Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary
Nicole Comeaux, J.D., M.P.H., Director

Letter of Direction #63

Date: **June 1, 2021**

To: **Centennial Care Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division**

Subject: **4.16 Grievances & Appeals Systems Revisions**

Title: **Grievances & Appeals Systems**

The purpose of this Letter of Direction (LOD) is to inform the Centennial Care Managed Care Organizations (MCOs) of revisions made by the Center for Medicaid and Medicare Services (CMS) implementing final revisions related to the Grievances and Appeal Systems section of the Centennial Care Managed Care Contract. This LOD is effective immediately and the obligation is to follow current revisions.

Section 4.16.3.6 of the Managed Care Agreement will be revised to state:

The CONTRACTOR shall have a process in place that assures that an oral or written inquiry from the Member seeking to Appeal an Adverse Benefit Determination is treated as an Appeal (to establish the earliest possible filing date for the Appeal). unless the Member or the provider requests an expedited resolution.,
In accordance with CFR438.402 and 438.406, the member is not required to submit a written, signed appeal after an oral appeal is submitted.

Section 4.16.8.1.1 of the Managed Care Agreement will be revised to state:

A Member may request a State Fair Hearing if he or she is dissatisfied with an Adverse Benefit Determination that has been taken by the CONTRACTOR and the Member has exhausted the CONTRACTOR's internal Appeal process. In accordance with CFR 438.408, members timeframe to request a state fair hearing after an adverse benefit determination is no less than ninety (90) Calendar Days and no more than 120 Calendar Days. The Representative, the estate representative of a deceased Member, or a provider acting on behalf of the Member and with the Member's written consent, may request a State Fair Hearing on behalf of the Member.

Section 4.16.9 of the Managed Care Agreement will be revised to state:

The CONTRACTOR shall establish and maintain written policies and procedures for the filing of provider Grievances and Appeals. A provider shall have the right to file a Grievance or an Appeal with the CONTRACTOR. Provider Grievances or Appeals shall be resolved within thirty (30) Calendar Days. If the provider Grievance or Appeal is not resolved within thirty (30) Calendar Days, the CONTRACTOR shall request a fourteen (14) Calendar Day extension from the provider. If the provider requests the extension, the extension shall be approved by the CONTRACTOR. A provider shall have the right to file an Appeal with the CONTRACTOR regarding provider payment issues and/or Utilization Management decisions.
In accordance with CFR 438.400(b)(3)**,** the denial, 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" at 447.45(b) of this chapter is not an adverse benefit determination.

Please contact Kathy Leyba at Katherine.Leyba@state.nm.us or at 505-795-3736 for questions related to this LOD.

This Letter of Direction will sunset upon inclusion in the Medicaid Managed Care Services Agreement.