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# What's In A Notice? How Notices Of Action Protect Consumers In Medicaid Managed Long-Term Services And Supports

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## About This Guide

This Guide is designed for advocates and individuals who provide assistance to seniors and persons with disabilities in need of Medicaid long-term services and supports. The focus of the Guide is on notice and appeal rights in states delivering these services through managed care. The National Senior Citizens Law Center (NSCLC) strives to make the information in this Guide as accurate as possible as of the publication date (November 20, 2014). However, many of the details in the state-specific examples provided may change as states seek Medicaid waiver amendments or update state managed care contracts.

NSCLC advocates for the rights of low-income seniors and persons with disabilities to access healthcare. NSCLC cannot represent individuals in their claims for benefits, but we can provide technical assistance and advice to advocates.

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# Introduction

Notices of action are the cornerstone of health care rights for low-income Medicaid consumers. The notice is the written vehicle that informs a Medicaid applicant or recipient of her constitutionally protected right to challenge a decision regarding crucial Medicaid services, and explains how to exercise that right. While "old" problems with the contents and timing of notices of action continue, new problems are arising as many states shift delivery of Medicaid long-term services and supports (LTSS) to managed care organizations (MCOs).[1] Concepts of protected property interests and procedural due process rights may be foreign to MCOs accustomed to measuring out services through utilization management and prior authorization criteria. To limit problems, states should require MCOs to use standardized notices of action that provide clear and complete information, do not overwhelm the reader, and empower Medicaid consumers to contest improper MCO actions. If an MCO has used a deficient notice, consumers or their representatives should cite the notice's inadequacy as grounds for restoring services.

This brief provides background information on notices of action, including an explanation of what type of MCO behavior constitutes an action that gives rise to due process protections. The brief describes the information that must be included in each notice of action. It also discusses continuation of services or aid-paid-pending in the managed LTSS (MLTSS) context. Practice tips based upon recent experiences in Kansas, Florida, and New Jersey as those states transitioned to MLTSS are included on issues of individual and systemic advocacy.

1 *See* Appendix A for further information on the basics of managed long-term services and supports.

The brief's appendices include background information on: long-term services and supports; managed care; state fair hearings; MCO appeals, grievances and complaints; regulatory definitions of "*action*;" and language access requirements.

## What is a Notice of Action?

A notice of action is a written notification provided to Medicaid applicants or recipients (referred to as Medicaid consumers in this brief) whenever there is a decision, called an *action*, affecting their Medicaid benefits.[2] The written notice of action is part of the larger set of procedural due process protections afforded Medicaid consumers by the U.S. Constitution, the Supreme Court decision in *Goldberg v. Kelly*, the Medicaid Act, federal regulations, and a large body of federal and state case law.[3] (In addition to the right to written notice, Medicaid consumers also have rights to a hearing before an impartial decision-maker; continuation of services pending a final decision, in most circumstances; review of the case file prior to and during a hearing; and the ability to present evidence and to cross-examine witnesses.) In managed care, these foundational rights often are supplemented by details provided by the contracts between the states and MCOs. However, state Medicaid agencies retain responsibility for

2 An action is sometimes referred to as an "adverse action," but the term "adverse" can be misleading, especially in the managed care context. For example, a consumer's service plan may not be seen as "adverse," but it is appealable to the extent that the plan does not include all of the services or types of services requested by the consumer.

3 *Goldberg v. Kelly*, 397 U.S. 254 (1970) (Due Process Clause of the U.S. Constitution requiring, prior to termination of welfare benefits, that consumer be provided with effective notice and evidentiary hearing before impartial decision-maker). *See also* the Medicaid Act, 42 U.S.C. §1396a(a)(3).

ensuring that Medicaid programs operate in a manner fully consistent with constitutional and statutory due process requirements.

