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Understanding Notices & Appeal Rights in Medicaid Managed Long-Term Services & Supports

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The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

Webinar Series on “An Advocate’s Library”

- Thank you to
 - The Retirement Research Foundation
 - Atlantic Philanthropies

Webinar Logistics

- All attendees are on mute
 - For technical questions, use chat box
 - For substantive questions, use questions box
- E-mail trainings@nsclc.org if unable to access webinar
- Slides and recording will be at nsclc.org
- We will be answering questions at the end

Today's Presentation:

Focus

- Notice, appeal & hearing rights in context of Medicaid managed long-term services and supports (MLTSS)

Context

- Primarily adverse service authorizations (e.g. denial or limited authorization of personal care assistance)

Sources of Appeal Rights

14th Amendment Due Process Protections Goldberg v. Kelly, 397 U.S. 254 (1970)

General
Medicaid

42 CFR 431,
Subpart E

Managed
Care

42 CFR 438,
Subpart F

MCO
Contracts

Background:

Medicaid Managed Care and Long-Term Services & Supports

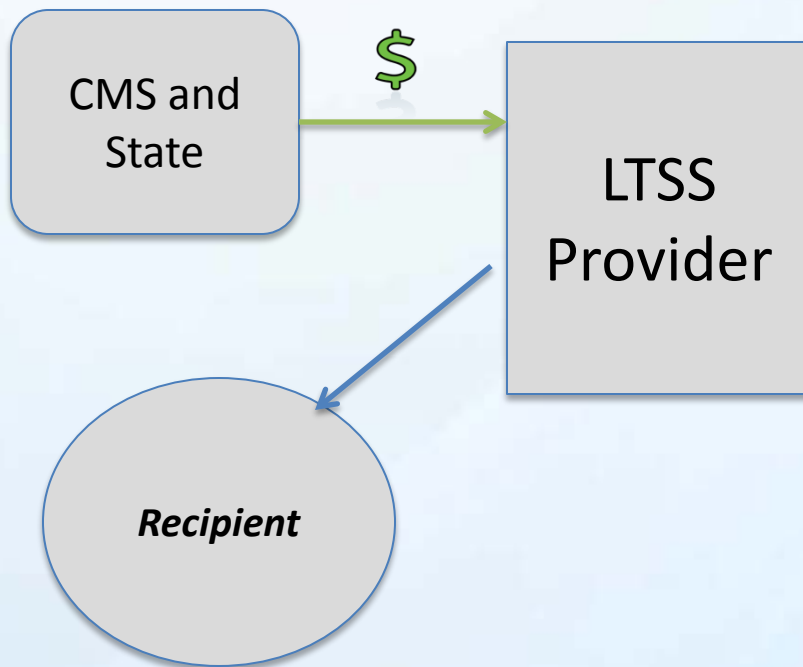
Background: National Scope of MLTSS

8 states in 2004 → 29 states as of 06/01/14

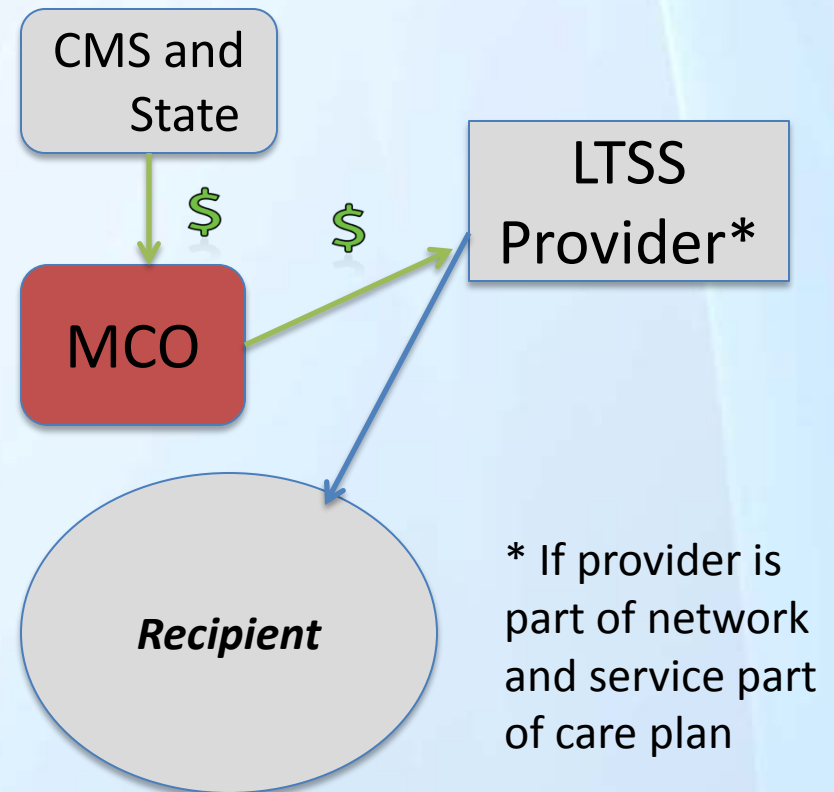
AL, AZ, CA, DE, FL, GA, HI, IL, KS, LA, MA, MI,
MN, MO, NE, NV, NH, NJ, NM, NY, NC, OH, OR,
PA, RI, TN, TX, WA, WI

Managed Care → Delivery System

Fee for service LTSS



Managed LTSS



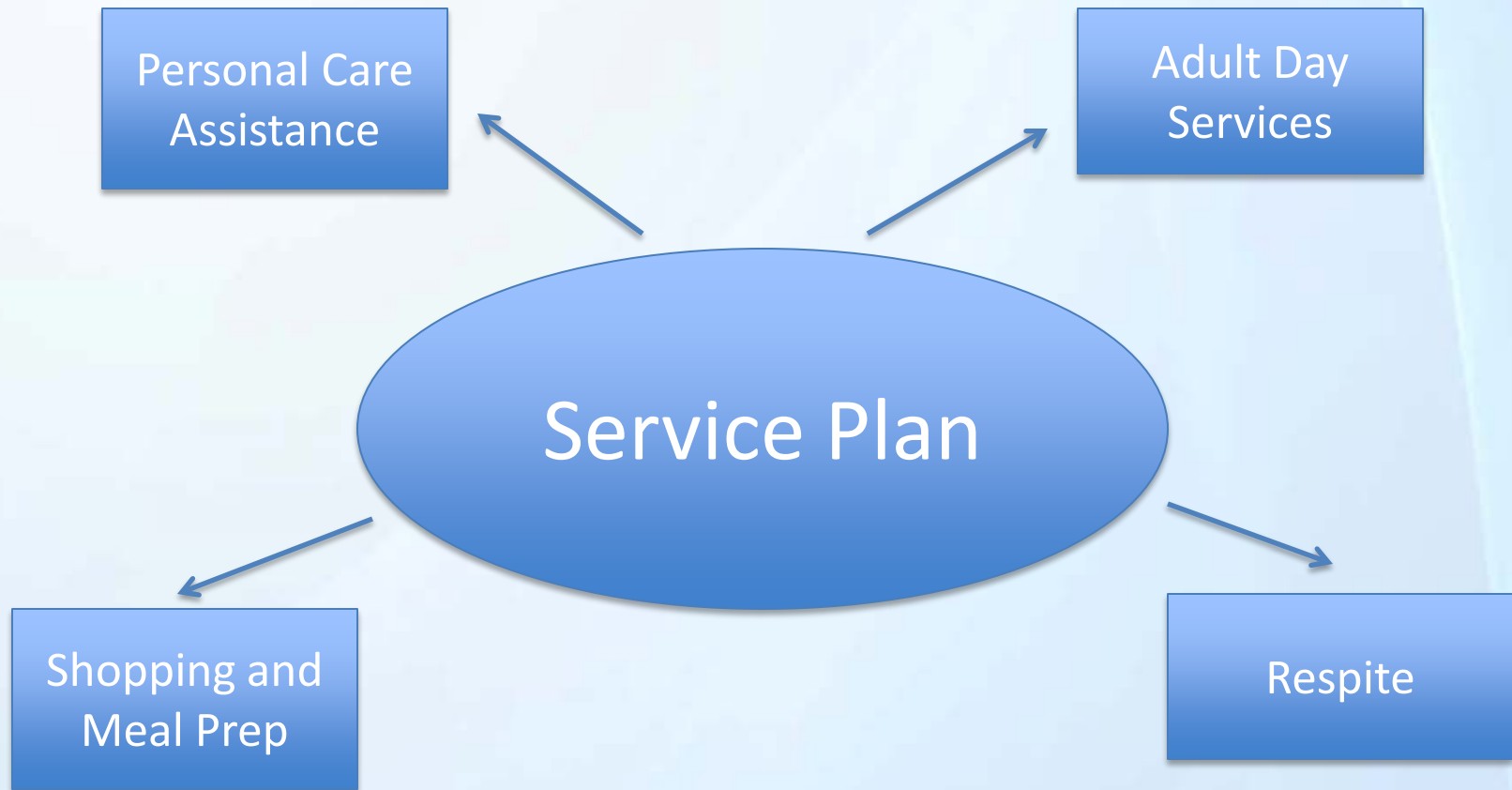
Background: What are Long-Term Services & Supports

