Session Outline

- Medicaid background
- Medicaid managed care overview
  - Necessary components
- Registering complaints
  - Discrimination
  - Grievances
  - Appeals
What judges say

• Byzantine construction” makes Medicaid “almost unintelligible to the uninitiated”

• Medicaid Act is “an aggravated assault on the English language”

• Medicaid “regulations so drawn they have created a Serbonian bog”
Medicaid Basics

• Entitlement
  • Covered population groups, *e.g.*
    • Dual Medicare eligibles, “poor elderly,” SSI, children, pregnant women, people with disabilities
  • Covered services
    • Mandatory and optional
    • *e.g.* Hospital, physician, home health, nursing facility

• Due process notice and hearing rights if eligibility/services are denied/terminated
Medicaid Managed Care

• 74% of Medicaid population
• All states but AK, WY
• High enrollment (>95%): HI, ID, MO, OR, SC, TN, VT

SOURCES: Kaiser Family Foundation (www.kff.org); CMS (www.cms.gov)
Medicaid Managed Care Rules

• Final rule issued May 6, 2016
  • First regulatory overhaul in more than a decade
  • Goals: Modernization, Alignment, and Transparency
    • Emphasis on increasing coverage of LTSS, people with disabilities
Medicaid Managed Care Rules-vocab

• Capitation v. Fee for service
• Risk Contracts
• Managed Care Entities
  • MCO (managed care organization)
  • PIHP, PAHP – prepaid health plan (inpatient and ambulatory)
  • PCCM – primary care case management (managed fee for service)
  • PCCM entities – PCCM with administrative functions
  • PACE (Program of all-inclusive care for the elderly)
Enrollee Rights and Protections

Right to:

• Adequate provider networks
• Timely access to services, including specialists
• Receive information on available treatment alternatives
• Disenroll due to poor quality or lack of access
• Be treated with respect and dignity
• Be free from discrimination
• Participate in health care decisions
Resolving Problems

- Grievances
- Appeals
- Court Actions
- Administrative & Court Actions to Address Discrimination
Medicaid Due Process: Legal Authority

- 14th Amd., U.S. Const.
- 42 U.S.C. § 1396a(a)(3)
- 42 U.S.C. § 1396u-2(b)(4)
- 42 C.F.R. pts. 431, 438 pt E (MC)
- Contracts (MC)

DUE PROCESS = NOTICE & OPPORTUNITY TO BE HEARD
Grievance

• An expression of dissatisfaction about any matter other than an adverse benefit determination

• Can be filed *any time*
• Oral or written
• Resolution: w/i 90 calendar days of MC receipt
Appeals

NAME CHANGE

Action = Adverse Benefit Determination =

- Denial, reduction, suspension, termination, delay of service
- Denial/limited approval based on medical necessity, appropriateness, setting, effectiveness
- Disputes involving cost sharing
Appeals – Basic ground rules

- Only one level of appeal
- Enrollee gets “any reasonable assistance”
  - Auxiliary aides
  - Interpreter services
- New option: External medical review
- Exhaustion of appeal process required!
  - Exception: Deemed exhaustion
Appeals: Adequate written notice

• The Adverse benefit determination (ABD)
• Reasons for ABD
  • Including right to be provided free of charge reasonable access to information relevant to the ABD
• Right to appeal
  • In-plan & state fair hearing
• Circumstances for expedited appeal
• Rights to continued benefits
  • Recoupment
Appeals: Timing of notice

- Termination, suspension, reduction: mailing at least 10 days* before date of ABD
- Denial of payment: at time of the ABD
- Standard service authorization requests: as expeditiously as possible, and w/i 14 days
- Expedited service authorization request: as expeditiously as health requires, and w/i 72 hours

* counting uses calendar days
Appeals – Enrollee rights & responsibilities

• Enrollee must file w/i 60 calendar days* of ABD notice

• Clock starts w/oral or written appeal
  • NOTE: follow up on oral request (unless expedited)

• Enrollee rights during review:
  • Review complete case file
  • Present evidence/arguments in writing/in person
Appeals - Resolution