**PRACTICE TIP:** MCO contracts may include terms that are more beneficial to consumers than the bare federal regulations. For example, according to the New Jersey MCO contract, when a consumer files a timely internal MCO appeal of previously authorized services, the benefits will be extended during the appeal process; the consumer does not need to separately request continuation of services. By contrast, under the relevant federal regulation, 42 C.F.R. § 438.420(b)(5), an enrollee must request extension of the benefits.[4]

### Advocate's Library of MCO Contracts

NSCLC has developed the on-line Advocate's Library: State Practices in Managed Long Term Services and Supports. The Library provides a summary of relevant contract provisions by topic, along with a page number citation for each cited provision. While not exhaustive of all state MLTSS contracts, the library includes provisions governing notices and appeals in MCO contracts from Arizona, Florida, Kansas, Tennessee, and Wisconsin.

The Library is available here: http://www.nsclc.org/index.php/ltss-contracts-index-appeals-notices/.

## What is an MCO action?

As states move their Medicaid LTSS programs from fee-for-service payment to managed care, confusion is arising over what kinds of MCO decisions or behavior constitute *actions* that trigger due process rights. In particular, states, MCOs, consumers and advocates – and even legislators – have trouble parsing out the difference between MCO actions (which give rise to constitutionally protected MCO appeal and fair hearing rights) and MCO conduct that is something other than action. Consumer challenges to these less-than-actions are generally referred to as grievances or complaints.[5]

For consumers and consumer advocates, one important rule of thumb is that an MCO has taken an action when an MCO decision or behavior negatively impacts the consumer's eligibility, services, or access to services; even authorizations for fewer hours of services than what the consumer believes is required by her care needs may constitute MCO action. This action triggers the consumer's right to receive a written, timely, and constitutionally adequate notice of action as well as access to the full appeals process, including an internal MCO appeal and/or a state fair hearing.

Federal regulations define *action* in two different sets of rules: Subpart E of 42 C.F.R. Part 431 applies generally to *all* Medicaid fair hearings, and Subpart F of 42 C.F.R. Part 438 applies solely to consumer claims in Medicaid managed care systems.[6] Here are some real-life examples of MCO activities that, under the regulations, are considered *actions*:

- Thomas is a newly eligible Medicaid

4 *See* Contract Between State Of New Jersey Department Of Human Services Division Of Medical Assistance And Health Services And Contractor 74 art. 4.6.4(C)(6) (2014), http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf. [hereinafter NJ Contract].

5 *See* Appendix B for additional information on grievances and complaints, and Appendix C for additional information on appeals and fair hearings.

6 This brief's Appendix D provides a side-by-side comparison of these subparts from sections 431 and 438.

beneficiary under his state's Medicaid home and community-based services (HCBS) managed care system. He needs assistance with dressing in the morning, help with household chores, shopping and cooking throughout the day, and assistance getting ready for and into bed at night. His best estimate is that he needs 40 hours of personal care assistance each week to live safely in his own home. After meeting with an MCO nurse who performs an assessment, he receives a letter in the mail informing him that his MCO will only authorize 10 hours of personal care assistance. This limited authorization of a requested service is considered an *action*.

- Maribeth for many years has been on her state's HCBS waiver for individuals with physical disabilities. She has complex medical needs, including tracheotomy care. Her service plan has included eight hours a day of private duty nursing, a necessity during the nighttime hours to keep her airways free while sleeping. Recently, her state transitioned to managed care; soon after, she received a visit from her new MCO nurse. The nurse explained that Maribeth did not meet national standards for private duty nursing and, soon thereafter, a letter came in the mail informing her that her private duty nursing hours were being terminated. The MCO did not offer Maribeth any other services or supports to replace those lost. This termination of a previously authorized service is considered an *action*.

- Philip has advanced dementia and lives in a nursing home. With his wife's help, Philip was screened for HCBS services through his state's managed care demonstration waiver and, at a service planning meeting, was told he soon could return home with appropriate services. A key aspect of the plan was that Philip would attend an adult day program five days a week, which would allow his wife to keep working. Then, weeks and weeks went by. His wife's voice messages to Philip's MCO case manager went unanswered. Finally, after consulting with an MLTSS advocate, Philip's wife requested a fair hearing from the state Medicaid agency. Soon thereafter, Philip received a notice denying the adult day services altogether. Both the failure to provide services in a timely manner, and the denial of a type of requested service, are considered *actions*.

