NHeLP
NATIONAL HEALTH LAW PROGRAM

101 East Weaver St.-Suite G-7
Carrboro, NC 27510
(919) 968-6308
Fax (919) 968-8855

Issue Brief
Appeal Rights and Medicaid Benefit Reductions[1]

produced by
Jane Perkins

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I. Introduction

This Issue Brief will discuss appeal rights that apply when Medicaid services are reduced or terminated, with particular focus on prior authorization practices. Lawyers often call these appeal rights, "due process." As discussed herein, "due process" refers to constitutional and statutory requirements for the state to provide Medicaid enrollees with written notice and an impartial hearing before it denies, reduces or terminates Medicaid-covered services. After providing background and case-based illustration of the types of problems that are occurring as states introduce service restrictions, the Issue Brief will summarize the legal requirements for due process and offer recommendations for assuring due process.

II. Background on services restrictions and prior authorization

As the economic recession continues, states are searching for ways to reduce Medicaid expenditures. Medicaid services are being scrutinized for elimination or reduction and for application of more restrictive utilization controls. In fiscal year 2010, 20 states reported such benefit modifications to the Kaiser Commission on Medicaid and the Uninsured—the largest number of states reporting restrictions in one year since the Commission initiated annual surveys of state Medicaid programs in 2001. *See* Kaiser Comm'n on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid at* 3 (Oct. 2010), *available at* www.kff.org/medicaid/upload/7580-07.pdf. Most of the reported changes involved utilization controls, particularly for therapeutic, personal care, and dental services. *Id.*

One of the utilization controls commonly implemented by states is prior authorization. A number of states are seeking to more aggressively employ its use. Prior authorization requires the health care prescriber to obtain approval from the state Medicaid agency or its contractor before providing the care or treatment. Prior authorization can be applied to a range of Medicaid services, from inpatient hospital services to home health services and outpatient prescription drugs.

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Despite its widespread use, prior authorization has received little attention in the research literature. A 2003 study of prescription prior authorization programs by the Kaiser Commission concluded that

> [t]here appears to be limited monitoring of the effects of prior authorization on beneficiaries and providers at the state level. Thus, although some basic information is available about issues such as waiting times for decisions, in most states virtually nothing is known about the effect of prior authorization on individual beneficiaries' access to appropriate, medically necessary medications.

Kaiser Comm'n on Medicaid and the Uninsured, *Prior Authorization for Medicaid Prescription Drugs in Five States: Lessons for Policy Makers* at 1 (Apr. 2003) (studying programs in California, Georgia, Oklahoma, Oregon, and Washington). As noted by the Commission, an audit of California's Medi-Cal prior authorization program raised issues about timeliness of decision-making on prior authorization requests but found only "very small numbers" of appeals of denials. *Id.* at 22. The problems noted in California are not unique to that state.

In 2006, the North Carolina Medicaid agency contracted with a private company to conduct prior authorization of behavioral health services, including community support services, intensive in-home services, home and community-based waiver services, psychologist services, and inpatient/residential care. The prior authorization period for these services ranged from 60 days to a year.

Medicaid enrollees experienced significant reductions and loss of covered services. Early in 2008, they filed a lawsuit *McCartney v. Cansler,* No. 7:08-cv-00057-H (E.D.N.C.), alleging that the reductions and terminations were being made without adequate notice to enrollees and without allowing them the opportunity to explain to an impartial decision-maker why the decision was wrong. The following case example, taken from allegations set forth in the amended complaint, illustrates the problems:

> DM is a 12-year-old Medicaid enrollee diagnosed with Fragile X syndrome, autism, and epilepsy. Prior to 2007, DM was authorized to receive Medicaid services, including doctor visits, prescriptions, case management, rehabilitative care, personal care, and 34 hours per week of community support services (CSS).
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> In May of 2007, DM's case manager submitted a prior authorization form to the private contractor requesting reauthorization of the CSS for an additional 60-days. Over a month later and following repeated telephone calls, the contractor telephoned the case manager and informed her that DM would be authorized for only 21 hours per week of CSS from June 9, 2007 until July 27, 2007. No written notice of the reduction was provided. Meanwhile, on June 27th the case manager submitted a request for continued services for the next authorization period. Three weeks later, the contractor sent a written notice to DM and his case manager approving CSS for the 60-day period (July 28-Sept. 21), but for fewer hours than were requested. The written notice contained confusing information, but DM's mother appealed the reduction in hours. The contractor and Medicaid agency then instructed DM's case manager not to send any requests for reauthorization of services while the appeal was pending. However, an appeal was never heard. In early December of 2007, DM's mother and case manager participated in a telephone conference with a hearing officer for the Medicaid agency who stated that, if a hearing were to occur, the only issue would be whether Medicaid had made the correct decision in reducing DM's