Long-Term Services & Supports (LTSS)

Institutional
Services

Home &
Community-
Based Services
(HCBS)

Background: Examples of HCBS in MLTSS



**The Grievance System:
What can recipients do if they
disagree with an MCO decision
or are unhappy with services?**

What is a Managed Care Grievance System? 42 CFR 438.402

* Internal Grievance Process

* Internal Appeal Process

* Access to the State's Fair Hearing
System



Complaints about
things other than
actions =
Grievances

Actions =
Appeals/Hearings

Definition of Grievance from the Florida Contract

Fl. Contract, Attachment 11, p. 97.

Complaint

- The lowest level of challenge and provides the Managed Care Plan an opportunity to resolve a problem without it becoming a formal grievance. Complaints shall be resolved by close of business the day following receipt or be moved into the grievance system.

Grievance

- A grievance expresses dissatisfaction about any matter other than an action.

Definition of Grievance from the New Jersey Contract

NJ Contract, Article 1.

Complaint

- A protest by an enrollee as to the conduct by the MCO that is communicated to the Plan and that could be resolved by the Plan within 5 business days.

Grievance

- Means an expression of dissatisfaction about any matter or a complaint that is submitted in writing, or that is orally communicated and could not be resolved within five (5) business days of receipt.

Definition of Grievance from the Kansas Contract

Request for Proposal
p.70

- A grievance is an expression of dissatisfaction about any matter. Grievances may include: denial of service, partial denial of service, not given clear and accurate information from staff, lack of action being taken on a case, quality of care, aspects of the business relationships such as rudeness of an employee or failure to respect the Member's rights

Kansas Contract
Atch. C , p. 4.

- An 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 of a provider or employee, or failure to respect the member's rights.

Internal Grievance Procedure:

Be Aware of the Risk!



MCO Appeals and State Hearings: Protections for Medicaid MLTSS Recipients

What are these protections?

- What is an Appeal?
- What types of “actions” can be appealed through plan appeal and/or State hearing?
- What are the requirements around written notice?
- How does a MLTSS recipient request an appeal and/ or a State hearing?
- Is a plan required to maintain services during the appeal? What about during the hearing?
- What rights do recipients have during the appeal and hearing process?

What is an Appeal?

Appeal means a request for review of an action, as “action” is defined in this section.

42 CFR 438.400(b)

What is an “Action”?