In all of these situations, the MCO has taken an *action* that requires the MCO to provide the consumer with a timely written notice of action.[7] The notice is the mechanism by which a consumer is informed of the MCO's decision and the reason for that decision, and receives the information needed to request review of the decision.

**PRACTICE TIP**: A Medicaid consumer's right to an MCO appeal or state fair hearing does not depend on receiving a notice of action from the MCO. For example, one type of appealable action is the failure by the MCO to provide services in a timely manner, as defined by the state.[8] In this scenario, there may not be a notice of action, but the right to challenge the action applies regardless.

7 42 C.F.R. § 438.404(c) sets the timeframes within which an MCO must mail the notice. *See also* 42 C.F.R. § 431.211.

8 42 C.F.R. § 438.404 (c) (5).

# Service Plans and Notices of Action

Medicaid MLTSS consumers receive services and supports in accordance with their service plan or plan of care. The plan must be developed during a person-centered planning process that is led, to the extent possible, by the consumer, but also includes a case manager as well as other people chosen by the consumer.[A]

> **PRACTICE TIP:** Check your state's MCO contract for consumer protections regarding a person-centered service planning process and limitations on utilization management. Utilization management (including prior authorization) is the process by which an MCO is supposed to ensure that a participant receives medically or clinically appropriate or necessary services; it is not meant to merely limit or restrict care. In accord, for example, the New Jersey MCO contract specially states that an MCO "shall not deny benefits to require [consumers] to go through the appeal process in an effort to forestall and reduce needed benefits," but "shall provide all medically necessary services. If a dispute arises concerning the provision of a service or the level of service, the service, if initiated, shall be continued until the issue is resolved."[B]

Due process protections require that an MCO provide written notice and appeal/fair hearing rights whenever an MCO denies, reduces, terminates, suspends, or limits authorization of requested services, including the type or level of service. Advocates are justified in arguing, then, that every service plan or plan of care (whether an initial plan, revised plan, or yearly redetermination) must include a notice of action informing the MLTSS consumer of her right to appeal the entire plan, or any part of the plan (e.g., personal care assistant hours) that is less than what was requested or could have been requested.

For example, the New Jersey contract requires that MCOs ensure that MLTSS consumers "are clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery."[C] The contract also requires that plans of care include documentation of consumer's agreement or disagreement with a list of statements that include "I agree with the plan of care," "I had the freedom to choose the services in the plan of care," and "I had the freedom to choose the providers of my services based on available providers."[D] Due process requires that consumers who disagree with these statements be afforded notice and appeal rights.

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A 79 Fed. Reg. 2948 (Jan. 16, 2014). For more information on the service planning requirements set forth in the new HCBS rule, see NSCLC "Just Like Home: An Advocate's Guide to Consumer Rights in Medicaid HCBS," (May 2014), http://www.nsclc.org/wp-content/uploads/2014/Advocates-Guide-HCBS-Just-Like-Home-05.06.14.pdf and "Conflict Free Case Management: Themes in States Working to Implement New Systems," (October 2014), http://www.nsclc.org/wp-content/uploads/2014/10/Conflict-Free-Case-Management-Issue-Brief.pdf.

B *See* NJ Contract, 68 art. 4.6.4(A)(1).

C *See* NJ Contract, 13 art. 9.5.1(C)(3).

D *See* NJ Contract, 26 art. 9.6.3(G).

## What information must be included in a notice of action?

Due process requires states and MCOs to include a great deal of information in notices of action. Also, written notice must use easily understood language and formats, keeping in mind the circumstances of those receiving the notices, and be translated into prevalent non-English languages.[9]

All of these requirements are crucial if due process protections are to be meaningful for consumers. If written notice is incomplete, unclear, or not understandable, there is a real risk that Medicaid consumers will not appreciate the importance of notices and may miss the opportunity to challenge harmful MCO action.