hours between July 28 and September 21. The hearing could not address DM's current or future needs for CSS, and evidence concerning current or future needs would not be accepted. Based on this conversation, DM's mother dismissed the appeal because it would have been meaningless.

On December 21st, DM's case manager submitted another prior authorization request for continued CSS. A month later, the case manager contacted the contractor and was told that DM's appeal had been dismissed and there was no authorization for DM to receive any CSS services. The contractor instructed the case manager to withdraw the December 21st request and to obtain approval for another service—1.25 hours per week of case management.

After DM lost his CSS, his behavior worsened considerably. He began having multiple tantrums per day at school. In February 2008, DM was put into handcuffs by a police officer at the school because his teachers did not know how to calm him. Thereafter, DM's case manager submitted yet another prior authorization request, for 21 hours per week of CSS. The contractor telephoned her, informing her that the request would be denied, that DM would be approved for five hours per week of CSS for a short period of time and that, during that time, DM should make appointments to obtain evaluations—even though, as the case manager explained, DM had already had those evaluations. About two and one-half weeks later, the contractor issued a written notice of its decision. Again, the notice was confusing. Among other things, it did not cite the legal authority forming the basis for the decision. It also included a checklist of "alternative services" as a basis for the denial; however, the contractor had already been informed by the case manager that these "alternatives" were clearly inappropriate for or unavailable to DM.

During telephone conversations occurring over the time period described above, utilization reviewers discouraged DM's providers from requesting services or encouraged them to withdraw requests for the services that they had prescribed. Also over this time period, the contractor's decisions to reduce and terminate services were made without requesting information from treating clinicians, giving weight to the opinions of those treating clinicians, or making any findings that DM's condition had medically improved. It also appeared that the private contractor was basing its decisions to reduce and terminate DM's services on unpromulgated, internal guidelines about how many hours would be approved.

The *McCartney* case was filed to address these problems, which clearly affected all aspects of the coverage decision: (1) the initial decision-making process (e.g. application of secret coverage standards); (2) access to the hearing process (e.g. improper notices, oral discouragement); and (3) the hearing itself (e.g. improper dismissals of hearing requests, delays in hearings, refusal to provide *de novo* hearings).

III. Legal Requirements

It has long been recognized that Medicaid enrollees have a property interest in Medicaid benefits. *See generally Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972) (noting that property interests subject to due process are created by "existing rules or understandings that stem from an independent source such as state law—rules or understandings that secure certain benefits and that support claims of entitlement to those benefits"). Because they have a property interest, Medicaid enrollees' benefits are protected

by the Due Process Clause of the U.S. Constitution. See U.S. Const., amend. XIV, § 1; *Goldberg v. Kelly*, 397 U.S. 254 (1970) (holding that when welfare benefits are terminated, the recipient has due process rights to an effective notice and pre-termination hearing); *Mathews v. Eldridge*, 424 U.S. 319 (1976) (holding due process rights vary among property interests and the specific dictates require consideration of, first, the private interest affected by the action; second, the risk of an erroneous deprivation of that interest through the procedures being used and the probable value of additional procedures; and third, the government's interest, including the fiscal and administrative burdens the additional procedural requirement would entail).

The Medicaid Act and implementing regulations also require states to provide the opportunity for a fair hearing when an individual's claim for assistance is denied or not acted on with reasonable promptness. *See* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250; 42 C.F.R. § part 438 (complaint procedures for managed care systems); *see also Id.* at § 431.205(d) (explicitly requiring hearing system to meet *Goldberg* standards). For a recent case, finding § 1396a(a)(3) creates federal rights enforceable under 42 U.S.C. § 1983, *see McCartney v. Cansler,* 608 F. Supp. 2d 694, 698-99 (E.D.N.C. 2009), *aff'd on other grounds*, 382 Fed. Appx. 334 (4th Cir. 2010).

