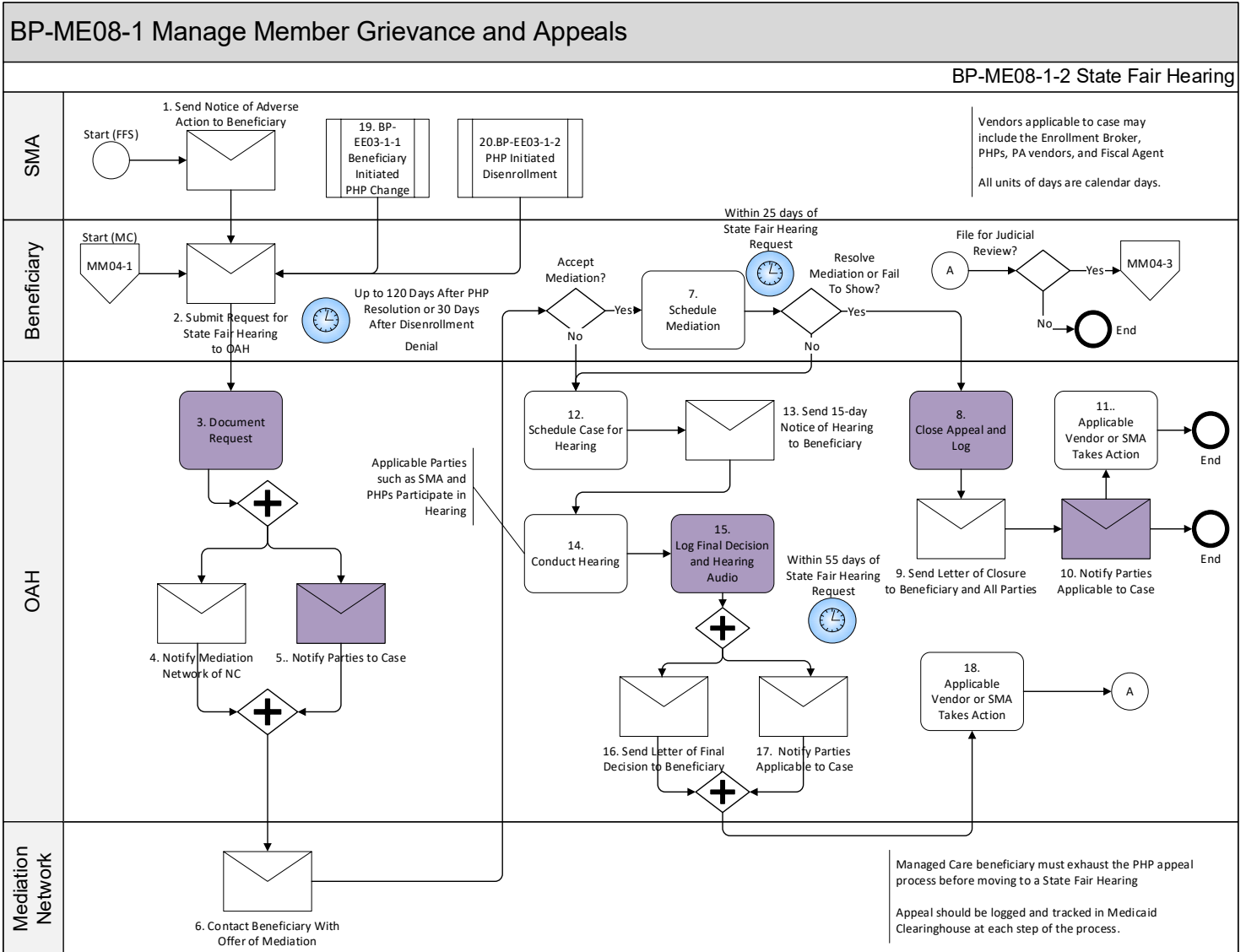
3.2.3 BP-EE03-1-2 PHP Initiated Disenrollment



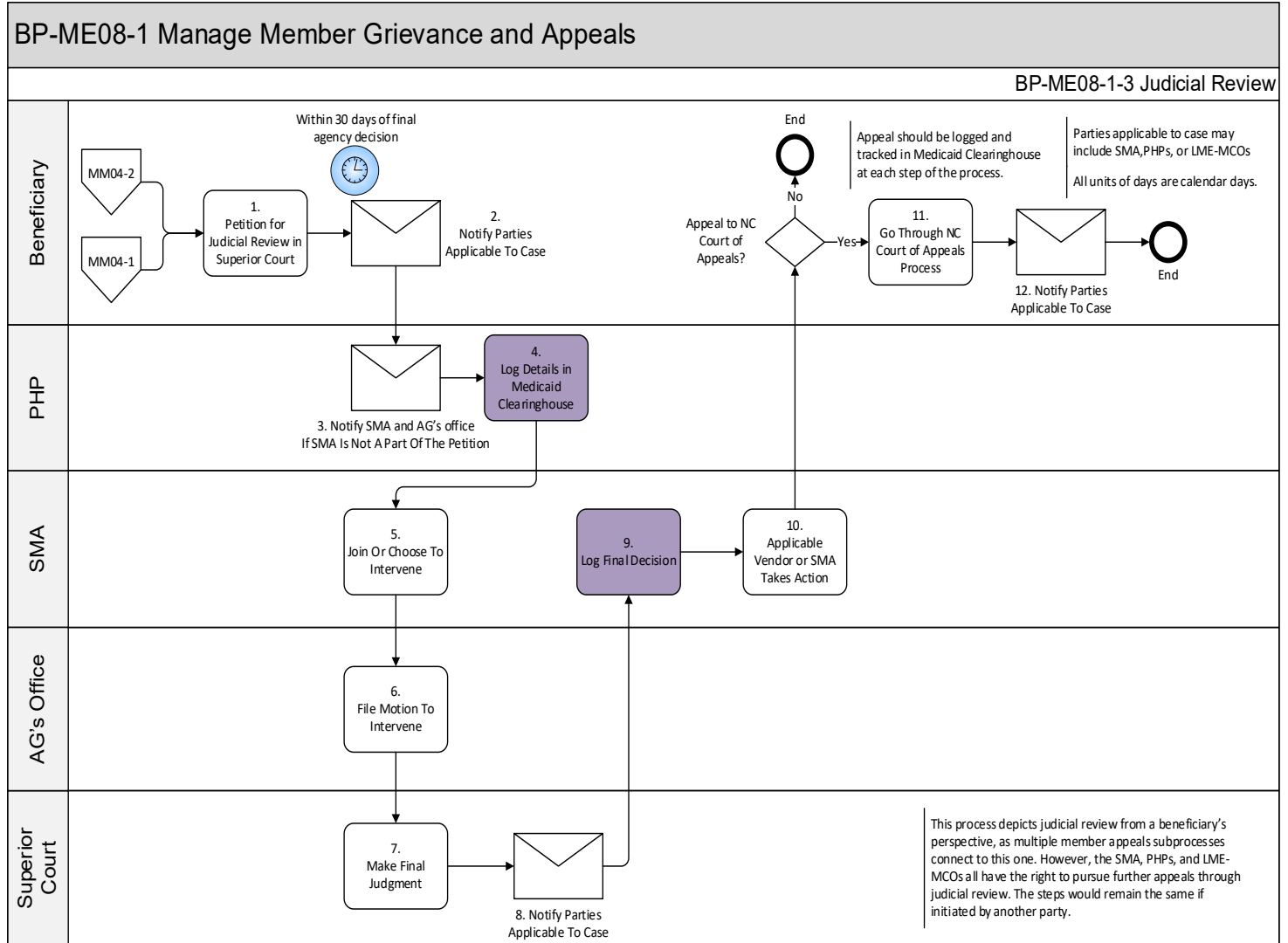
3.2.4 BP-EE03-1-3 Disenroll from Medicaid