Federal regulations specify the information that must be provided in a written notice of action.[10] Under the regulatory scheme, Medicaid managed care notices must contain:

- An **explanation of the action** the MCO has taken or intends to take
- The **reasons** for the action
- The specific r**egulations** that support the action[11]
- Information about the right to an internal MCO **appeal**
- Information about the right to request a state **fair hearing**, subject to possible exhaustion of MCO internal appeal rights
- The **procedures** for exercising these rights, including timeframes during which the consumer must take action
- The circumstances under which an **expedited appeal** is available
- Information about the right to **continuation of benefits**, instructions on how to request continued benefits, and any potential obligation to re-pay

**PRACTICE TIP**: Where the state does not require the MLTSS participant to exhaust MCO appeal rights first, a state hearing may be requested **instead of** a plan appeal, **at the same time as** a plan appeal, or **after** a plan appeal. The notice should make that clear. The standardized Kansas notice of action uses this language: "You or your representative can ask [MCO name] to review its decision by asking for an appeal. . .This is called an "[MCO name] appeal". . .You may also ask for a State Fair Hearing **instead of** an [MCO name] appeal **or at the same time**." The notice goes on to explain how a consumer may request an appeal, a hearing, or both. Consult with Medicaid experts in your state about the pros and cons of filing simultaneous plan and state fair hearing appeals.[12]

9 42 C.F.R. §§ 438.10(c), (d), 438.404(a). *See* Appendix E for more information about language access requirements.

10 42 C.F.R. §§ 431.210, 438.404.

11 Note that this requirement is only found in 42 C.F.R. Part 431, Subpart E, and not in the managed care regulations of Part 438. 42 C.F.R. § 431.210(c) provides that the notice must list the specific regulations that support the action, or the change in federal or state law that requires the action.

12 For information about the MLTSS in California, for instance, consult NSCLC's "Advocates Guide to the CCI" 40-41 (June 2014), http://www.nsclc.org/wp-content/uploads/2014/06/PDF-FINAL-CCI-Guide-Version-3-06.27.14.pdf.

## Arguing against deficient notices for individuals and system-wide

An important concern in MLTSS is whether the notice includes a copy of any assessment used by the MCO to determine the consumer's eligibility for services, or scope of need. Generally, MCOs use assessment tools that "score" the applicant or participant, using some kind of algorithm and point system, on her functional ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs).[13] The assessment tool may also look at the person's informal supports, including the availability and ability of family or friends to provide assistance, and other resources for assistance available in the community. The points or score may then be used to determine eligibility for a particular service or the amount of services (such as hours of personal care assistance) that an individual is eligible to receive.[14] Clearly, there is a direct connection between the assessment tool results and the service plan (including but not limited to specific service authorizations) developed for each MLTSS consumer.[15]

Federal and state case law can help Medicaid consumers and their legal representatives advocate for access to this information – both on a systemic level (e.g., that the contract require that this information be provided with every service plan and notice of action) and on an individual appeal or fair hearing level (e.g., through access to the case file, before and during an appeal or hearing). Here are several suggestions:

- A notice of action must provide a Medicaid consumer with a **detailed individualized explanation** of the reason(s) for the action being taken, in terms that are **comprehensible to the consumer**. Where the action involves the calculation of income or resources, the notice must include or attach the **specific calculations used to reach the decision**. Specific financial calculations are analogous to specific "scoring" on service assessment tools.[16]

- One way to meet the constitutional requirement that a notice detail the reasons for a proposed action is the **inclusion of the actual assessment tool,** including assumptions about alternative resources or supports, with the notice of action. Since the assessment tool is normally the basis upon which a service plan is developed, it is arguably the critical document in translating the raw information provided by the consumer into MCO-authorized hours and services. If the assessment tool is not included, the MCO in the notice must otherwise adequately explain and detail the basis for a decision to deny, limit, reduce, or terminate services

13 While each state may define ADLs and IADLs somewhat differently, ADLs generally refer to personal activities like bathing, getting dressed, eating, toileting, and mobility. IADLs generally refer to activities that help a person live independently, like managing medications, the ability to use transportation, housework, laundry, shopping, and preparing meals.

14 Assessment tools are also used to determine Medicaid functional eligibility based on meeting a level of care.

15 MCOs often use the term "prior authorization" rather than service authorization. Advocates may want to review the provisions of the state MCO contract pertaining to utilization management and prior authorization. Prior authorization may be required for many LTSS services such as personal care assistance services and private duty nursing, and is sometimes used by MCOs to justify cuts in services.