Due process rights apply to actions affecting mandatory and optional Medicaid services. *See generally Md. Dep't of Health & Mental Hygiene v. Brown*, 935 A.2d 1128, 1145 (Md. Ct. App. 2007) (noting federal and state Medicaid fair hearing rights apply to optional and mandatory services). Due process also attaches to requests for prior authorization and continued benefits. *See Ladd v. Thomas*, 962 F. Supp. 284 (D. Conn. 1997), *same case*, 14 F. Supp. 2d 222 (D. Conn. 1998); *Perry v. Chen*, 985 F. Supp. 1197 (D. Ariz. 1996); *Kessler v. Blum*, 591 F. Supp. 1013 (S.D.N.Y. 1984). *Compare Kapps v. Wing,* 404 F.3d 105, 115 (2d Cir. 2005) (noting "every circuit to address the question … has concluded that applicants for benefits, no less than current benefits recipients, may possess a property interest in the receipt of public welfare entitlements") *with Schreur v. Dep't of Human Services,* _ N.W.2d. _, 2010 WL 2505921 (Mich. App. Jun. 22, 2010) (holding due process protections outlined in *Goldberg* apply only to Medicaid recipients and not applicants for benefits).

As commonly understood, due process requires:

(1) Written notice prior to the date of an intended action

If the Medicaid agency intends to take an action that is adverse to a recipient, he or she must receive advance written notice of the intended action. An adverse action includes the termination, suspension or reduction of Medicaid covered services. *See* 42 C.F.R. § 431.201.

When the intended action involves termination, suspension, or reduction of services (as opposed to an initial request for services), the notice generally must be sent at least ten days before the date of the action and inform the individual of how he can receive continued benefits pending the outcome of the an appeal (sometimes called aid paid pending). *See Id.* at §§ 431.206, 431. 211, 431.214. *But see Id.* at § 431.213 (specifying circumstances when same-day notice can be used). *See Perry*, 985 F. Supp. at 1203 (requiring managed care contractors to inform individuals of rights to aid paid pending)

The notice must be "reasonably calculated, under all the circumstances," to inform the individual of the action being taken and "be of such a nature as reasonably to convey" information regarding the right to appeal. *Mullane v. Central Hanover Bank & Trust Co*., 339 U.S. 306, 314 (1950); *see Goldberg,* 397 U.S. at 267-68 (requiring welfare recipients to receive "timely and adequate notice detailing the reasons for a proposed termination").

The notice must contain a statement of the intended action, reasons for the action, specific legal support for the action, and an explanation of the individual's hearing rights. *See Id.* at § 431.206, 431.210. *See, e.g., V.L. v. Wagner,* 669 F Supp. 2d 1106, 1120-21 (N.D. Cal. 2009) (finding plaintiffs likely to succeed on due process claim where individuals with disabilities and/or inability to read English would not be able to understand "difficult to read" notices of reductions in Medicaid-covered in-home support services); *Ortiz v*. *Eichler*, 616 F. Supp. 1066 (D. Del. 1985) (holding adequate notice must include the specific regulations supporting the action and an explanation of the reasons for the intended action), *aff'd*, 794 F.2d 889, 892 (3d Cir. 1986) (requiring notice to include "detailed individualized explanation of the reason(s) for the action being taken, … in terms comprehensible to the claimant," including calculations used to make the decision).

It is not enough for the notice to be a generic form that identifies possible reasons for the action. *See generally Gray Panthers v*. *Schweiker*, 652 F.2d 146, 167-68, n. 44 (1980) (rejecting agency-approved Medicare notices that failed to inform beneficiaries which of two different reasons for the decision applied). In *Baker v. Dep't of Health & Soc. Services*, the Alaska Medicaid agency had implemented a 13-page Personal Care Assessment Tool (PCAT) for state-contracted nurses to use to determine eligibility. 191 P.3d 1005 (Alaska S. Ct. 2008). In the months following introduction of the PCAT, over 900 individuals experienced reductions of services. Affected individuals complained that the written notices they received did not convey critical data that would allow them to appeal the determination. Citing *Goldberg*, the court ruled for the plaintiffs. The court rejected the agency's argument that "notice" should be broadly construed to include not only the written notice but also other information enrollees received about the assessment process. Because the plaintiffs were welfare recipients, the court found that the agency needed to go to "greater lengths—incurring higher costs and accepting inconveniences—to reduce the risk of error" and to "be as transparent as possible in its methodology." *Id.* at 1010-11.