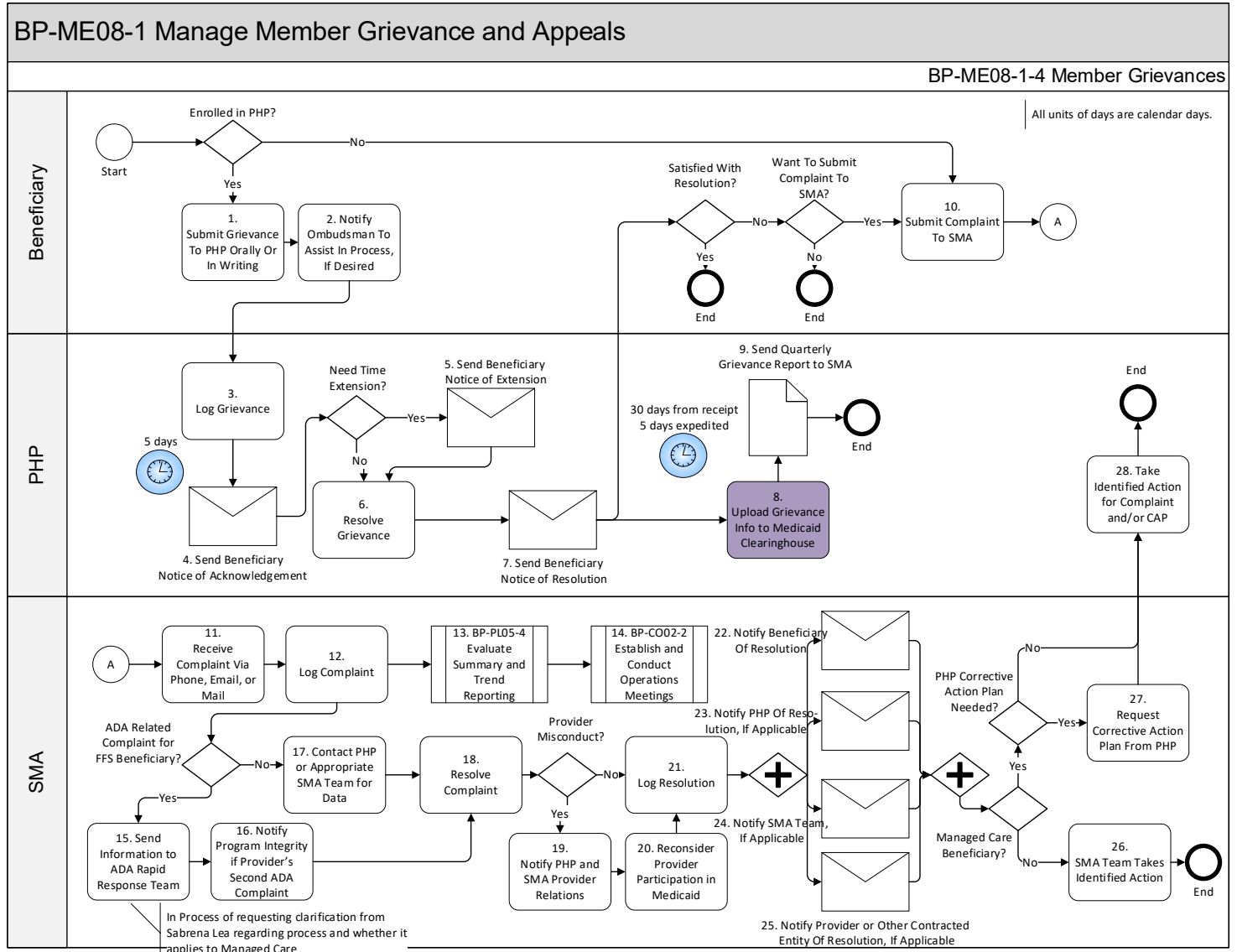
BP-ME08-1-2 State Fair Hearing



BP-ME08-1-3 Judicial Review

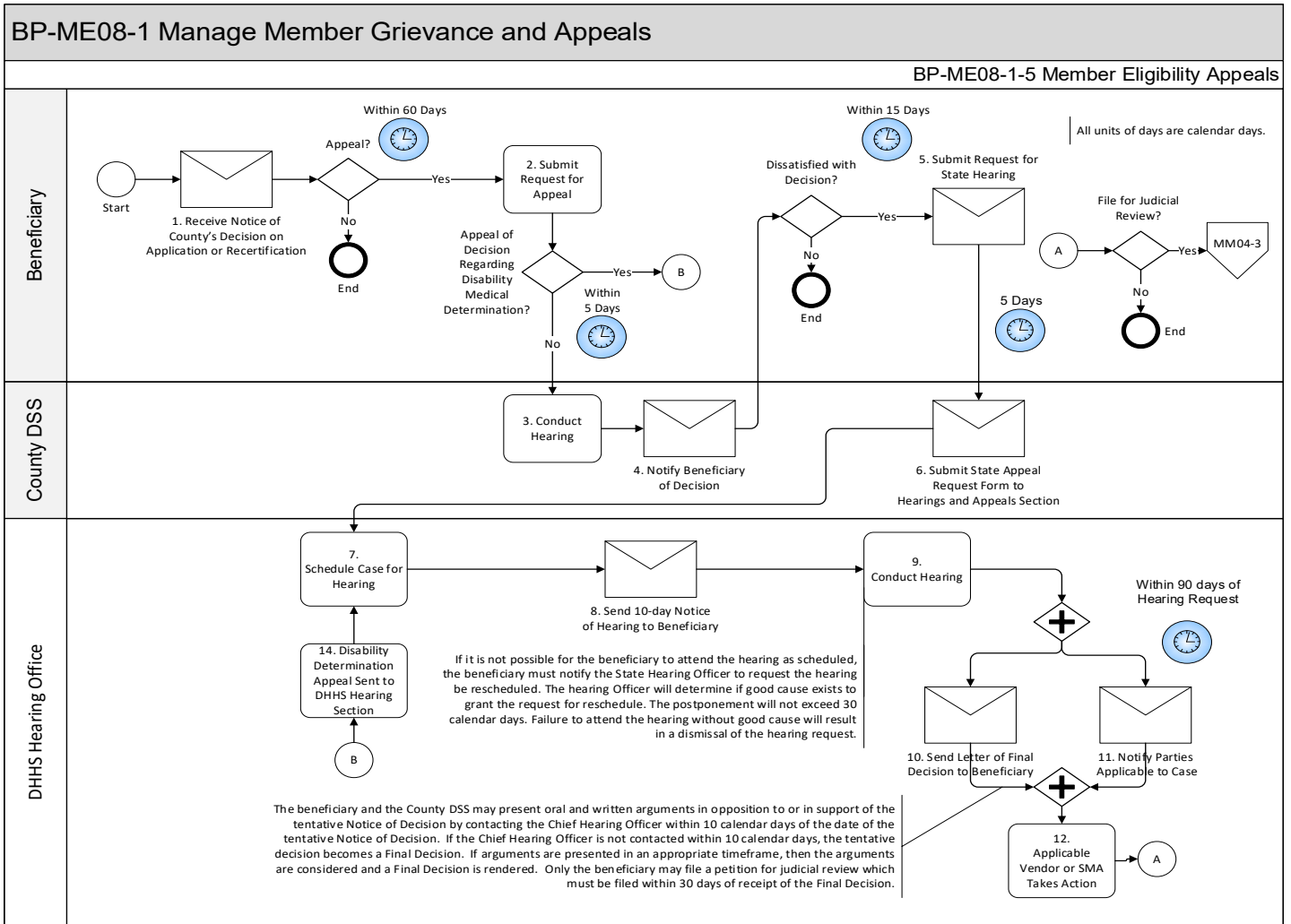


BP-ME08-1-4 Member Grievances



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BP-ME08-1-5 Member Eligibility Appeals



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Process Steps and Definition

BP-EE03-1-1 Beneficiary Initiated PHP Change			
Process Number	Process Name	Process Description	Associated Requirement Number
BP-EE03-1-1.1	Receive Report of MC Exempt Population with FFS Default	Managed Care exempt individuals will be defaulted to a specific PHP (Tribal, Tailored Plan and Foster Care when implemented) or to FFS. These individuals can switch between managed care and FFS or between PHPs at any time. They will receive instruction encouraging them to contact the Enrollment Broker (EB) to move to managed care. For efficiency, the SMA may send the EB a monthly report with new MC Exempt beneficiaries for the EB to actively reach out to.	
BP-EE03-1-1.2	Indicate Desire to Switch PHPs or Exempt Switch to FFS	The beneficiary receives notification of their PHP assignment and instruction to contact the EB if they want to change their PHP. The beneficiary contacts the EB to change their PHP or switch to FFS.	
BP-EE03-1-1.3	Pull Member Record and Provide Choice Counseling	When the beneficiary contacts the Enrollment Broker, the EB will pull the member record from NC FAST to access the member data. The Enrollment Broker provides the beneficiary with details about all PHPs the beneficiary is eligible for to help them decide which PHP to select.	
BP-EE03-1-1.4	Select New PHP, Tribe Option, Tailored Plan or FFS (if Eligible)	The beneficiary selects a new PHP. If beneficiary is part of a special population, they may select a special plan. An exempt beneficiary can also request to return to FFS. The beneficiary must make an appropriate selection with the aid of the Enrollment Broker – auto assignment will not be done when a change has been requested.	
Clinical With Cause Change Request			
BP-EE03-1-1.5	Review Request and Make Determination	The Enrollment Broker (EB) will open a request in MaxEB and send the documentation regarding the beneficiary's with cause request to change PHPs. A team at the SMA will evaluate the situation and render a decision if the criteria are met to allow a PHP change. The decision needs to be made within 7 days. Once the decision is made, the effective date will be no later than the first day of the second month following the month in which the request was made.	
BP-EE03-1-1.6	Send Notice of Denied Change	If the State Medicaid Agency denies the with cause clinical request, the EB will generate a denial notice, including	