16 *Ortiz v. Eichler*, 794 F. 2d 889, 893-94 (3rd. Cir. 1986).

based on the assessment results.[17] Some states, like New Jersey, require that MCOs provide copies of the pertinent assessment with each notice of action.

- Where an MLTSS consumer is already receiving services and the MCO seeks to reduce or terminate previously authorized services, the notice of action must include an **explanation of the change in the MLTSS consumer's physical or functional capabilities** since the last eligibility or service plan determination. Courts have concluded that, if an individual has once been determined to be eligible for social service benefits, due process prevents a termination (or reduction) of those benefits **absent a demonstration of change in circumstances**, or other good cause. Due process of law demands that MCOs are bound by previous pre-managed care assessments, except where they have proof of changed circumstances and that change is adequately detailed in the notice.[18]

- A notice of action that **does not substantially comply** with federal and state requirements cannot provide the basis for the deprivation of Medicaid benefits, including MLTSS. In other words, if the MCO or state gets the notice wrong – for example, fails to include details like the regulation upon which the action is based – the MCO may not terminate, suspend or reduce services **until an effective notice is served**.[19]

## Continuation of services or "aid-paid-pending"

An MLTSS beneficiary has the right, rooted in *Goldberg v. Kelly*, to continuation of services, also called "aid-paid-pending," until a decision is rendered in her appeal or fair hearing, if she requests the extension of benefits in a timely manner.[20] An explanation of the circumstances under which Medicaid MLTSS are continued, including information on how to request continued benefits and any potential obligation to re-pay, must be included in the notice of action.

Continuation of services has been an area of difficulty in managed LTSS. In New Jersey, personal care assistant (PCA) services transitioned to managed care within fee-for-service HCBS waivers in 2011, before the

17 *Baker v. Alaska*, 191 P. 3d 1005, 1010-1011 (Alaska 2008) "The obvious challenge for any court applying Goldberg is to determine what level of detail is required. . . . Where the recipient has a 'brutal need' for the benefit at issue . . . courts have traditionally required that agencies go to great lengths–incurring higher costs and accepting inconvenience–to reduce the risk of error. Recipients of PCA services are arguably as dependent on their benefits as are welfare recipients, without them, they may be unable to do things as basic as bathing, preparing a meal or using the toilet. . . . It follows that the agency should be required to make every reasonable effort to reduce the risk of erroneously depriving PCA services recipients of their benefits. In this context of notice, such effort might amount to erring on the side of providing too much detail respecting the basis for the agency's decision rather than too little."

18 *Weaver v. Colorado Dept. of Social Services*, 791 P. 2d 1230, 1234 (Colo. Ct. App. 1990). For more information, see the National Health Law Program's fact sheet, ""Q & A: The Burden of Proof in Administrative Hearings" (July 1, 2011), available online at http://www.healthlaw.org/publications/qa-burden-of-proof-in-administrative-hearings#.VFA3QhaiFyU.

19 *Id*. at 1233.

20 42 C.F.R. §§ 431.230, 438.420.

entire LTSS system transitioned to MLTSS in 2014. Perhaps because the MCOs were unfamiliar with the Medicaid concept of continuation of services, some Medicaid consumers found themselves cut off from services after the initial MCO re-assessment for PCA services, without any due process protections including the ability to request continuation of services. In other cases, the MCO cut services during the pendency of an MCO appeal or state fair hearing, relying on the fact that the period of prior authorization had expired.[21] In many cases, the consumers facing those sudden cuts or terminations had been on HCBS waivers for years, and the loss of services caused real harm. The New Jersey Medicaid agency responded by making it clear in the MCO contract and in its policy that when the consumer requests an MCO appeal or state fair hearing with continuation of benefits in a timely manner, the MCO is obligated to continue those services until a final decision is reached.[22]

Kansas has helped protect MLTSS consumers from the sudden loss of needed services by eliminating the need for Medicaid consumers to separately request continuation of services; the request for an MCO appeal or state fair hearing is sufficient to trigger continuation of services. The state also greatly reduced the risk that a consumer would be liable for repayment after an unfavorable decision, limiting recovery to situations in which fraud had occurred. The state Medicaid agency brought together MCOs, advocates, and consumers to provide input into new, mandatory, standardized notice of action language — including this language regarding continuation of services:

> If [MCO name]'s action reduces, suspends, or terminates previously authorized HCBS Program services, those services will continue for 33 days from the mailing date of the Notice of Action to allow you time to file an [MCO name] appeal or ask for a State Fair Hearing. If you ask for an [MCO name] appeal or a State Fair Hearing, your current HCBS Program services will continue for the duration of the [MCO name] appeal or the date of the decision in your State Fair Hearing. If your [MCO name] appeal is denied or the action taken by [MCO name] is approved by the Office of Administrative Hearings, you will <u>not</u> have to repay [MCO name] for service(s) provided during the [MCO name] appeal and/or State Fair Hearing, unless fraud has occurred.[23]

**ADVOCACY TIP:** You may want to put pressure on your state Medicaid agency to contractually require MCOs to use a standardized form notice of action. Recently, advocates in Kansas, New Jersey, and Florida have successfully pushed for one standardized notice form to be used by all of the MCOs.[24] *Because it is difficult to develop*

21 Language in the federal Medicaid MCO regulations has been interpreted by MCOs to not require continuation of benefits if the "original period covered by the original authorization has … expired." 42 C.F.R. § 438.420(b)(4). These regulations do not, and cannot, take away Medicaid beneficiaries' due process rights. While federal advocacy around this issue continues, please note that state advocates have been successful in arguing that this language should not be in state MCO contracts, thereby assuring continuation of services until a decision is rendered in the appeal or hearing. For more information about this issue, please contact the author.

22 NJ Contract 74 art. 4.6.4(C)(6) (2014); *see also* NJ Contract 68 art. 4.6.4(A)(1) (2014).

23 On file with authors.

24 *See* NJ Contract, 73 art. 4.6.4(C)(1), where it states: "The Contractor must use the Notice of Action template letters developed by DMAHS

*a notice that is both readable and conveys all of the complex information accurately, states should require MCOs to use a standard notice form that is developed in cooperation with advocates and consumers.*

## Conclusion

Notices of action that comply with due process requirements are critically important. As many states shift to managed LTSS, advocates will face new due process challenges with MCOs that may be unfamiliar with these constitutionally protected rights. Advocates should push for systemic reforms to ensure that MCOs use standardized notices of action that provide clear and complete information, do not overwhelm the reader, and empower Medicaid consumers to contest MCO decisions that do not meet their needs. Advocates should also use due process protections where appropriate to assist individual consumers in restoring services.

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and provided to the Contractor. These template letters explain the appeal process upon the notice of action and at the conclusion of each stage in the appeal process. The use of the DMAHS Notice of Action template letters is mandatory. The template letters cannot be altered by the Contractor with the exception of the addition of any NCQA required language. None of the DMAHS template letter language can be deleted."

# Appendix

## Appendix A

### What are Medicaid Managed Long-Term Service and Supports (MLTSS)?

Medicaid LTSS are services and supports provided to Medicaid-eligible consumers who need help with everyday personal tasks like taking a bath, getting dressed, or getting in and out of bed, as well as household tasks like laundry, shopping, and meal preparation. They can be provided in an institutional setting, such as a nursing home, or in a home and community-based setting, such as a person's home or an assisted living facility. The array of assistance a state may provide is wide, and can include services and supports such as personal care assistance, chore aid, homemaker assistance, home modifications, home-delivered meals, transportation, and even things like raking the lawn or shoveling snow.

Managed care is simply a delivery system for long-term services and supports. Historically, states provided Medicaid benefits to eligible consumers through a fee-for-service model: the state would contract with service providers, like home health agencies, which would provide the service (e.g., 10 hours of personal care assistance each week) to the Medicaid consumer, and the state would pay the agency. In a Medicaid managed care system, the state contracts with managed care organizations that, in turn, contract with service providers. Each month, the state pays the MCO a set or capitated amount for each Medicaid MLTSS consumer enrolled in the plan. The MCO uses this capitated payment to pay for and manage services and supports for the consumer.