(2) A pre-termination hearing before an impartial hearing officer

An individual must be allowed a reasonable time to request a hearing. The agency can require the request to be in writing. *See* 42 C.F.R. § 431.221. *But see Angelo v. Toia*, 402 N.Y.S.2d 881 (N.Y. App. Div. 1978) (statute of limitations for requesting hearing tolled when agency fails to comply with notice requirements).

If the individual requests a hearing, he or she must generally be given recourse to the hearing process. Federal regulations provide an exception for automatic changes in coverage due solely to a change in state or federal law. In these instances, the state agency must provide notice of the change but not a fair hearing. *See* 42 C.F.R. § 431.220(b); *see also Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 997 (N.D. Cal. 2010) (refusing to allow agency to "pass the buck" to private contractors and finding plaintiffs likely to succeed on due process claim where agency planned no pre-termination notice of reduction of Medicaid-covered adult day services). *Compare Rosen v. Goetz*, 410 F.3d 919 (6th Cir. 2005) (refusing to require pre-termination hearings for all affected recipients when change in coverage resulted from change in state law) *with Harriman v. Dep't of Children & Families*,

867 So.2d 1264 (Fla. Ct. App. 2004) (requiring hearing when claimant challenged termination of benefit for reasons other than the change in law automatically affecting her benefits).

Prior to the hearing, the individual must have an opportunity to examine his or her case file, as well as all policies and documents that form the basis for the decision. *See* 42 C.F.R. § 431.242. In other words, the decision must be based on "ascertainable standards." *Holmes v. New York City Hous. Auth.,* 398 F.2d 262, 265 (2d Cir. 1968). In *Salazar v. District of Columbia*, a federal district court recently required a managed care company to disclose the clinical coverage guidelines it uses to deny services even though the company claimed the guidelines were protected trade secrets. 596 F. Supp. 2d 67 (D.D.C. 2009), *modified by*, _ F. Supp. 2d _, 2010 WL 4553534 (D.D.C. Nov. 12, 2010). *See also* 42 C.F.R. §§ 438.10(f)(6)(v) (requiring state and managed care contractors to provide all enrollees information about amount, duration and scope of benefits in sufficient detail to ensure that enrollees understand the benefits to which they are entitled). *See generally Morton v. Ruiz,* 415 U.S. 199, 232 (1974) ("No matter how rational or consistent with congressional intent a particular decision might be, the determination of eligibility cannot be made on an *ad hoc* basis by the dispenser of the funds."). For additional discussion, *see* Jane Perkins, National Health Law Program, *Q & A: Due Process Issues with Private Contractors* (Oct. 2008) (available from TASC or NHeLP).

The hearing must be fair, meaning that it must occur at a "reasonable time, date and place" and be conducted by an impartial hearing officer. 42 C.F.R. § 431.240; *see, e.g., Schweiker v. McClure*, 456 U.S. 188 (1982) (impartial hearing officer a necessary prerequisite). The hearing must provide the individual with "an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally." *Goldberg*, 397 U.S. at 268; *see also Ortiz,* 794 F.2d at 895-96 (hearing officer could not admit into evidence or consider statements by witnesses who were not present at hearing for confrontation by the claimant); *see also* 42 C.F.R. § 431.242. For additional discussion, *see* Robert P. Capistrano, *Making the Fair Hearing More Fair*, 44 CLEARINGHOUSE REV. J. OF POV. L. & POL. 96 (July-Aug. 2010).

The hearing decision must "rest solely on the legal rules and evidence adduced at the hearing." *Goldberg*, 397 U.S. at 271. The recipient should be able to obtain a *de novo* hearing when either a local evidentiary hearing or an agency's decision on the application is appealed. *See* 42 C.F.R. §§ 431.232, 431.233 (requiring *de novo* hearing on appeal from local evidentiary hearing); *see Curtis v. Roob*, 891 N.E.2d 577, 280 (Ind. Ct. App. 2008) (allowing plaintiffs to proceed with due process complaint against state policy prohibiting claimants from offering at the appeal hearing evidence of disability not contained in the initial application or considered by the agency). The right to a *de novo* hearing is crucial and should not be confused with *de novo* review. Under *de novo* review, the hearing officer steps into the shoes of the previous decision-maker, reviews the same evidentiary record and decides whether the decision was right or wrong. By contrast, a *de novo* hearing is not limited to the existing record, so new evidence and argument can be introduced. *Cf. Murphy v. Curtis,* 930 N.E.2d 1228 (Ind. Ct. App. 2010) (holding *de novo* hearing must include additional evidence relevant to Medicaid disability decision under review but need not include open-ended inquiry into every conceivable condition that claimant might have).