Managed Care Regs
42 CFR 438.400(b)

Medicaid
Fair Hearing Regs
42 CFR 431.201

ACTION

42 CFR 438.400(b)

- A decision to **deny** or give only **limited authorization** of a requested service
- A decision to **reduce, suspend, or terminate** previously authorized services
- A decision to **deny**, in whole or in part, payment for a service
- The **failure to provide** services in a timely manner
- The **failure to act** within the timeframes required for resolution of a grievance, appeal, or expedited appeal
- For a resident of a rural area with only one MCO, a decision to **deny** a Medicaid enrollee's request to exercise the right to services outside the network

ACTION

42 CFR 431.201

- **Action** means a termination, suspension, or reduction of Medicaid eligibility or covered services. . .It also means adverse determinations a State with regard to the preadmission screening and annual resident review requirements . . .
- **Adverse determination** means a determination . . .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.

Examples from State Contracts

Florida

- Contract definition parallels the federal regulations.
Fl. Contract, Atch. II, p. 6.

Kansas

- The failure of the health plan to act within established time requirements (42 CFR 438.408(b)) for service accessibility.
Kan. Contract, Atch. C, p. 1.

New Jersey

- Denial of access to specialty care
- Denial of a choice of provider
- Denial of continuation of care
NJ Contract, Atch. 4, p. 62.

Notice of Action

Managed Care Regs
42 CFR 438.404

Medicaid
Fair Hearing Regs
42 CFR 431.201

What must a plan include in the written Notice of Action?

Statement of the intended action

Reason

Specific Regulation

Right to Appeal

Right to Hearing*
subject to possible exhaustion of appeal rights

What else must a plan must include in the written Notice of Action?

Procedures for exercising these rights

Expedited Appeals

Right to Continued Benefits

Example of Notice Language from Kansas re: action and reason

Dear [Member name]:

We have made the following changes to the services you may receive. This is called an “adverse action.” We are required to provide you with information about the decision and your rights to appeal.

We have taken the following action:

The above action is being taken because:

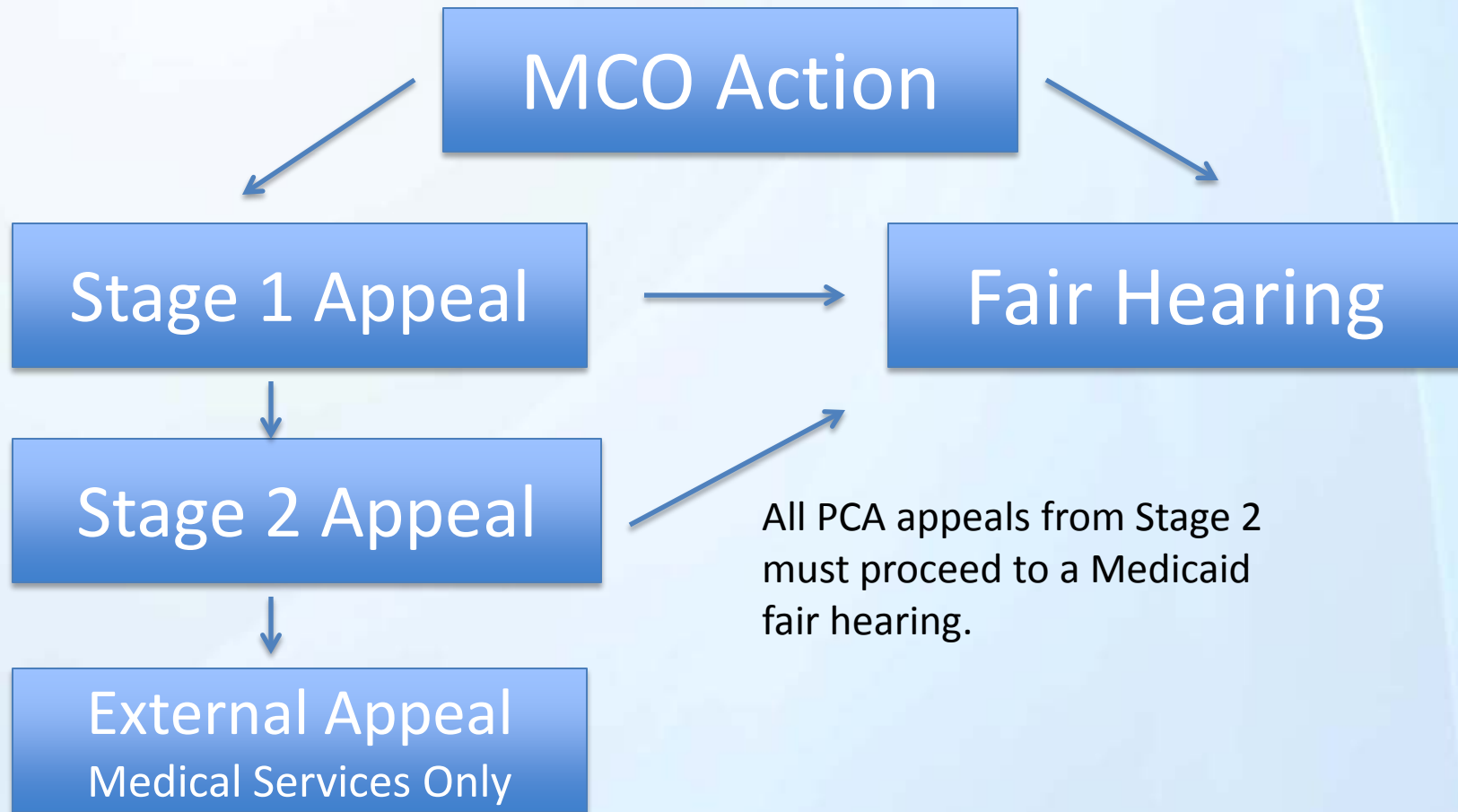
The effective date of this adverse action is: ____