## Appendix B

### What are Grievances and Complaints?

Under the federal regulations for Medicaid managed care, an expression of dissatisfaction about any matter other than an action is called a grievance. Subjects appropriate for a grievance include, but are not limited to, the quality of care a consumer has received, or aspects of interpersonal relationships, such as rudeness. Medicaid consumers who are dissatisfied with their MCOs in these kinds of ways have a right to file a grievance with their MCO. Where the state permits, a provider may also file a grievance on a consumer's behalf, but only with the consumer's written consent. The time within which a Medicaid consumer may file a grievance is set by the state, and is usually in the MCO contract. For example, in Kansas consumers have 180 days to file a grievance.[25]

MCOs must provide reasonable assistance to consumers in helping to complete required grievance forms, and must acknowledge the receipt of each grievance. Grievance decision-makers must be individuals who were not involved in any previous level of review. Under

25 Kan. Contract, Atch. D. p. 2.

certain circumstances, the individual must have appropriate clinical expertise. The grievance must be resolved within 90 days from the date the MCO received the grievance (which may be filed orally or in writing, as determined by the state).

Some states, like New Jersey, also provide for a complaint process. New Jersey's managed care contract provides that a consumer may file a complaint as to the conduct of the MCO or failure of MCO to act for any matter in which the consumer feels aggrieved. The matter must be resolved within 5 days or shall be treated as a grievance. The New Jersey contract is silent as to when unresolved complaints should be treated as appeals or fair hearing requests, which raises due process concerns.[26]

**Why does the definition of grievance in the contract matter so much?**

The way that "grievance" is defined in managed care contracts is crucial. If grievance is defined too broadly, consumers' issues may be improperly categorized as grievances or complaints instead of receiving the extra protections that come from the appeal and fair hearing processes.

> **The Kansas Example.** In Kansas, the confusion between grievance and appeal definitions threatened to deprive consumers of their right to enter the appeal and fair hearing process. The state later addressed the issue in its MCO contract language.
>
> The Request for Proposal in Kansas originally defined grievance as "an expression of dissatisfaction about any matter. Grievances may include: denial of service, partial denial of service, . . . quality of care . . . [and] rudeness of an employee . . . ." This definition unfortunately included denials and partial denials—events that give rise to due process rights—in the same category as lower level grievances. There is some reason to believe that the confusion found in the definition of grievance and complaints led to the misdirection of some consumer appeals in the early days of Kansas MLTSS.
>
> The definition of grievance was later corrected in the Kansas MCO contract. The revised definition is "[a]n expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness . . . ."[27]

*MCO contracts should accurately and clearly identify what constitutes a grievance and ensure that the definition of grievance does not improperly overlap with actions that give rise to appeal and fair hearing rights.*

26 *See* NJ Contract, 27 art. 5.15.1(B).

27 Kansas Contract Atch. C, p. 14 (June 2012)

# Appendix C

**MCO Appeals and Fair Hearings**

Challenging MCO actions can be more confusing than in traditional Medicaid appeals because there are two tracks the appeal can follow — one internal to MCOs and the other through regular state Medicaid fair hearings. While the MCO regulations found at Subpart F of 42 C.F.R. Part 438 provide the detail, here are several of the most important highlights:

- Most MCO decisions that negatively affect services in any way are actions and give rise to due process protections, including the appeal and hearing process. **Beware: MCOs may mischaracterize consumer complaints about actions as grievances, thereby denying the consumer full due process protections.**
- Where the state does not require the MLTSS participant to exhaust MCO appeal rights first, a state fair hearing may be requested **instead** of an MCO appeal, **at the same time** as an MCO appeal, or **after** an MCO appeal.
- Consumers have the right to **an expedited resolution** of an MCO internal appeal where the time for a standard resolution could seriously jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. This is most important in cases involving denials or limited authorizations of requested services because the consumer does not have the right to continuation of services, since the services in question have not been provided previously.
- The MCO appeal procedures must:
    - Treat **oral inquires** seeking to appeal actions **as appeals** to establish the earliest possible filing date for the appeal
    - Give the consumer or her representative an opportunity before and during the appeal to **review her case file**, including all medical records and other documents considered (in reduction or termination of services cases, advocates may also want to look at pre-managed care assessments and records)
    - Give the consumer, including those in the expedited track, an opportunity to present evidence and make legal arguments, **in person as well as in writing**
    - While it may be self-evident, the MLTSS participant or her representative is **a party to the appeal**
- For consumers who request a state fair hearing, the regulations at Subpart E of 42 C.F.R. Part 431 apply, but note that under the managed care rules, 42 C.F.R § 438.408 (f), the MCO is a **party to the hearing** and **is bound** by the hearing officer's decision where that decision reverses the MCO decision.