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	Include Appeal Rights	details about appeals rights, to send to the beneficiary.	
BP-EE03-1-1.7	Notify EB of Decision	The request from the EB needs to be closed out and the outcome shared with the EB. There will not be an enrollment change on the member's record because the request was denied.	
BP-EE03-1-1.8	Update Record in EB System	The enrollment broker will update their system to show that the PHP change request was denied.	
BP-EE03-1-1.9	BP-ME08-1-2 State Fair Hearing	If the beneficiary wishes to appeal the denied PHP request after receiving their denial notice from the EB, they will contact the state following the appeal instructions in the letter. This would be handled under the Manage Member Grievance and Appeals process, BP-ME08-1-2 State Fair Hearing.	
BP-EE03-1-1.10	Update Member Record	The beneficiary's record in NC FAST is updated with details about the approved PHP change.	
BP-EE03-1-1.12	Notify EB of Decision	The Enrollment Broker is notified that the PHP change request submitted by the beneficiary was approved. The PHP change is also reflected in the member record, which the Enrollment Broker can access by pulling the data as needed for choice counseling.	
BP-EE03-1-1.11	Send Notice to Beneficiary Confirming Change	The EB sends a notice to the beneficiary confirming that their PHP change request was approved.	
BP-EE03-1-1.13	Send File to NCTracks	The change in the beneficiary status is sent in the daily file between NC FAST and NCTracks.	
BP-EE03-1-1.14	Update Member Record	The beneficiary's record in NCTracks is updated with details about the approved change of PHP.	
BP-EE03-1-1.15	BP-FM11-1 Manage Capitation Payment	Changes to the beneficiary record in NCTracks and NC FAST will kick off changes in the capitation payments. The payment for the beneficiary will need to be sent to a different PHP. Depending on the effective date of the change, there may also need to be a recoupment from the first PHP if they are no longer responsible for the beneficiary.	
BP-EE03-1-1.16	Send File to PHPs and Applicable Vendors	The 834 file sent to the PHPs will indicate that a beneficiary is disenrolled from one PHP and enrolled in another.	
BP-EE03-1-1.17	Disenroll Member	PHP 1 disenrolls beneficiary from their plan.	
BP-EE03-1-1.18	Send Beneficiary Disenrollment Notice	PHP 1 sends a disenrollment notice to the beneficiary. The file should indicate the beneficiary changed coverage to another plan. The letter should reflect this.	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

BP-EE03-1-1.19	Send Transition of Care Info to PHP 2	If requested by the new plan, PHP 1 can send any applicable transition of care information to the beneficiary's new covering entity.	
BP-EE03-1-1.20	Enroll Member	PHP 2 enrolls the beneficiary into their plan.	
BP-EE03-1-1.21	Send Welcome Packet and ID Card	PHP 2 sends the beneficiary a welcome packet and ID card.	
BP-EE03-1-1.22	Send Data to NCTracks with PCP	PHP 2 sends NCTracks details about the beneficiary's enrollment and assigned PCP.	
<i>Standard Request Within Change Period</i>			
BP-EE03-1-1.23	Update Record in EB System	If the beneficiary made the request within the 90-day change period or is a member of a special population exempt from the 90-day change period, the request will be approved and updated in the enrollment broker's system.	
BP-EE03-1-1.24	Send Data to NC FAST	The enrollment broker will send data of the PHP change from their system to NC FAST real-time.	
BP-EE03-1-1.25	Update Member Record	The beneficiary's record in NC FAST is updated with details about the PHP change.	
BP-EE03-1-1.26	Send FFS Welcome Letter/ID Card	If it is a Tribal member who has requested moving back to FFS from the Tribal PHP default, a FFS Welcome letter and ID card will need to be triggered.	
BP-EE03-1-1.27	Send Notice to Beneficiary Confirming Change	The EB sends a notice to the beneficiary confirming that their PHP change request or request to move to FFS was approved and processed by the SMA.	
BP-EE03-1-1.28	Send File to NCTracks	The change in the beneficiary status is sent in the recipient eligibility file between NC FAST and NCTracks.	
BP-EE03-1-1.29	Update Member Record	The beneficiary's record in NCTracks is updated with details about the approved change of PHP.	
BP-EE03-1-1.30	BP-FM11-1 Manage Capitation Payment	Changes to the beneficiary record in NCTracks and NC FAST will kick off changes in the capitation payments. The payment for the beneficiary will need to be sent to a different PHP. Depending on the effective date of the change, there may also need to be a recoupment from the first PHP if they are no longer responsible for the beneficiary.	
BP-EE03-1-1.31	Send File to PHPs and Applicable Vendors	The 834 file sent to the PHPs will indicate that a beneficiary is disenrolled from one PHP and enrolled in another.	
BP-EE03-1-1.32	Disenroll Member	PHP 1 disenrolls beneficiary from their plan.	
BP-EE03-1-1.33	Send Beneficiary Disenrollment Notice	PHP 1 sends a disenrollment notice to the beneficiary. The file should indicate the beneficiary changed	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

		coverage to another plan. The letter should reflect this.	
BP-EE03-1-1.34	Send Transition of Care Info to PHP 2 Upon Request	If requested by the new plan (or FFS), PHP 1 can send any applicable transition of care information to the beneficiary's new covering entity. The transition of care information may include data received from the SMA at implementation regarding the beneficiary.	
BP-EE03-1-1.35	Enroll Member	PHP 2 enrolls the beneficiary into their plan.	
BP-EE03-1-1.36	Send Welcome Packet and ID Card	PHP 2 sends the beneficiary a welcome packet and ID card.	
BP-EE03-1-1.37	Send Data to NCTracks with PCP	PHP 2 sends NCTracks details about the beneficiary's enrollment and assigned PCP.	
		If a standard beneficiary (i.e. not exempt or special population) requests to change their PHP but they are past the 90-day change period, they will not be granted a change unless they have grounds to request a "with cause" change consideration. If the beneficiary's concerns do not meet "with cause" criteria, no change will be made.	
<i>BP-EE03-1-1a Non-Clinical With Cause Change Request</i>			
BP-EE03-1-1.38	Review Request and Make Determination	If the beneficiary has a with cause non-clinical request, the enrollment broker will review the beneficiary's request. Requirements define what is a "non-clinical with cause" request. The SMA can also add criteria for clinical requests that the EB can approve. An example might be if a PHP has been determined to have poor performance with select services and a beneficiary requests a change because they cannot get those services. The review needs to be completed within 7 days.	
BP-EE03-1-1.39	Include Determinations in Regular Reports to SMA	Enrollment Broker (EB) will provide data on volume and outcome of with cause requests they have handled so that the SMA can include this information in any overall program reporting	
BP-EE03-1-1.40	Update Record in EB System	The EB will update their system to show the result of the review and, if approved, the change to the member selected new PHP.	
BP-EE03-1-1.41	Send Data to NC FAST	The EB will send data on the approval or denial of request, including the PHP change (if approved) from their system to NC FAST.	
BP-EE03-1-1.42	Send Notice Denying Change Include Appeal Rights	If the beneficiary's request was denied, the EB will generate a notice to the member informing them of the denial.	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

