MEDICAID MANAGED CARE

APPEALS AND GRIEVANCES

Managed Care in Iowa

- Iowa switched to managed care for Medicaid on 4/1/16
- Initial and ongoing eligibility determinations are still made by DHS, not an MCO.
- 3 MCOs in Iowa:
  - Amerihealth Caritas
  - Amerigroup
  - United Healthcare
- Once approved for Medicaid, Medicaid members are assigned to an MCO and allowed to switch within 90 days of enrollment
- Each MCO has its own statewide network of providers
- Each MCO has its own appeal procedure and grievance procedure

Managed Care Covers:

A. Long-term supports and services (i.e. nursing home care and waiver services)
B. SSI-related Medicaid (old age and disability)
C. FMAP-related Medicaid (families)
D. Prescriptions
E. Hawk-I program for children
F. Iowa Health and Wellness program

But Does Not Cover:

G. Dental care
H. Emergency Medicaid for undocumented individuals
I. Presumptive eligibility for Medicaid
J. Medically Needy Program

Services and coverage groups that are not under managed care are referred to as "fee for service" or FFS.

Grievances and Appeals

What Law Applies?

- Both state and federal law
  - 42 C.F.R. Part 438 deals with managed care
    - Subpart F deals with Grievance and Appeal System
  - 441 IAC chapter 73 deals with managed care
    - 73.12 deals with appeals of MCO actions
    - 73.13 deals with State Fair Hearings
    - 73.15 deals with Grievances

MCO grievances

- Regulations for MCO grievances are at 441 IAC 73.15:
  - "*The managed care organization shall have policies and procedures for review of any nonclinical incidents, nonclinical complaints, or nonclinical concerns. Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.*"

What is a grievance?

- Complaint about something other than a change or reduction in services
  - Examples: poor care from provider, customer service issues with MCO, issues with case manager or rights not respected

Timing of Grievance

- Enrollee can file a grievance at any time
- May file orally or in writing
- MCO will make a decision within 90 days from receipt

Filing an Appeal – Grounds

- 42 CFR §438.402; 441 IAC 73.12(1)
  - Reduction, suspension or termination of previously provided service
  - Denial or limited authorization of requested service (including type or level)
  - Denial (in whole or part) of payment of service
  - Failure to provide services in a timely manner
  - Failure to act within required timeframes
  - For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.

Filing an Appeal

- Notice of Action from MCO (now called adverse benefit determination)
  - Reduction, suspension or termination of previously provided service
  - Denial or limited authorization of requested service (including type or level)
  - Denial (in whole or part) of payment of service
- No Notice of Action
  - Failure to provide services in a timely manner
  - Failure to act within required timeframes
  - *For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.*
- Medicaid recipients/MCO enrollees must first file an appeal with the MCO (excepting dental issues, because not covered by Managed Care)

Which of the following can you appeal to an MCO?

A. Denial of prior approval for a requested service
B. Termination of eligibility for a Medicaid Waiver program
C. Reduction in the amount of hours of services you receive per week or month in a Medicaid Waiver program
D. The MCO does not make a decision within a timely manner
E. The MCO fails to provide services within a timely manner
F. For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.
G. Quality of Care you receive from a provider
H. Problems with your case manager

ANSWERS

A. Denial of prior approval for a service
B. Termination of eligibility for a Medicaid Waiver program
C. Reduction in the amount of hours of services you receive per week or month in a Medicaid Waiver program
D. The MCO does not make a decision within a timely manner
E. The MCO fails to provide services within a timely manner
F. For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.
G. Quality of Care you receive from a provider
H. Problems with your case manager

MCO appeals

Iowa regulations for MCO appeals are at 441 IAC 73.12:

73.12(2) *Appeal process.* The managed care organization appeal process shall be approved by the department and shall:

a. Allow for the appeal request to be submitted in writing or verbally. If the request is submitted verbally, it must be followed up with a written submission.
b. Require acknowledgment of the receipt of a request for an appeal within three working days.
c. Allow for participation by the enrollee and the provider.
d. Provide for resolution of nonexpedited appeals to be concluded within 45 calendar days of receipt of the request unless an extension is requested.
e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within three business days of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to October 16, 2015.
f. Ensure that the review will be made by qualified professionals who were not involved with the original action.
g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

Expedited Appeals

- If the issue is urgent, the member can ask for an expedited appeal. Those should be reviewed within 3 days as opposed to normal appeals, which can take 30-90 days.
- 441 IAC 73.12 (2) MCO appeal process shall:

e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within three business days of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to October 16, 2015.

