Medicaid Managed Care Final Regulations Grievance & Appeals Systems

Issue Brief No. 2

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This issue brief will review selected provisions in the final rule, *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability* implementing the requirements governing grievance and appeals systems in Medicaid managed care (Subpart F of the final regulations).[1] We also include recommendations for state advocates to ensure robust implementation of these provisions to ensure full implementation of these crucial provisions in their states.

Definitions and effective date (42 C.F.R. § 438.400)

The final regulations make a few changes to the definitional section of the grievance and appeal regulations that affect the entirety of Subpart F.

First, the regulations bring prepaid ambulatory health plans (PAHPs) within the requirements of subpart F, which previously applied only to managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). This change recognizes the evolution of PAHPs from small group practice entities to private or government operated entities that manage a whole subset of Medicaid benefits, such as dental or behavioral health benefits. There is an exception. Non-emergency medical transportation (NEMT) PAHPs are not subject to subpart F, therefore beneficiaries denied services by a NEMT PAHP will continue to use the state fair hearing process set forth in 42 C.F.R. §§ 431.200-431.246. They will, however, have no access to a grievance process.

Second, the event that triggers appeal rights has experienced a name change: "action," the term used in previous regulations, has been replaced by the phrase "adverse benefit determination."[2] An "adverse benefit

[1] *Medicaid and Children's Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27,498-27,901 (May 6, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

[2] 42 C.F.R. § 438.400(b); see 81 Fed. Reg. at 27,507 (noting this is the standard terminology used throughout the health care industry).

determination" includes the existing regulatory definition of an "action" (*e.g.*, the denial, reduction, suspension, termination or delay of a service) and is expanded to include denial or limited authorization determinations based on "requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit" and dispute involving "cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities."[3] This later expansion was strongly supported by NHeLP and other advocacy groups.

The Subpart F, grievance and appeal regulations become effective for the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. The rating period is "the twelve month period for which capitation rates are developed under a managed care contract, to address States that have multi-year managed care contracts."[4]

General requirements (42 C.F.R. § 438.402)

Enrollees can file both grievances and appeals, depending on the nature of the disagreement. If state law permits, and with the written consent of the enrollee, a provider or authorized representative may request an appeal, file a grievance, or request a state fair hearing on the enrollee's behalf.[5]

Grievances. Each MCO, PIHP and PAHP (other than NEMT PAHPs) must have a grievance system in place for enrollees. The grievance process allows enrollees to express dissatisfaction with matters that are not adverse benefit determinations, such as being treated rudely. Grievances also include disputes over an extension of time proposed by an MCO, PAHP, or PIHP to make an authorization decision.

Grievances can be filed with the MCO, PIHP, or PAHP *at any time*. The enrollee can file the grievance orally or in writing and, as determined by the state, with either the state or with the health plan. At the conclusion of the grievance process, the enrollee cannot appeal the matter even if he disagrees with the resolution.

Appeals. Each MCO, PAHP, and PIHP must have an appeal system in place for enrollees. There can be only one level of appeal, however, enrollees must exhaust that appeal before requesting a state fair hearing.

The enrollee must file the appeal within 60 calendar days from the date of the adverse benefit determination notice from the MCO, PIHP, or PAHP. The appeal can be filed orally or in writing (which includes on line filing). Unless an expedited appeal is requested, an oral appeal must be following by a written, signed appeal by the enrollee. However, the filing of the oral appeal starts the clock for the MCO, PIHP or PAHP to decide the appeal.

In general, then, an enrollee must exhaust the plan-level appeal and can request a state fair hearing only after receiving notice that the adverse benefit determination has been upheld. Notably, however, there is an

[3] *Id*. at §§ 438.400(b)(1), (7).
[4] CMS, Medicaid and CHIP Final Rule (CMS 2390-F) Implementation Dates (Apr. 25, 2016), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf (last visited May 9, 2016).
[5] *See* 42 C.F.R. § 438.402(c)(1)(ii). As used in this issue brief, the term "enrollee" thus includes authorized providers and representatives, except that, as noted below, providers cannot request continued benefits pending the appeal and/or fair hearing.

exception to exhaustion: If the MCO, PIHP, or PAHP fails to adhere to the "notice and timing requirements" contained in § 438.408 (discussed below), the enrollee is deemed to have exhausted the in-plan appeal process and can immediately request an impartial state fair hearing.[6]

There is another significant change in the final regulations. States are authorized to offer and arrange for external medical reviews.[7] The external medical review is discussed in the resolution and notification section of this issue brief.