BP-EE03-1-1.43	Update Member Record	If the beneficiary's request was approved, the record in NC FAST is updated with details about the outcome and the PHP change. The effective date will be no later than the first day of the second month following the month in which the request was made.	
		The next steps to confirm an approved change and update all necessary records follow steps BP-EE03-1-1.27 through BP-EE03-1-1.37.	
BP-EE03-1-2 PHP Initiated Disenrollment			
Process Number	Process Name	Process Description	Associated Requirement Number
BP-EE03-1-2.1	Submit Request to EB for Member Disenrollment	The PHP initiates the disenrollment process by submitting a request to the Enrollment Broker (EB). The PHP can only make such a request if the situation meets the very specific criteria identified in the contract.	
BP-EE03-1-2.2	Route to SMA work queue in MaxEB	The EB transmits the PHP's disenrollment request to the State Medicaid Agency through the MaxEB system within 3 calendar days of receiving the request.	
BP-EE03-1-2.3	Review Request and Make Determination	The State Medicaid Agency reviews the PHP's disenrollment request within 4 calendar days.	
BP-EE03-1-2.4	Notify PHP 1 of Denial	If the PHP's request is denied, the EB will send a denial notice to the PHP with 3 calendar days of receipt of the determination.	
BP-EE03-1-2.5	BP-EE02-2-1 PHP Auto- Assignment	If the PHP's disenrollment request is approved, the beneficiary will be auto-assigned to a new PHP through the PHP Auto-Assignment process.	
BP-EE03-1-2.6	Update Record	The beneficiary's record is updated in NC FAST with their newly auto-assigned PHP	
BP-EE03-1-2.7	Make Data Available to EB	NC FAST makes the updated data available to the Enrollment Broker to pull as needed for choice counseling and to send the enrollment notices.	
BP-EE03-1-2.8	Notify Beneficiary of Disenrollment and New Enrollment	The beneficiary will receive a notice informing them that they will be disenrolled from PHP 1 and enrolled into PHP 2 that is generated by NC FAST.	
BP-EE03-1-2.9	BP-ME08-1-2 State Fair Hearing	If the beneficiary wishes to appeal the denied PHP request after receiving their denial notice from the EB, they will contact the state following the appeal instructions in the letter. This would be handled under the Manage Member Grievance and Appeals process, BP-ME08-1-2 State Fair Hearing.	
BP-EE03-1-2.10	Send Data to NCTracks	NC FAST sends data about the beneficiary's disenrollment and new enrollment to NCTracks.	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

BP-EE03-1-2.11	Update Member Record	The beneficiary's disenrollment and reenrollment information is updated on their record in NCTracks.	
BP-EE03-1-2.12	BP-FM11-1 Manage Capitation Payment	Changes to the beneficiary record will be distributed to internal systems which will kick off changes in the capitation payments. The payment for the beneficiary will need to be sent to a different PHP. Depending on the effective date of the change, there may also need to be a recoupment from the first PHP if they are no longer responsible for the beneficiary.	
BP-EE03-1-2.13	Send 834 and Eligibility File to PHPs and Applicable Vendors	NCTracks sends an 834 and global eligibility file containing details about the beneficiary's disenrollment and reenrollment to both PHPs and any other vendors.	
BP-EE03-1-2.14	Disenroll Member	PHP 1 disenrolls beneficiary from their plan.	
BP-EE03-1-2.15	Send Disenrollment Notice to Beneficiary	PHP 1 sends a disenrollment notice to the beneficiary.	
BP-EE03-1-2.16	Send Transition of Care Info to PHP 2 Upon Request	PHP 1 sends any applicable transition of care information to the beneficiary's new PHP upon request from that PHP.	
BP-EE03-1-2.17	Enroll Member	PHP 2 enrolls the beneficiary into their plan.	
BP-EE03-1-2.18	Send Welcome Packet and ID Card	PHP 2 sends the beneficiary a welcome packet and ID card.	
BP-EE03-1-2.19	Send Data to NCTracks with PCP	PHP 2 sends the State Medicaid Agency details about the beneficiary's enrollment and assigned PCP.	
BP-EE03-1-2.20	BP-EE03-1-1 Beneficiary Initiated PHP Change	After receiving their ID card and welcome packet, if the beneficiary does not want to keep their new PHP, they will go through the Beneficiary Initiated PHP Change process; however they cannot be reassigned to the previous PHP.	
BP-EE03-1-3 Disenroll From Medicaid			
Process Number	Process Name	Process Description	Associated Requirement Number
BP-EE03-1-3.1	BP-EE01-2 Conduct Redeterminations	The beneficiary went through the redetermination process, either due to the annual requirement or due to a change in circumstance and was found ineligible for Medicaid.	
BP-EE03-1-3.2	Update Member Record with Term Date	The beneficiary's record is updated in NC FAST with their Medicaid termination date.	
BP-EE03-1-3.3	Send Termination Letter to Beneficiary	A termination letter is generated by NC FAST and is sent to the beneficiary.	
BP-EE03-1-3.4	Make Data Available to EB	If a beneficiary contacts the Enrollment Broker after disenrolling from Medicaid, the Enrollment Broker can pull the member record to view that the member is disenrolled.	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