Who Do You File With?

Grievance

Appeal

State Fair Hearing

Who Do You File With?

Grievance	----------	MCO
Appeal	----------	MCO
State Fair Hearing	----------	DHS/DIA

How Long to File an Appeal?

- Amerihealth Caritas – 60 days
- Amerigroup – 60 days
- United Healthcare – 60 days
- Must be filed within the number of days from the date on the notice of action (NOT date of receipt).
- **Continuation of benefits must be made within 10 days of receipt or date on the notice

Who Can File an Appeal?

- MCOs are requiring third parties (including attorneys) to have written permission from the Medicaid member to file an appeal for the member.
- Appeals can be filed orally, on the phone, but must be followed up with a written appeal. If you want to help a client file an appeal on the phone, you should have the client on the phone with you when you call the MCO.

Must you appeal to MCO or can you skip to State Fair Hearing?

- Must file with the MCO first—called the exhaustion requirement.
  - New reg at 441 IAC 7.1 definition of "First-level review," and 7.2(5)(a) "Conditions of an aggrieved person" for "Managed care organization coverage" now includes "has been notified that the first-level review process through a MCO has been exhausted and remains dissatisfied with the outcome."
- Changes effective 7/12/17
- Federal regulations also require MCO level of exhaustion (42 CFR 438.408(f)(1)).

Resolution of Appeals

- Must resolve as expeditiously as the member's health condition requires
- Rules after 7/1/17
  - Appeals—30 days unless extension requested

What about Deemed Exhaustion?

(f) *Requirements for State fair hearings*—
(1) *Availability.* An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

- 42 CFR 438.408

If you Don't Like the MCO's Decision, Then What?

- After the MCO makes a final decision on 1st level of appeal, a member can request a state fair hearing
- State fair hearing is a hearing before an administrative law judge (either by telephone or in-person)
- Make the request within 120 calendar days from the date of the MCO's notice of resolution.

State Fair Hearing cont.

- This request goes to DHS
  - Can be filed online at https://secureapp.dhs.state.ia.us/dhs_titan_public/appeals/appealrequest (there is a Spanish version as well)
  - In-person at local DHS office
  - Telephonically – (515) 281-3094
  - E-mail – *appeals@dhs.state.ia.us*
  - Through U.S. Mail –

    Department of Human Services
    Appeals Section
    1305 E Walnut Street, 5th Floor
    Des Moines, IA 50319

Problems in Other States

A. Large reduction in number of hours per week for home and community based waiver services
B. Unable to find a provider you need within your managed care network
C. Determination that someone no longer meets level of care for nursing facility
D. Having to reschedule or forego needed care because procedures are not approved by MCO

What Does MCO Have to Do at First-Level Review?

- State law does not provide guidance.
- Must look to federal law.

Due Process Applies

Due process applies at the State Fair Hearing level. Does it apply at the MCO level?

Yes – MCO must give you notice and an opportunity to request an appeal. You won't necessarily get a hearing. They should be providing a copy of relevant documents so you can have a meaningful opportunity for an appeal and to submit information in support of your appeal.

Due Process (cont.)

- New FINAL Federal regs require:

438.406 Handling of grievances and appeals.

(a) *General requirements.* In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. *This includes, but is not limited to, auxiliary aids and services upon request*, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Due Process (cont.) 438.406

(b) *Special requirements.* An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal.

Due Process (cont.) 438.406

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

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

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

Due Process (cont.) 438.406

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

Due Process (cont.) 438.406

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and *testimony* and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for *this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c)* in the case of expedited resolution.