• Decision maker
  • No previous involvement
  • “Appropriate clinical expertise” if medical necessity at issue
  • Consider all information submitted by enrollee
Appeals - Resolution

• Timing
  • Standard: w/i 30 days of receipt
  • Expedited: w/I 72 hours of receipt
    • Standard review could “seriously jeopardize enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function”
    • Possible extension: up to 14 days

• Form of decision on appeal
  • Written
  • Translation and alternative formats required
  • Provide results
  • Explain right to appeal and continued benefits
Continued Benefits

• Enrollee files timely appeal (w/i 60 days of ABD notice);
• Appeal involves termination, suspension, reduction of previously authorized service;
• Service was ordered by an authorized provider;
• Period covered by original authorization has not expired; and
• Timely request for continued benefits (i.e., w/i 10 days of ABD notice)
Appeals -- Effectuation

• ABD Affirmed
  • Enrollee can obtain state fair hearing
  • If final, MCO can recoup *if*
    • Furnished solely because of the con’t benefit requirement *and*
    • To the extent consistent with *state* policy

• ABD Reversed:
  • “Authorize or provide” services as expeditiously as enrollee’s health requires, w/i 72 hours from receiving notice of reversal
Fee-for-Service Regular Appeal

**Action**
- Notice must be provided at least 10 days prior to action, with few exceptions. § 431.211.
- Enrollee must request continued benefits prior to action

**State Fair Hearing**
- Decision w/ 90 days post filing. 42 C.F.R. § 431.244(f)

Individual must have “reasonable time” to request hearing (not more than 90 days). 42 C.F.R. § 431.221.

State sets actual limit, so time may vary, but no higher than 90 days after notice of action was mailed.
Managed Care Regular Appeal

**Adverse Benefit Determination**
- Notice must be provided at least 10 days prior to action
- Enrollee has up to 10 days to request continued benefits

**MC Internal Appeal**
- Decision w/i 30 calendar days after plan receives appeal
- Only one level permitted
- State option to set shorter turnaround requirement

**State Fair Hearing**
- Decision w/i 90 days post filing (after you subtract days between internal appeal and request for SFH)
- Time used for MC internal appeal would be included in the 90 day limit here.
- “Deemed exhaustion”

Individual has up to 60 calendar days from date on notice to file. § 438.402(c)(2)

State option for direct path to SFH was removed in final MC regulation. 438.402(c)(1).
Managed Care Expedited Appeal

**Adverse Benefit Determination**
- Notice must be provided at least 10 days prior to action
- Enrollee has up to 10 days to request continued benefits

**MC Internal Appeal**
- Decision as health condition requires (Max. 72 hours post request, with limited extension exceptions)
- Only one level permitted

**State Fair Hearing**
- Decision as health condition requires (Max. 3 working days)
- Clock starts from state's receipt of case file from plan
- "Deemed exhaustion"

Individual has up to 60 days to file, but normally would be much faster.

Plan must honor provider request to expedite. Plan may honor enrollee request.

Individual has 120 days to request fair hearing after plan decision, though usually this would happen much faster.
Nondiscrimination – § 1557

- 42 U.S.C. § 18116 (Section 1557 of the Affordable Care Act)
- Prohibits discrimination on the basis of:
  - race
  - color
  - national origin - LEP
  - sex
  - age
  - disability - ADA amendments definition
- Incorporates by reference Title VI (race, color, national origin), Title IX (sex), Age Discrimination Act (age), and Section 504 of the Rehabilitation Act (disability)
Enforcement Mechanisms

- Administrative Complaints
  - File with Department of Health and Human Services’s (HHS) Office for Civil Rights (OCR)
  - State Insurance Commissioners

- Federal Litigation
  - Regulations make clear that Section 1557 authorizes an express right of action for an individual to file suit in federal district court
    - Both disparate impact and intentional discrimination claims

- Other Possible Enforcement Options
  - Marketplaces (certification process)
  - Center for Consumer Information and Insurance Oversight (CCIIO) at HHS
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