BP-EE03-1-3.5	Send Recipient File to NCTracks	Recipient data file with details about beneficiary's disenrollment is sent to NCTracks by NC FAST.	
BP-EE03-1-3.6	Update Member Record	The beneficiary's record is updated in NC Tracks with details about the beneficiary's disenrollment.	
BP-EE03-1-3.7	Update Other Subsystems	NCTracks updates other state systems that need notification about the beneficiary's disenrollment.	
BP-EE03-1-3.8	Send 834 / Eligibility File to PHP and Applicable Vendors	834 / Global Eligibility file is sent by NCTracks to the PHP and any other vendors who require notification about the beneficiary's disenrollment.	
BP-EE03-1-3.9	Disenroll Member	The PHP disenrolls the member from their plan.	
BP-EE03-1-3.10	Send Disenrollment Letter to Beneficiary	The PHP sends a disenrollment letter to the beneficiary. The letter should be specific to this scenario where the beneficiary is ineligible for Medicaid, rather than the scenario where the beneficiary is changing PHPs.	
BP-EE03-1-2.11	BP-FM11-1 Manage Capitation Payment	Changes to the beneficiary record will be distributed to internal systems which will kick off changes in the capitation payments. The payment for the beneficiary will need to be sent to a different PHP. Depending on the effective date of the change, there may also need to be a recoupment from the first PHP if they are no longer responsible for the beneficiary.	

BP-ME08-1-2 State Fair Hearing

Process Number	Process Name	Process Description	Associated Requirement Number
BP-ME08-1-2.1	Send Notice of Adverse Action to Beneficiary	The SMA sends a Notice of Adverse Action to beneficiaries enrolled in the Fee-For-Service (FFS) program when an adverse action is taken, such as when a prior authorization is denied.	
BP-ME08-1-2.20	BP-EE03-1-1 Beneficiary Initiated PHP Change	If a beneficiary submits a request to the Enrollment Broker to change PHP enrollment and the request is denied, the beneficiary can submit a request for a State Fair Hearing. The disenrollment request process is outlined in BP-EE03-1-1 Beneficiary Initiated PHP Change.	
BP-ME08-1-2.21	BP-EE03-1-2 PHP Initiated Disenrollment	If a beneficiary is disenrolled from a PHP because of a request made by the PHP, the beneficiary can appeal the decision. The PHP Initiated Disenrollment process is outlined in BP-EE03-1-2 PHP Initiated Disenrollment.	
BP-ME08-1-2.2	Submit Request for State Fair Hearing to OAH	If the beneficiary is enrolled in FFS and the adverse action was not an eligibility decision nor an NC Health Choice decision, the beneficiary can	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

		submit a request for a State Fair Hearing. The request is sent to the Office of Administrative Hearings (OAH). If the beneficiary is enrolled in Managed Care, a request can be submitted to OAH for a State Fair Hearing after the PHP appeal process is exhausted.	
BP-ME08-1-2.3	Document Request	OAH documents each State Fair Hearing request received in the Medicaid Clearinghouse.	
BP-ME08-1-2.4	Notify Mediation Network of NC	OAH notifies the Mediation Network of NC of the appeal details so they can contact the beneficiary with an offer of mediation.	
BP-ME08-1-2.5	Notify Parties Applicable to Case	Vendors applicable to the case are notified through the Medicaid Clearinghouse. This can include the Enrollment Broker, PHP, Fiscal Agent, SMA or PA Vendor. If the case should involve continuation of benefits, this allows the PHP, PA vendor, and/or Fiscal Agent to coordinate the continuation of benefits.	
BP-ME08-1-2.6	Contact Beneficiary with Offer of Mediation	The Mediation Network of NC contacts the beneficiary with an offer of mediation. The beneficiary has the choice to accept or reject the offer of mediation.	
BP-ME08-1-2.7	Schedule Mediation	If the beneficiary accepts the offer of mediation, the mediation is scheduled within 25 calendar days of receipt of State Fair Hearing request.	
BP-ME08-1-2.8	Close Appeal and Log	If the mediation is resolved or the beneficiary fails to show for the mediation, the appeal is closed and logged by OAH in the Medicaid Clearinghouse.	
BP-ME08-1-2.9	Send Letter of Closure to Beneficiary and all Parties	OAH sends the beneficiary and all applicable parties a Letter of Closure once the appeal is closed and logged.	
BP-ME08-1-2.10	Notify Vendors Applicable to Case	The vendors applicable to the case are notified by the Medicaid Clearinghouse when the appeal is closed by OAH.	
BP-ME08-1-2.11	Applicable Vendor or SMA Takes Action	The applicable vendor or the SMA takes action depending on the final agency decision.	
BP-ME08-1-2.12	Schedule Case for Hearing	If the beneficiary does not accept the offer of mediation or the beneficiary is not satisfied with mediation, the case is scheduled by OAH for hearing.	
BP-ME08-1-2.13	Send 15-day Notice of Hearing to Beneficiary	OAH sends a Notice of Hearing to the beneficiary 15 days prior to the scheduled hearing. The beneficiary	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

		can informally contact OAH to reschedule the hearing if needed.	
BP-ME08-1-2.14	Conduct Hearing	The hearing is conducted by OAH. The SMA, PHP, and Enrollment Broker may participate in the hearing if needed.	
BP-ME08-1-2.15	Log Final Decision and Hearing Audio	After the hearing, the final decision is logged in the Medicaid Clearinghouse and a copy of the hearing audio is stored by the OAH. The SMA can request the hearing audio from OAH.	
BP-ME08-1-2.16	Send Letter of Final Decision to Beneficiary	OAH sends a Letter of Final Decision to the beneficiary. The final decision must be sent to the beneficiary within 55 calendar days of the State Fair Hearing Request.	
BP-ME08-1-2.17	Notify Vendors Applicable to Case	The vendors applicable to the case are notified of the final decision through the Medicaid Clearinghouse. This allows them to take appropriate action based on the hearing outcome.	
BP-ME08-1-2.18	Applicable Vendor or SMA Takes Action	The applicable vendor or the SMA takes action depending on the final decision.	
		If the beneficiary requests a Judicial Review after the resolution of the State Fair Hearing process, the process proceeds to BP-ME08-1-3.	
BP-ME08-1-3 Judicial Review			
Process Number	Process Name	Process Description	Associated Requirement Number
BP-ME08-1-3.1	Petition for Judicial Review in Superior Court	This process is from the perspective of the beneficiary. However, the PHP, LME-MCO, or SMA may petition for judicial review based on the outcome of the State Fair Hearing process. The beneficiary submits a petition for Judicial Review in Superior Court if they are not satisfied with the result of the State Fair Hearing.	
BP-ME08-1-3.2	Notify Parties Applicable To Case	As part of the petition process, the legal representation of the beneficiary filing serves notice to the applicable parties. This may include the PHP or the SMA, depending on the case.	
BP-ME08-1-3.3	Notify SMA and AG's office If SMA Is Not A Part Of The Petition	If the PHP/LME-MCO is served notice of the petition, but the SMA was not, the PHP/LME-MCO must notify the SMA and Attorney General (AG)'s office of the petition.	
BP-ME08-1-3.4	Log Details in Medicaid Clearinghouse	The PHP/LME-MCO logs the details of the case in the Medicaid Clearinghouse if notified by the legal representation of the beneficiary filing the petition.	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