There are a number of provisions in the final rule that may require advocacy at the state leave. Some states have refused to recognize legal representatives and beneficiary advocates as authorized representatives. Unfortunately, CMS refused commenters' requests to specify the list of authorized representatives and instead deferred the matter to the states. CMS does, however, agree "in principle" that legal representatives and beneficiary advocates may effectively serve as authorized representatives.[8] As a result, this debate could continue in the states, albeit aided somewhat by CMS's statement of support.

Protections must also be in place for oral appeals to ensure that the appeal is acknowledged and the resolution timeframe runs from the date the oral appeal is received by the managed care plan. States should explicitly require plans to acknowledge receipt of the oral appeal in writing, along with its date. Some health plans argued for dismissing oral appeals within 10 days if no written or signed follow-up was received, so this could be an area that requires particular attention.

The regulation requiring exhaustion and allowing only one in-plan appeal level will require close attention. Currently, states have the option to employ various in-plan appeal processes. Some health plans have multiple levels of in-plan review while many states allow enrollees to obtain an impartial state fair hearing without first exhausting an in-plan appeal. Thus, advocates in affected states will need to monitor implementation of these regulations in policies and contracts to ensure that there is only one level of in-plan appeal that operates as specified in the final regulations.

Further, the guarantee of deemed exhaustion should be aggressively implemented. All of the circumstances listed in the designated regulation must be recognized in state policy and managed care contracts.[9] If the notice and meeting timeframes for standard and expedited resolution of appeals are not met, it should be clear that deemed exhaustion will occur. Deemed exhaustion should also include situations where notice is provided in a manner that does not incorporate necessary translation or alternative formats such that the enrollee's time to appeal or request continuation of benefits is impeded. States have the option to deem exhaustion on a broader basis than required under the final rule. Because the enrollee is not before an impartial reviewer during the in-plan appeal, advocates should work to broaden deemed exhaustion, to include situations where the health plan does not provide: clear explanation of the enrollee's right to continued benefits; timely notice of appeal rights or

[6] 42 C.F.R. § 438.402(c)(1)(i)(A) (called deemed exhaustion in the final rule and this issue brief).
[7] 42 C.F.R. § 438.402(c)(1)(i)(B).
[8] 81 Fed. Reg. at 27510.
[9] *See* 42 C.F.R. § 438.408 (discussed below).

rights to continued benefits; notices written at an appropriate reading level; and notices that offer auxiliary aids and services, free of cost, during the appeal.

Finally, the adverse benefit determination notice must be dated. In the past, some health plans have used notices that do not reflect a date on the face of the notice.

Advocacy Tips

- **Counsel enrollees to keep a record of all relevant information initial filing of appeals, including dates and names of in-plan contacts.**
- **Monitor development of policies, contracts, and practices to ensure that beneficiaries need exhaust only one level of in-plan appeal and that plans fully implement the requirement for deemed exhaustion.**

Timely and adequate notice of adverse benefit determinations (42 C.F.R. § 438.404)

Enrollees must receive timely and adequate notice of an adverse benefit determination. The notice must be accessible to individuals who have disabilities or who are limited English speaking. Each notice must explain:

(1) The adverse benefit determination that has been made or that is intended.
(2) The reasons for the determination, including "the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits."
(3) The right to request an appeal of the adverse benefit determination, including information on exhausting the one level of appeal, and to request a state fair hearing.
(4) The process for exercising the right to appeal
(5) The circumstances under which the appeal can be expedited and how to request an expedited appeal.
(6) The enrollee's right to have benefits continued pending resolution of the appeal, how to request continued benefits, and the circumstances under which the enrollee may be required to pay the costs of these services.[10]

[10] 42 C.F.R. § 438.404(b).

