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NATIONAL HEALTH LAW PROGRAM

Fact Sheet # 4

Medicaid Managed Care: Grievances and Appeals

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Introduction

Medicaid managed care plans operate in 47 states and the District of Columbia, enrolling a total of 71% of all Medicaid beneficiaries. When Medicaid expands in 2014, many of the newly eligible beneficiaries will likely enroll in Medicaid managed care plans. This series outlines basic principles of grievance and appeal processes to help beneficiaries and advocates get the most out of Medicaid managed care and hold the plans and state Medicaid agencies accountable.

Medicaid applicants and recipients, including those enrolled in managed care plans, are entitled to notice and an opportunity to be heard by an impartial decision-maker when eligibility or services are denied or terminated. (*See Goldberg v. Kelly*, 375 U.S. 254 (1970); *J.K. v. Dillenberg,* 836 F Supp. 694 (D. Ct. Ariz. 1993)).

The Law Says:

When a managed care plan denies, terminates, or reduces services, enrollees must receive **notice of the action.** That notice must:

- Explain the action that the managed care plan has taken or intends to take, the reasons for the action, and specific legal authority that supports it. (42 C.F.R. §§ 438.404(b)(1),(2); 42 C.F.R. § 431.210(c)).
- Be mailed to the enrollee at least 10 days before the action, unless there are exceptional circumstances, such as fraud. (42 C.F.R. §§ 431.211, 431.213-14; 438.404(c)(1),(3)).
- Describe the enrollee's right to file an appeal with the managed care plan, and, if the State does not require the enrollee to exhaust the managed care plan's appeal procedures first, the enrollee's right to a state fair hearing; explain the process for requesting an appeal and, if applicable, a state fair hearing. (42 C.F.R. §§ 438.404(b)(3)-(5)).
- Be available in non-English languages spoken by a significant number or percentage of enrollees or potential enrollees in the state. (42 C.F.R. §§ 438.404(a), 438.10(c)).

- Be easily understandable and available in alternative formats to accommodate people with disabilities and those with limited reading proficiency. (42 C.F.R. §§ 438.404(a), 438.10(d)).

Medicaid managed care plans must establish **internal grievance and appeals procedures** for Medicaid enrollees. (42 U.S.C. § 1396u-2(b)(4)). Under those procedures:

- The enrollee has the right to file an **appeal** with the managed care plan to complain about a delay, denial, limitation, or termination of services. (42 C.F.R. § 438.400(b)). The managed care plan must also establish a process for **expedited appeals** when a speedy resolution is warranted by the enrollee's health or functioning. (42 C.F.R. § 438.410).
- The enrollee has the right to file a **grievance** with the managed care plan or the State (at the State's selection) to complain about matters other than delays, denials, limitations, or terminations of services. (42 C.F.R. § 438.400(b)).
- The managed care plan should generally resolve an **appeal** within 45 days, and should resolve a **grievance** within 90 days. (42 C.F.R. § 438.408(b)).

Whenever eligibility or services are denied or terminated, beneficiaries must be given an opportunity for an impartial **state fair hearing** before the state Medicaid agency. (42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-250).

- A State may require an enrollee in a Medicaid managed care plan to exhaust the MCO's internal appeals process before it will consider a request for a state fair hearing. (42 C.F.R. § 438.402).
- A State must issue a hearing decision within 90 days of the hearing request. (42 C.F.R. 431.244(f)).

Whenever enrollees challenge a termination of eligibility, or a termination, suspension, or reduction of services, they have a right to **continuing benefits** ("aid paid pending"):

- An enrollee who files an appeal with the managed care plan within 10 days of mailing the notice or before the effective date of the action must receive continuing benefits pending the resolution of the managed care plan's internal appeal. (42 C.F.R. § 438.420).
- An enrollee who requests a state fair hearing within 10 days of receiving written notice of a proposed action must receive continued services ("aid paid pending") pending the state fair hearing decision or the service limits of a previously authorized service expire. (42 C.F.R. §§ 431.230, 431.210(e)).

States and Medicaid managed care plans must issue and publicize their dispute resolution procedures. (42 C.F.R. §§ 431.206(a), 438.10(g)(1)).