BP-ME08-1-3.5	Join or Choose To Intervene	The SMA can choose to join the case if served or may choose to intervene in the case if not served.	
BP-ME08-1-3.6	File Motion To Intervene	If the SMA chooses to intervene in the case, the AG's office files a motion to intervene.	
BP-ME08-1-3.7	Make Final Judgment	Superior Court makes the final judgment of the case.	
BP-ME08-1-3.8	Notify Parties Applicable To Case	Once the final judgment is made, Superior Court notifies the parties applicable to the case.	
BP-ME08-1-3.9	Log Final Decision	Once the SMA is notified of the final judgment, the decision is logged by the SMA in the Medicaid Clearinghouse.	
BP-ME08-1-3.10	Applicable Vendor or SMA Takes Action	The applicable vendors and/or SMA takes action based on the final decision.	
BP-ME08-1-3.11	Go Through NC Court of Appeals Process	If a beneficiary is not satisfied with the final decision of Judicial Review, they can appeal to the NC Court of Appeals. The process for the NC Court of Appeals is the same as Judicial Review, except with a different court.	
BP-ME08-1-3.12	Notify Parties Applicable to Case	The parties applicable to the case are notified throughout the NC Court of Appeals process.	

BP-ME08-1-4 Member Grievances

Process Number	Process Name	Process Description	Associated Requirement Number
BP-ME08-1-4.1	Submit Grievance to PHP Orally or In Writing	If the beneficiary is enrolled in a PHP, a grievance will first be submitted to the PHP. This can be done orally or in writing.	
BP-ME08-1-4.2	Notify Ombudsman to Assist In Process, If Desired	The Ombudsman program can assist beneficiaries in the grievance process. The beneficiary can contact the Ombudsman program for assistance at any time in the process.	
BP-ME08-1-4.3	Log Grievance	The PHP logs the grievance internally when received from the beneficiary.	
BP-ME08-1-4.4	Send Beneficiary Notice of Acknowledgement	The PHP must send the beneficiary a Notice of Acknowledgement of Receipt of Grievance within 5 days of receiving the grievance.	
BP-ME08-1-4.5	Send Beneficiary Notice of Extension	The PHP has 30 days from receipt of the grievance to resolve the grievance. A time extension is allowed in certain cases. If an extension is needed and meets the requirements, the PHP sends a Notice of Extension of Timeframe for Resolution to the beneficiary.	
BP-ME08-1-4.6	Resolve Grievance	The PHP resolves the grievance. This must be completed within 30 days of receipt of the grievance,	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

		unless an extension is provided. In the case of an expedited grievance, the grievance must be resolved within five days.	
BP-ME08-1-4.7	Send Beneficiary Notice of Resolution	The PHP sends the beneficiary a Notice of Resolution with the details of the resolution.	
BP-ME08-1-4.8	Upload Grievance Info to Medicaid Clearinghouse	The PHP must enter details on each grievance in the Medicaid Clearinghouse.	
BP-ME08-1-4.9	Send Quarterly Grievance Report to SMA	The PHP must include data on member grievances processed in the Quarterly report to the SMA. The report will include details such as the beneficiary name, description of grievance, resolution, dates. Grievance summary data will also be included with various totals.	
BP-ME08-1-4.10	Submit Complaint To SMA	If the member is not satisfied with the resolution of the grievance by the PHP, or the member is not enrolled in a PHP, the member can submit a complaint to the SMA.	
BP-ME08-1-4.11	Receive Complaint Via Phone, Email, or Mail	The SMA receives complaints from beneficiaries via phone, email, or mail.	
BP-ME08-1-4.12	Log Complaint	The SMA logs the complaint once it is received.	
BP-ME08-1-4.13	BP-PL05-4 Evaluate Summary and Trend Reporting	If the complaint was regarding a PHP, the SMA tracks it. The complaints are evaluated to identify trends in PHP performance. This process is outlined in BP-PL05-4. Evaluation Summary and Trend Reporting.	
BP-ME08-1-4.14	BP-CO02-2 Establish and Conduct Operations Meetings	The results of the trend analysis is discussed with the PHPs during regular operational meetings. This process is outlined in BP-CO02-2 Establish and Conduct Operations Meetings.	
BP-ME08-1-4.15	Send Information to ADA Rapid Response Team	The SMA has developed a Rapid Response for ADA related complaints. If the complaint is related to ADA, and it is a FFS beneficiary (need verification) the Rapid Response team evaluates and responds to the situation.	
BP-ME08-1-4.16	Notify Program Integrity if Provider's Second ADA Complaint	Program Integrity is notified if the same ADA complaint has been made for a provider more than once. Program Integrity will identify if additional action needs to be taken.	
BP-ME08-1-4.17	Contact PHP or Appropriate SMA Team for Data	Depending on whether or not the beneficiary is a FFS or a Managed Care beneficiary, an SMA Team or a PHP will be contacted for information regarding the complaint.	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