The notice must be mailed as follows:

(1) For termination, suspension, or reduction of a previously authorized Medicaid-covered service, generally at least 10 days before the date of the action (with the exceptions currently authorized at 42 C.F.R. §§ 431.213, 431.214).
(2) For denial of payment, at the time of the action affecting the claim.
(3) For standard service authorization decisions that deny or limit services, as expeditiously as possible and, unless an extension is granted, within an outside limit of 14 calendar days.[11] If the MCO, PIHP, or PAHP extends the timeframe, it must give the enrollee written notice of the reason for the decision to extend, inform the enrollee of her right to file a grievance if she disagrees, and issue and carry out its determination as expeditiously as the enrollee's health condition requires and not later than an additional 14 calendar days.
(4) For expedited service authorization decisions (requested by the provider or agreed to by the health plan upon enrollee request), as expeditiously as the enrollee's health condition requires, within an outside limit of 72 hours. The deadline can be extended up to 14 calendar days upon enrollee request or if the MCO, PIHP, or PAHP "justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest."
(5) If a service authorization is not reached within the specified timeframes, this constitutes a denial and, thus, deemed exhaustion.[12]

The grievance and appeal process will not work without timely and adequate notices. Unfortunately, in-plan notices have been the source of recurrent problems for Medicaid enrollees, in terms of content, readability, timing, and delivery. Thus, publication of these final regulations provides a new opportunity to work with the state and health plans to advocate for policies and managed care contract provisions that contain specific requirements for timely and adequate notices. Further, advocates should work with the state to develop notice templates that all health plans will be required to use. Short of this, all MCOs, PIHPs, and PAHPs, should be required to develop and use notice templates and to obtain pre-clearance from the state prior to first use. The templates should be publicly available.

Expedited service authorization can be critical to the enrollee's health, and procedures must be clear. In particular, plans, providers and enrollees need clear instruction on the timing and procedures for MCOs, PIHPs, and PAHPs to obtain extensions from the State agency. Finally, the regulations uniformly use a calendar day (as opposed to a business day) approach to counting timeframe deadlines. A number of states will need to adjust their policies to reflect this change.

[11] Service authorizations are addressed at 42 C.F.R. § 438.210 and will be addressed in depth in a future NHeLP issue brief.
[12] 42 C.F.R. § 438.404(c).

Advocacy Tips

- **Advocate for policies and managed care contract provisions that contain specific requirements for timely and adequate notices, as well as uniform notice templates that are publicly available.**
- **Advocate that state agencies provide clear instructions to plans, providers, and enrollees about expedited service authorizations.**

Handling of grievances and appeals (42 C.F.R. § 438.406)

MCOs, PIHPs, and PAHPs must give the enrollee "any reasonable assistance" in completing forms and other procedural steps to file a grievance or appeal, including auxiliary aids, upon request, including providing interpreter services and toll-free numbers that are accessible to people with disabilities.

MCOs, PIHPs, and PAHPs must have a process for handling grievances and appeals that: (1) acknowledges receipt, (2) ensures that the individual who make the decisions on the grievance or appeal were neither involved in any previous level of review or decision-making nor a subordinate of any such individual, and (3) are individuals with "appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease," if the appeal involves denial based on no medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal that involves clinical issues.[13]

When deciding the grievance or appeal, the individual must take into account all comments, documents, records, and other information submitted by the enrollee, including information that was not submitted to or considered in the initial adverse determination. The plan must also provide the enrollee with a reasonable opportunity, "in person and in writing," to present evidence and make legal and factual arguments.[14] The MCO, PIHP, or PAHP must provide the enrollee and his representative with the case file, including medical records and any new or additional evidence considered or generated by or at the direction of the MCO, PIHP, or PAHP in connection with the appeal. This information must be provided free of charge and sufficiently in advance.[15]

Over the years, managed care plans' procedures for resolving disputes have been inconsistent and confusing for enrollees. These regulations should bring improvement, but it is critical for the details to be spelled out in the state's contracts with the managed care plans and that the procedures are clear to enrollees. Enrollee handbooks and notices should inform enrollees that auxiliary aids and services will be provided, free of charge,

[13] 42 C.F.R. § 438.406(b)(2).
[14] *Id*. at § 438.402(b)(4).
[15] *Id*. at § 438.402(b)(5).

to help with grievances and appeals. Health plans should acknowledge receipt of the grievance or appeal in writing. The acknowledgement should be dated and clearly show the date the grievance or appeal was received (including, if applicable, the date of the oral appeal). The state should develop clear policies for deciding which individuals within the health plan will be deemed to have appropriate clinical expertise to decide appeals involving clinical issues, medical necessity, or expedited review. State licensing provisions should be reviewed, as some states require clinically based decisions to be made by providers who are licensed in the state (and some multi-state plans use centrally located utilization reviewers).