There can be problems:

- **Basic Due Process Requirements**:
  - Medicaid managed care plans are not familiar with constitutional and federal statutory due process protections and ignore them.
  - States do not offer guidelines for internal grievance and appeals processes for participating managed care plans or train them about fair hearing requirements.

- **Notices:**
  - Managed care plans use their own grievance and appeal procedures without providing formal notice of adverse decisions or notifying enrollees about their right to state-level fair hearings.
  - Managed care plans use notices that are inadequate, incomplete, incomprehensible or incorrect.
  - Notices do not explain continued benefits.
  - Notices are not available in languages other than English.
  - Notices are not available in alternative formats to accommodate enrollees with disabilities.

- **Grievance and Appeal Procedures**:
  - Managed care plans routinely disenroll people who complain rather than processing their grievances or appeals.
  - Cryptic or unnecessarily burdensome grievance and appeal mechanisms encourage enrollees to limit filings and disenroll rather than complain.
  - Members have no way to complain about denials in emergency and urgent care situations.
  - Enrollees are unable to register complaints with health plans because phone lines are perpetually busy or complaint forms are lost or ignored.
  - Interpreters are not available for state fair hearings to allow limited English speakers to fully participate.

- **State Fair Hearings:**
  - States that condition fair hearing access on exhaustion of MCOs' internal grievance and appeal procedures fail to issue decisions within 90 days as required by law.

- Fair hearings and hearing decisions are not provided in accessible formats and accommodations are not being made for people with disabilities to enable them to participate fully in their hearing.
- Key personnel, including state or contracting agents' employees (e.g., utilization reviewers, managed care employees) do not appear at the hearing.
- State hearing officers take longer than 90 days to issue hearing decisions.

- **Continuing Benefits:**
  - Managed care plans limit care or refuse to cover disputed services in disregard of the "aid paid pending" rule.
  - Services are being prior approved for only limited periods of time or limited amounts, after which the state and its agents treat the request for the service as a new request not subject to continued benefits.

Consumer Protections are Needed Now:

- **Basic Due Process Requirements**:
  - Medicaid managed care plans must be familiar with constitutional and federal statutory due process protections.
  - The State must:
    - offer guidelines for internal grievance and appeals processes for participating MCOs,
    - train MCOs about fair hearing requirements, and
    - monitor managed care plans and sanction them if they repeatedly fail to comply with due process requirements.
  - **Notices:**
    Managed care plans' notices must:
    - be complete and accurate,
    - state the action that the managed care plan has taken or intends to take,
    - explain the reasons for that action, including the specific legal authority for the action,
    - describe the enrollee's right to file an appeal with the managed care plan, and, if the State does not require the enrollee to exhaust the managed care plan's appeal procedures first, the enrollee's right to a state fair hearing,
    - set out the process for requesting an appeal and, if applicable, a state fair hearing,
    - outline the process for obtaining continued benefits,

- be easily comprehensible,
- be made available in languages other than English,
- be available in alternative formats to accommodate people with disabilities, and
- be mailed to the enrollee within the applicable time periods.

- **Internal grievance and appeal procedures**:
  - State must sanction managed care plans that disenroll people just because they have filed grievances or appeals.
  - Managed care plans' grievance and appeals procedures must be well-publicized, simple and accessible.
  - Grievance and appeals processes must allow enrollees to make complaints via phone, mail or in person.
  - Managed care plans must confirm and respond to complaints promptly,
  - Managed care plans must establish and publicize an expedited review process for emergency and urgent care situations.
  - Managed care plans must inform enrollees of their right to a state fair hearing, and explain the process for requesting one.

- **State fair hearing*:***
  - Hearing decisions must be issued within 90 days of requests for state fair hearings, even if the State requires exhaustion of the MCO's internal process first.
  - Managed care plans must produce key staff as witnesses in appeals and state fair hearings.
  - The State fair hearing process must be fully accessible to people with disabilities.

- **Continuing Benefits:**
  - Enrollees who timely request state fair hearings must receive continued benefits pending the state fair hearing decision.

For more information, contact Abbi Coursolle at coursolle@healthlaw.org.