BP-ME08-1-4.18	Resolve Complaint	After obtaining the response from the SMA Team or the PHP, a resolution will be made for the complaint.	
BP-ME08-1-4.19	Notify PHP and SMA Provider Relations	SMA will notify either the PHP or the SMA Team of the resolution.	
BP-ME08-1-4.20	Reconsider Provider Participation in Medicaid	If it is determined that there was misconduct by the provider, the appropriate provider or network relations team will be notified. As part of a quality review, the misconduct of the provider should be reviewed and a determination made if it is no longer appropriate for the provider to be seeing Medicaid beneficiaries.	
BP-ME08-1-4.21	Log Resolution	The complaint resolution should be logged by the SMA.	
BP-ME08-1-4.22	Notify Beneficiary of Resolution	All the applicable parties need to be notified of the resolution. This would include the beneficiary.	
BP-ME08-1-4.23	Notify PHP of Resolution, if Applicable	If the beneficiary is managed care, the affected PHP must be notified of the resolution.	
BP-ME08-1-4.24	Notify SMA Team if Applicable	If the beneficiary is FFS, the affected SMA team must be notified of the resolution.	
BP-ME08-1-4.25	Notify Provider or Other Contracted Entity of Resolution if Applicable	If it is a FFS beneficiary, there may be other affected entities the SMA would notify. A provider that must take action or another contracted entity (such as a prior authorization vendor) that must take action in the resolution.	
BP-ME08-1-4.26	SMA Team Takes Identified Action	If it was a FFS beneficiary, the SMA team will take the actions identified by the resolution.	
BP-ME08-1-4.27	Request Corrective Action Plan from PHP	If in the course of resolving the complaint it is deemed that there is a larger issue with the PHP, the SMA might request a Corrective Action Plan (CAP) so that the PHP can solve for the issues causing beneficiary complaints.	
BP-ME08-1-4.28	Take Identified Action for Compliant and/or CAP	The PHP, if it is a managed care beneficiary, will take the actions identified in the resolution and if required, will take actions identified in a corrective action plan.	
BP-ME08-1-5 Member Eligibility Appeals			
Process Description	Process Description	Process Description	Process Description
BP-ME08-1-5.1	Receive Notice of County's Decision on Application or Recertification	The beneficiary receives notice from the County DSS office of a decision to grant, deny, terminate, or modify assistance regarding an application, or recertification. The notification includes the appeal rights of the beneficiary.	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

BP-ME08-1-5.2	Submit Request for Appeal	If the beneficiary chooses to appeal the decision, he or she makes a request for an appeal to the County DSS office. The request must be submitted within 60 days from the date of the notification.	
BP-ME08-1-5.3	Conduct Hearing	If the beneficiary is appealing a decision regarding disability medical determination, the appeal will go straight to the DHHS Hearings & Appeals Section for review (connects to step BP-ME08-1-5.14) and a local county hearing is not held. Otherwise, the local County DSS will conduct a hearing within 5 days of the request and render a decision.	
BP-ME08-1-5.4	Notify Beneficiary of Decision	The beneficiary is notified of the decision made in the local County DSS hearing.	
BP-ME08-1-5.5	Submit Request for State Hearing	If the beneficiary is dissatisfied with the decision made in the local County DSS hearing, he or she can submit a request for a State Hearing. This request must be made within 15 calendar days of the notification mailing.	
BP-ME08-1-5.6	Submit State Appeal Request Form to Hearings and Appeals Section	Within 5 calendar days from the date of the request for State appeal, the County DSS completes the DSS-1473 State Appeal Request form and submits it with applicable records/notices to the DHHS Hearings & Appeals Section.	
BP-ME08-1-5.14	Disability Determination Appeal Sent to DHHS Hearings & Appeals Section	The DHHS Hearings & Appeals Section will receive the disability determination appeal from DSS County Office.	
BP-ME08-1-5.7	Schedule Case for Hearing	Once the County DSS office submits the State Appeal Request, the case is scheduled by the DHHS Hearings & Appeals Section for a hearing.	
BP-ME08-1-5.8	Send 10-day Notice of Hearing to Beneficiary	The DHHS Hearings & Appeals Section sends a Notice of Hearing to the beneficiary and the County DSS giving reasonable notice of at least 10 days prior to the scheduled hearing. If it is not possible for the beneficiary to attend the hearing as scheduled, the beneficiary must notify the State Hearing Officer to request the hearing be rescheduled. The Hearing Officer will determine if good cause exists to grant the request for reschedule. The postponement will not exceed 30 calendar days. Failure to attend the hearing without good cause will	

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

		result in a dismissal of the hearing request.	
BP-ME08-1-5.9	Conduct Hearing	The hearing is conducted by a State Hearing Officer from the DHHS Hearings & Appeals Section. The appeal hearing is recorded. In the absence of the filing of a petition for judicial review, the DHHS Hearings & Appeals Section may erase or destroy the recording of the appeal hearing 180 days after the final decision is mailed.	
BP-ME08-1-5.10	Send Letter of Final Decision to Beneficiary	DHHS Hearings & Appeals Section sends a tentative Notice of Decision to the beneficiary and the County DSS. The tentative Notice of Decision must be sent within 90 calendar days of the State Appeal Request. The beneficiary and the County DSS may present oral and written arguments in opposition to or in support of the tentative Notice of Decision by contacting the Chief Hearing Officer within 10 calendar days of the date of the tentative Notice of Decision. If the Chief Hearing Officer is not contacted within 10 calendar days, the tentative decision becomes a Final Decision. If arguments are presented in an appropriate timeframe, then the arguments are considered, and a Final Decision is rendered. Only the beneficiary may file a petition for judicial review which must be filed within 30 days of receipt of the Final Decision.	
BP-ME08-1-5.11	Notify Vendors Applicable to Case	The vendors applicable to the case are notified of the final decision. This allows them to take appropriate action based on the hearing outcome.	
BP-ME08-1-5.12	Applicable Vendor or SMA Takes Action	The applicable vendor or the SMA takes action depending on the final decision.	
		If the beneficiary requests a Judicial Review of the DHHS Hearings & Appeals Section Final decision, the process proceeds to BP-ME08-1-3.	

Version

DATE	SECTION UPDATED	CHANGE