Some states and health plans improperly limited the appeal to evidence that was before the plan when the initial adverse decision was made. These final regulations clearly prohibit this, and advocates should ensure this practice stops.

The regulations include provisions that should address the recurrent problem of enrollees being refused access to the clinical or coverage guidelines that were used or referred to when making the determination. On multiple occasions, health plans have protected these guidelines as trade secrets.[16]

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Advocacy Tips

- **Work with states and plans to ensure that handbooks and notices inform enrollees of their rights to accessible information and the means to obtain it.**
- **Ensure that contracts require health plans to acknowledge receipt of all grievances and appeals (including oral requests) in writing.**
- **Advocate with state agencies and plans to ensure that they do not improperly limit the scope of evidence admissible at appeal.**

[16] *See*, *e.g.*, Jane Perkins, National Health Law Program, *Demanding Ascertainable Standards: Medicaid as a Case Study*, Clearinghouse Article (Mar. 2016), http://www.povertylaw.org/clearinghouse/tags/health (last visited May 10, 2016).

Resolution and notification (42 C.F.R. § 438.408)

MCOs, PIHPs, and PAHPs must resolve grievances and appeals as expeditiously as the enrollee's health condition requires, within state established timeframes that may not exceed the following:

(1) For resolution of grievances and notice to the enrollee, within 90 calendar days from the day the health plan receives the grievance.
(2) For resolution of standard appeals and notice to the affected parties, within 30 calendar days from the day the health plan receives the appeal, unless extended.
(3) For resolution of expedited appeals and notice to the affected parties, within 72 hours after the health plan receives the appeal, unless extended.
(4) As noted, these timeframes can be extended by up to 14 calendar days if the enrollee requests it or the MCO, PIHP, or PAHP shows to the satisfaction of the state agency that there is a need for additional information and how the extension is in the enrollee's interest. The MCO, PIHP, or PAHP must give the enrollee written notice of the reason for a decision to extend the timeframe within 2 calendar days (to include notice of the right to file a grievance about the decision). Once the extension is granted, the appeal must be resolved as expeditiously as the enrollee's health condition requires and no later than the date of the extension.[17]

The regulations address the format of the notice. For grievances, the State agency must establish the method that the health plan will use to notify the enrollee of the resolution and ensure those methods meet the language and accessibility requirements of § 438.10. The health plans' appeal notices must be in writing and also meet the requirements of § 438.10.[18]

The written notice must include the results of the resolution process and the completion date. If the appeal is decided against the enrollee, the notice must contain information about the right to request a state fair hearing and how to do so, including the right to continued benefits. *Id.* at § 438.408(e).

States have the option to offer and arrange for an external medical review if the following conditions are met: (1) the review is entirely optional for the enrollee; (2) the review is not used as a deterrent to proceeding to a state fair hearing; (3) the review is independent of both the plan and the state; (4) the review is offered without cost to the enrollee; (5) the review does not extend the timeframe for conclusion of the in-plan review; and (6) the review does not disrupt continuation of benefits.[19]

[17] *See* 42 C.F.R. § 438.408(b)-(c).
[18] See also 81 Fed. Reg. at 27,636 ("We remind managed care plans that any necessary translation or alternative formats must be completed in a manner that does not impede the enrollee's ability, or reduce the enrollee's time, to request continuation of benefits….").
[19] *See* 42 C.F.R. § 438.408(f)(ii).