Due Process (cont.) 438.406

(5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, *and any new or additional evidence* considered, *relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP)* in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).

Due Process (cont.) 438.406

(6) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

Due Process (cont.)

- If the case is not resolved fully favorable to the Medicaid recipient at the MCO level appeal, then the notice must advise of right to ask for State Fair Hearing
- 441 IAC 73.12(2)

g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

Due Process (cont.)

- FINAL and CURRENT reg: 42 CFR 438.408:

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so.

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

(iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.

Anticipated Issues

- MCOs are supposed to continue benefits if the Medicaid member filed a timely appeal.
- Remember to advise clients to appeal within 10 days – both to MCO, and then to State (Fair Hearing level) – and request continuing benefits
  - Problems with providers not wanting to provide continuing benefits b/c of risk of repayment to MCO
- Medicaid HCBS waiver assessments – changes

Anticipated Issues (continued)

- Delays in care
- Denials of procedures (prior authorization)
- No Notice of Action from the MCO leading to problems with filing an appeal
- No clear reason given for denial/reduction/termination, leading to problems with presenting case on appeal
- 90 day authorizations despite no change in needs or level of care

No Notice of Action = No Appeal?

- A denial, reduction, or termination is appealable. No requirement that a written notice of adverse action be given in order for the adverse action to be an adverse action.
- The managed care rules make clear that an MCO's failure to provide adequate notice means that the internal appeal process is deemed to be exhausted, and the enrollee is entitled a state fair hearing. *See* 42 C.F.R. § 438.408(c)(3).

No Notice of Action = No Appeal? (cont.)

- The new managed care rules also specify that enrollees are entitled to a hearing when their plan "fail[s] to provide services in a timely manner." *See* 42 C.F.R. § 438.400(b)(4).

What is actually attending a State Fair Hearing like?

Hearing Format

- Telephonic unless in-person hearing requested
- Need to call in on time
- Expect one person to be designated to present the case (i.e. call witnesses, cross-exam MCO witnesses)
- Court proceeding, recorded and ALJ oversight

What are you trying to prove?

- Focus on the appealable issues stated on the notice of hearing
- Witnesses—be prepared to call and examine witnesses
- Exhibits—should be filed 5 days before the hearing and support the position
  - Eg. If appealing a denial of skilled nursing services, exhibits and witnesses need to focus on the need for the service, how the reduction will affect the member, does the evaluations/assessments support the need for the service

What are you trying to prove?

- For self-directed services or exceptions to policy:
  - can you show that other services were exhausted (non-waiver Medicaid)
  - lack of providers willing to serve individual
  - Rate of payment for providers is equal to the market
  - Use the MCO contract language to support arguments

Who will MCO have at hearing?

- Attorney represents MCO
- Witnesses could be LTSS Supervisor, Medical Director, Appeals Coordinator
- MCO will have submitted evidence and copy to the member
- Expect cross examination

How long for a Decision

- Depends if any written briefing is done by the parties
- 2-4 weeks for a written decision
- Are appeal rights to DHS Director and Judicial Review following ALJ proposed decision

Office of the State Long-Term Care Ombudsman

Managed Care Ombudsman Program

- Office serves as the advocate for MLTSS populations as included in IME's waiver request and in state code
  - 7 HCBS Waivers
  - Institutional care residents/tenants
- 2 managed care ombudsmen
- Duties include:
  - Educate and Inform
  - Advocate and Outreach
  - Assist with Grievances, Appeals, and State Fair Hearings
  - Collect Data and Report
  - Develop/Maintain Systemic Collaborations
- Meet with MCOs and IME on a monthly basis to discuss issues and problem solve
- Regularly meet with other stakeholder and advocacy organizations
- Issue monthly and quarterly reports

How to Be Your Own Best Advocate

- A Guide to How to Navigate Managed Care in Iowa
- https://www.iowaaging.gov/how-be-your-own-best-advocate-guide-how-navigate-managed-care-iowa

Questions?

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