Example of Notice Language from Kansas re: appeal vs. hearing

[MCO name] Appeal: You or your representative can ask [MCO name] to review its decision by asking for an appeal within 33 days of the mailing date of this Notice of Action. This is called an “[MCO name] appeal.” The [MCO name] appeal can be in writing or by calling us. You may also ask for a State Fair Hearing *instead of* an [MCO name] appeal *or at the same time*. You can ask for an [MCO name] appeal by phone, fax, or writing to us at: [address]

New Jersey's Always Has to Be Different

NJ Contract, Article 4, p. 62-63.



Is the MCO required to provide the MLTSS participant with a copy of any service authorization assessment?

There is a strong legal argument that the answer is YES!

Assessment Tools and Case Law

Ortiz v. Eichler,
794 F. 2d 889
(3rd. Cir. 1986)

- Issue: Adequacy of Notice
- Holding: Detailed individualized explanation of the reason for action

Baker v. Alaska,
191 P. 3d 1005
(Alaska 2008)

- Issue: Level of detail required in notice regarding PCA services
- Holding: Inclusion of the PCA assessment tool with Notice would satisfy due process.

K.W. v.
Armstrong,
2012 WL 3201172

- Issue: Failure of Notice to explain changes to LTSS budget
- Holding: Notice was inadequate because it failed to include an explanation of any changes

Language Access

42 CFR 438.404 & 42 CFR 438.10

Written notice
must be
available in
each prevalent
non-English
language

Oral
interpretation
services must
be available
free of charge

MCOs must
notify
enrollees of
these services
and how to
access them

How States define “prevalent”

Florida:

5%

Fl. Contract, Atch. 11, p. 49.

Kansas:

Spanish

Kan. RFP, 2.2.17.1.1

New Jersey:

5% or 200

NJ Contract, Article I, p. 18.

Timeframe for Notice of Action

42 CFR 438.404(c)

Terminations, Suspensions & Reductions

- Must be mailed at least 10 days before the date of the action

Denials of Payment

- At the time of any action affecting the claim

Denials or Limited Authorizations

- Standard Service Authorizations \leq 14 days
- Expedited Service Authorizations \leq 3 days

How to Request a Plan Appeal or a State Hearing 42 CFR 438.402

Who may file? Enrollee Provider	Timing ($20 \leq \text{Days} \leq 90$)	Procedures	Expedited Appeals
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Examples from State Contracts and Notices of Action