Depending on the policies at play, advocates may need to pay attention to a number of issues. The timeframes in the regulations are federal ceilings, so states can require resolution and notification to occur more swiftly.20 Advocates should push for swift in-plan resolutions, particularly when an extension has been granted at plan request. Also, all regulatory timeframes require decisions as expeditiously as the enrollee's health condition requires. Policies and contracts must explicitly recognize this and not simply implement a numerical deadline. When appropriate, the enrollee's appeal should explicitly document why a decision is needed sooner than the deadline.

It is important that policy and practice reflect that an extension cannot occur at the request of the health plan unless two conditions are met: there is a need for additional information, and it is established that the extension is in the enrollee's interest. The State agency decides this, not the health plan.

Policy and practice must also consistently reflect that both the resolution and the sending of the notice must occur within the time frame.

If the state decides to have an external medical review, advocates will need to monitor its implementation to ensure that all of the prerequisites, listed above, are in place; that health plan and state agency personnel have been trained on the prerequisites prior to first use; and that the review process is held to high accountability and transparency standards so that abuses do not occur.

Advocacy Tips

- **Advocate for contracts, policies, and procedures to provide for expeditious issuance of appeal decisions and notices, as the enrollee's condition requires, and to prohibit extensions of deadlines unless all regulatory prerequisites are satisfied.**
- **Monitor implementation of external medical review.**

Expedited resolution of appeals (42 C.F.R. § 438.410)

MCOs, PIHPs, and PAHPs must have an expedited review process for appeals. An expedited appeal occurs when the plan determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or in support of the enrollee's request) that taking the time for standard resolution "could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function."[21] Plans must ensure that punitive actions are not taken against providers who seek

[20] *See*, *e.g.*, 81 Fed. Reg. at 27517 ("If states find that managed care plans can resolve standard appeals faster than 30 calendar days, we believe that enrollees benefit from providing flexibility for states to impose tighter timeframes.")
[21] 42 C.F.R. § 438.410(a).

expedited resolutions. If the MCO, PAHP, or PIHP denies the enrollee's request, it must process the appeal under the requirements for standard resolution and give the enrollee notice of their right to file a grievance if she disagrees with the decision to deny expedited resolution.

Advocacy Tip

- **Monitor the implementation of expedited review. It is important that written policies make it clear that if the "provider indicates" the need for an expedited appeal, the health plan must decide the appeal expeditiously and cannot take punitive actions against the provider.**

Information about the grievance and appeal system (42 C.F.R. § 438.414)

The MCO, PIHP, or PAHP must provide the information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.[22]

Recordkeeping requirements (42 C.F.R. § 438.416)

The state must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of ongoing monitoring. The records must be accessible to the state and available upon request to CMS. The record must, at least, contain: (1) a general description of the reason for the appeal or grievance; (2) date received; (3) date of review; (4) resolution; (5) date of resolution; and (6) name of the enrollee for whom the appeal or grievance was filed.

Robust recordkeeping and reporting help ensure system accountability. And unlike most quality measures (e.g., HEDIS), grievance and appeal records provide a real-time picture of what is occurring at the plan level. Advocates should press their states for fuller public disclosure of grievances and appeals, including annual reports from states that include numbers and subject matter of grievances and appeals on an aggregate and plan level. The reporting should also document, by plan, the number of times the standard timeframe for resolution was extended, not at the request of the enrollee, and the number of times that requests for expedited reviews were denied, along with the subject matter of the request.

[22] 42 C.F.R. § 438.414 (incorporating the information about grievances and appeals required by § 438.10(g)(2)(ix)).

Advocacy Tip

- **Press states for full public disclosure of grievances and appeals, including reports with detailed information about numbers, subject matter, expedited appeals, and extension of timeframes for resolution.**

Continuation of benefits pending appeal and state fair hearing (42 C.F.R. § 438.420)

The regulations finalize a significant change that protects low-income people during the pendency of the appeal and state fair hearing. The MCO, PIHP, or PAHP *must* continue the enrollee's services if all of the following occur:

(1) The enrollee files a timely appeal under § 438.404(c) (that is, an appeal is filed within 60 calendar days from the date on the adverse benefit determination notice);
(2) The appeal involves termination, suspension, or reduction of a previously authorized service;
(3) The service was ordered by an authorized provider;
(4) The period covered by the original authorization has not expired; *and*
(5) The enrollee timely files for continuation of benefits (that is, the enrollee requests continuation of benefits on or before 10 calendar days of the health plan sending the notice of adverse benefit determination).