# Appendix D

***Federal Regulatory Definition of Action***

| 42 C.F.R. § 431.201*<br><br>Definitions | 42 C.F.R. § 438.400<br><br>Definitions |
|---|---|
| **Action means**<br><br>a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities to transfer or discharge resident and adverse determination made by a state with regard to the preadmission screening and annual resident review requirements of section 1919(3)(&) of the Act.<br><br>**Adverse Determination means**<br><br>a determination made in accordance with sections 1919(b)(3)(F) or 1919(e)(7)(B) that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.<br><br>**Service authorization request means**<br><br>a managed care enrollee's request for provision of a service<br><br>*42 C.F.R. § 431.220(a) also provides that the State must provide an opportunity for a hearing to any Medicaid applicant whose claim for services has been denied or is not acted on with reasonable promptness. | **Action means**<br><br>In the case of an MCO or PIHP:<br><br>(1) The denial or limited authorization of a requested service, including the type or level of service;<br><br>(2) The reduction, suspension, or termination of a previously authorized service;<br><br>(3) The denial, in whole or in part, of payment for a service;<br><br>(4) The failure to provide services in a timely manner, as defined by the state;<br><br>(5) The failure of an MCO or PIHP to act within the timeframes provided in §438.408(b) (the time frames for disposition of grievances or resolution of appeals); or<br><br>(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. |

# Appendix E

## Language Access Requirements

Federal statute, case law, regulation, and guidance protect the rights of Limited English Proficient (LEP) individuals.[28] Generally, the law requires that vital documents, including notices of action, be translated into prevalent non-English languages. Consistent with the "safe harbor" contained in federal guidance, most MCO contracts define "prevalent" as 5% of the MCO enrollees or potential enrollees, or 1,000 persons, whichever is less. Some states provide added protections. For example, in Arizona the federal standards are required for vital documents, but the state also requires all materials to be translated into a language spoken by 10% of the enrollees or 3,000 persons, whichever is less.

States and MCOs also must make oral interpretation services available free of charge to each enrollee and potential enrollee. This applies to all non-English languages. In addition, written materials must be available in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

Consistent with the requirement that the notice must be in easily understood language, many state MCO contracts require written notices to be written at specific grade levels (e.g., a 6th grade reading level).

**New Jersey Notice:** The notice of action used by MCOs in New Jersey states, "Additional help if you are LEP (Limited English Proficient) or disabled – This notice of action has been written in Spanish on the reverse side. If you need help in other languages, please see the attached Babel notice. If you are blind or otherwise disabled and need help accessing this notice, please call us at [800-number] or TTY/TDD" "[number]." New Jersey also includes a Babel notice on the back of envelopes that originate from the state.[29] (A "Babel notice," also known as a multilingual notice or stuffer, is a short notice in many different languages that notifies the reader that oral translation services are available over the phone.)

28 Title VI of the Civil Rights Act, 42 UCS 2000d et seq, (prohibiting conduct that has a disproportionate effect on Limited English Proficient (PEP) persons); *Lau v. Nichols*, 414 U.S. 563 (1974); 42 CFR 438.10; Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (2003). *See also V.L. v. Wagner*, 669 F Supp. 2d 1106, 1120-21 (N.D. Cal. 2009) (finding plaintiffs likely to succeed on due process claim where individuals with disabilities and/or inability to read English would not be able to understand "difficult to read" notices of reductions in Medicaid-covered in-home support services).

29 On file with authors.


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