➤ Florida

- Contract: 30 days from date of receipt of notice
- Notice: 30 days/appeals; 90 days/FH; 10 days/continued benefits

➤ Kansas

- Contract: 30 days
- Notice: 33 days for appeals, hearings and continued benefits

➤ New Jersey

- Contract: 90 days from date of Notice
- Notice: 90 days/appeals; 20 days/FH; 20 days/continued benefits - twice

Continuation of Benefits (Aid-Paid-Pending)

42 CFR 431.230

Maintaining
Services

42 CFR 438.420

Continuation of
Benefits

An MLTSS Participant is entitled to continuation of benefits when:

- Recipient files the appeal timely (w/in 10 days or prior to effective date of action)
- Appeal involves termination, suspension, or reduction of previously authorized service
- Services were ordered by provider
- Original prior authorization period has not expired
- Recipient requests an extension of benefits

The MCO must continue an MLTSS Participant's benefits until

- Recipient withdraws the appeal
- 10 days pass after mailing of appeal resolution notice unless, within the 10-day timeframe, recipient requests a State hearing with continuation of benefits
- State hearing office issues an adverse decision
- Time period or service limit has been met

Will the MLTSS participant be required to repay cost of services if the final decision is adverse?

- 42 CFR 438.420(d) provides that if the final resolution of the appeal upholds the MCO's action, the plan may recover the cost of the services.
- 42 CFR 431.230(b) also provides that if action is sustained by the hearing decision, recovery may be sought by the State

The Problem with Prior Authorization and Continuation of Benefits

42 CFR 438.420
(b)(4) and(c)(4)

New Jersey
Solution:

NJ Contract,
Article 4, p. 63.

Kansas
Solution:
STC 32 &
Notice

Language from the Kansas Notice of Action:

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 not have to repay [MCO name] for service(s) provided during the [MCO name] appeal and/or State Fair Hearing, unless fraud has occurred.

MLTSS Participant rights during the plan appeal process 42 CFR 438.406

Assistance filing Appeal

- MCOs must provide reasonable assistance in completing forms, including providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability.

Appeal Decision- Makers

- Cannot have been involved in previous level decision-making
- Must be healthcare professional if a denial is based on lack of medical necessity, a denial of an expedited appeal or involves clinical issues

MLTSS Participant rights during the plan appeal process 42 CFR 438.406

Oral Inquiries seeking to Appeal Actions

- Must be treated as appeals to establish the earliest possible filing date for the appeal, and must be confirmed in writing, until expedited.

Appeal Process

- Must have opportunity to appear in-person as well as in writing
- Must have opportunity to present evidence and allegations of fact or law
- Must have opportunity to examine the case file, including medical records both before & during appeal

Appeal Resolution 42 CFR 438.408

- Timeframe: ≤ 45 days for standard appeals and ≤ 3 days for expedited resolution of appeals
- MCO must provide a written notice of disposition
- Content of notice must include
 - Results of resolution process and date
 - If not wholly in favor of recipient, the right to request State hearing and how to do that
 - Right to continuation of benefits
- Provisions of Services

MLTSS Participant rights during the State Fair Hearing

Representation 42 CFR 431.206

- The MLTSS Recipient may represent himself or herself, may use legal counsel, a relative, a friend, or other spokesman

Timing 42 CFR 431.240

- The hearing must be at a reasonable time, date and place*

Hearing Decision-Maker

- Official who was not involved with initial determination of action in question
- Hearing officer has authority to request independent medical examination

MLTSS Participant rights during the State Fair hearing 42 CFR 431.242

Case File

- The MLTSS Recipient must be given the opportunity to examine the case file before and during the hearing

Establish pertinent facts

- Including bringing witnesses

Question or refute testimony or evidence

- Includes the opportunity to confront and cross-examine adverse witnesses

Hearing Resolution 42 CFR 431.244

- Decisions must be based exclusively on evidence introduced at the hearing
- Record is limited, and MLTSS recipient must have access to the record
- Decision must be written, ordinarily within 90 days of filing of appeal or hearing
- Public must have access to all hearing decisions

Questions?

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