If these conditions are met, the benefit must continue until the enrollee withdraws the appeal or fair hearing request, the enrollee does not request a state fair hearing within 10 calendar days after the health plan sends notification of its adverse resolution, or the state fair hearing is decided against the enrollee.

When an appeal or state fair hearing is concluded adverse to the enrollee, the MCO, PIHP, or PAHP can recover the costs of the services furnished to the enrollee during the pendency of the review, to the extent benefits were furnished "solely because of the requirements of this section" and to the extent it is consistent with *state* policy.[23]

Continuation of benefits was of the utmost importance to NHeLP and state advocates with whom we have been working. As the Supreme Court has recognized, low income people have a "brutal need" for continued benefits pending appeal that rises to the level of a constitutional protection.[24] However, health plans have been using prior authorization to undercut this entitlement. Prior to this regulation, a health plan would approve a set amount of a service, for example 60 days of home health, and at the end of the 60-day period say that the

[23] *Id.* at § 438.424(d); see 81 Fed. Reg. at 27516 ("[I]f the state does not exercise the authority for recoupment under §431.230(b) for FFS [fee for service], the same practice must be followed by the state's contracted MCOs, PIHPs, and PAHPs.").
[24] *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970).

enrollee had received the entire service (60 days of home health) with no right to continued benefits. Any request for additional home health was treated as a new service request. This construct was particularly harmful to Medicaid enrollees with chronic and disabling conditions that are not going to go away. With this new regulation, so long as the preconditions noted above are met, services must continue.[25]

Implementation will be critical. Advocates should particularly focus on the following points:

- While providers can act as an authorized representative for most purposes, the regulations do not allow the provider to request continued benefits. Thus, the right to continuation and the process for exercising the right must be consistently and clearly explained in written policies, contracts, enrollee handbooks, and notices aimed at enrollees and authorized representatives.
- The continuation of benefit requirements can be confusing, so reference to the regulatory preamble may be helpful as the regulation is implemented at the state and plan levels.[26] Under these requirements, an enrollee may request continuation of benefits *before* the enrollee requests an appeal. Managed care plans should specify in their notice that both the appeal and request for continuation of benefits may be filed concurrently.[27]
- One condition of continued benefits is that the original period of authorization has not expired. Advocates should make sure that providers, enrollees, and authorized representatives understand this requirement and that enrollees receive clear instruction as to its existence. This requirement will be particularly difficult to meet if the managed care plan does not provide the notice 10 calendar days before the termination or reduction as the regulation requires. However, as CMS verifies in the preamble, as revised, § 438.420 means that, in this situation, the enrollee has longer than the original authorization period to file the request for continued benefits. CMS illustrates:

  > [T]he enrollee's original authorization period expires on the 30th day of the month and the managed care plan mails the notice of the adverse benefit determination on the 29th day of the month. The enrollee would have until the 9th day of the following month, which exceeds the period of the original authorization period, to timely file a request for continuation of benefits.[28]

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[25] See 81 Fed. Reg. at 27636 (noting that under the 2002 regulatory preamble, if the plan did not authorize additional days, ending treatment as provided by the original authorization would not constitute a termination triggering the right to continued benefits. "For purposes of the continuation of benefits under this regulation, however, the removal of paragraph (c)(4) means that an enrollee must continue to receive benefits without interruption, if elected by the enrollee, through the conclusion of the SFH [state fair hearing] process if the enrollee appeals an MCO's, PIHP's, or PAHP's adverse benefit determination.")

[26] *See*, *e.g.*, 81 Fed. Reg. at 27,632 (stating that the regulatory changes mean that an enrollee must continue to receive benefits without interruption if the enrollee elects to continue benefits and that this change applies to all authorized services covered by the MCO, PIHP, or PAHP); *Id*. at 27,637 ("Whether the first or a latter authorization is in effect is itself immaterial so long as an authorization for the services that is subject to the adverse benefit determination has not expired or lapsed at the time of the enrollee's timely filing of a request for continuation of benefits [i.e., a request within 10 days of receiving the notice of an adverse benefit determination].")

[27] *See* 81 Fed. Reg. at 27637 (encouraging plans to include concurrent filing specifications).

[28] 81 Fed. Reg. at 27637.

- The regulations do not include a provision requiring states to notify the health plan when one of their enrollees has requested a state fair hearing. However, without this, the managed care plan might improperly allow services to lapse. CMS refused to amend the final regulations to address this problem but did agree with the concern and "encourages states" to review their policies and procedures for notifying plans of a state fair hearing request.[29]
- Advocates should ensure that policies address this gap.
- Policy and contracts should be clear that health plans can recover the cost of continued benefits only to the extent that the state does so. The policies should be clear that if a court has ordered continued benefits then recoupment cannot occur because the benefits are not being continued solely because of the federal regulation. And when recoupment is allowed, CMS's preamble encourages states and managed care plans to establish manageable repayment plans and to have monitoring mechanisms in place to ensure that plans are not taking punitive or negative actions against enrollees or engaging in excessive or abusive recoupment practices.[30]

Be aware that CMS took steps to address problems with service lapses at the front end as well, namely with respect to service authorization policies. Among other things, the final regulations provide that, when processing requests for initial and continuing services requests, "the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures that … [a]uthorize LTSS [long term services and supports] based on an enrollee's current needs assessment and consistent with the person-centered service plan."[31]

Effectuation of reversed appeal resolutions (42 C.F.R. § 438.424)

If the managed care plan or state fair hearing reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must "authorize or provide" the services as expeditiously as the enrollee's health condition requires and no later than 72 hours from the date it receives the notice of reversal. If the MCO, PIHP, PAHP, or fair hearing reverses a decision to deny authorization of service and the enrollee received the services while the appeal was pending, the MCO, PIHP, PAHP or State must pay for those services.[32]

Effectuation of reversals will be critical to enrollees in managed care plans, and advocates should work for clear policies. Unfortunately, this regulation could create and perpetuate a serious problem that current enrollees encounter, namely the situation where the managed care plan simply authorizes the service but then does nothing to actually provide the service. This is particularly troubling because the reversal makes official the enrollees' need for the service and Medicaid's coverage of it; however, it leaves the managed care plan to

[29] 81 Fed. Reg. at 27,638.
[30] *See* 81 Fed. Reg. at 27,638.
[31] 42 C.F.R. § 438.210(b)(2)(iii).
[32] *See also* 81 Fed. Reg. at 27521 ("If an enrollee paid for such services himself or herself, the enrollee must be reimbursed.")

continue to be paid (ahead of time) for providing the service but not doing so. State policy and contracts must therefore make it clear that the service actually needs to be provided to the enrollee.

Conclusion

The grievance and appeal regulations seek to modernize the Medicaid managed care procedures and protect beneficiary rights to due process. A number of opportunities exist for state advocates to strengthen or clarify the final regulations. NHeLP recommends the following activities:

- Monitor development of policies, contracts, practices, and implementation to ensure:
    - health plans acknowledge receipt of grievances and appeals in writing,
    - beneficiaries are required to exhaust only one level of in-plan appeal,
    - broadest possible implementation of the deemed exhaustion provision,
    - there are specific requirements for timely and adequate notices and uniform notice,
    - handbooks and notices inform enrollees of their rights to accessible information and the means to obtain it,
    - appeal decisions and notices are issued as expeditiously as the enrollee's condition requires, and
    - rights to external medical review, if any, are protected.
- Provide clear instructions to plans, providers, and enrollees regarding expedited service authorizations.
- Advocate with state agencies and plans to ensure that they do not improperly limit the scope of evidence admissible at appeal.
- Press states for full public disclosure of grievances and appeals, including reports with detailed information about numbers, subject matter, expedited appeals, and extension of timeframes for resolution.
- Counsel enrollees to keep a record of all relevant information about the initial filing of appeals.
- Monitor implementation of the crucial right to continued benefits pending appeal and ensure that states and plans observe the improved and expanded protections.

For more information on implementing these tips, please contact the National Health Law Program.