The right to present evidence orally does not necessarily extend to presenting the evidence to the hearing officer in person. Some states have recently begun to conduct hearings telephonically, and challenges to these practices have not generally been successful. *See Murphy v. Terrell*, _ N.E.2d _, 2010 WL 5123719 (Ind. Ct. App. Dec. 16,

2010) (collecting cases and holding unsuccessful applicants for Medicaid disability benefits do not have a constitutional right to an in-person administrative hearing).

Noting welfare recipients' "brutal need" for benefits, the Supreme Court has required a hearing to occur before benefits are terminated or reduced. *Goldberg,* 397 U.S. at 261; *id.* at 264 (holding "termination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits"). *See* 42 C.F.R. §§ 431.210.431.230 (requiring continued benefits pending outcome of hearing); *but see Id.* at § 431.230(b) (allowing agency to recover costs of continued benefits from the recipient if its decision is sustained).

The hearing decision must be provided in writing to the claimant, within 90 days of the date of the request for a hearing, and it must inform the individual of the reason for the decision and any additional administrative or judicial review that is available. 42 C.F.R. § 431.244. *See Shifflett v. Kozlowski,* 843 F. Supp. 133 (W.D. Va. 1994) (enjoining state Medicaid agency to comply with federal regulation's 90–day deadline); *compare Dickinson v. Daines*, 15 N.Y.3d 571 (N.Y. Ct. App. 2010) (holding violation of 90-day deadline does not require state to pay Medicaid benefits and noting limit may be enforced by a lawsuit to compel issuance of a decision); *Cloninger v. N.C. Dep't of Health & Human Services,* 691 S.E.2d 127, 131 (N.C. Ct. App. 2010) (finding constitutional due process rights not violated by failure to meet deadline where petitioner failed to take advantage of statutory right under N.C. Gen. Stat. § 150B-44 to compel the hearing officer to take action).

Finally, constitutional and statutory due process rights should not be ignored when a state implements a utilization control procedure such as prior authorization. Nevertheless, some states have refused to provide either continued benefits or appeal rights at the end of an authorized period of coverage, arguing that the individual has received the service—90 days of personal care services, for example—and, thus, further coverage requests are treated as initial requests (without continued benefits if there is an appeal). A case from Texas illustrates the dilemma this practice creates.

Jonathan C. was a nine-year-old boy who needed ongoing private duty nursing (PDN) services to address significant disabilities. In 2000, he was found eligible for Medicaid and PDN services, which were prior authorized in 60-day time periods. In 2004, when Jonathan's health care providers submitted a request for continuation of PDN (Sept.-Nov.), the Medicaid agency approved coverage but authorized a reduced number of PDN hours per week. Jonathan's mother appealed. While the appeal was allowed, the issue was limited to whether the services were correctly reduced during the specific 60-day time period covered by the prior authorization request (Sept.-Nov.). Jonathan withdrew the request because the hearing officer would not have time to render a decision before the last day of the prior authorization period. Instead, Jonathan's health care providers quickly submitted another authorization request for the November to January time period. Again, the state authorized reduced coverage, and Jonathan's mother appealed. The hearing was held in November. The hearing officer overturned the prior authorization decision in early December, approving the originally requested PDN service hours for the remainder of the prior authorization period. However, when the next prior authorization request was submitted, the agency again approved coverage at the reduced rate. At this point, Jonathan C. filed suit in federal court, because he could have

> continued to request a fair hearing, and even win those hearings, yet his nursing services would have been denied or reduced until the hearing decision were rendered,

> and, at best, he might have had a few days or weeks of services restored, if any at all, and Texas Medicaid could have denied each and every subsequent request for prior authorization periods thereafter.

Jonathan C. v. Hawkins, Civ. No. 9:05-CV-43, 2006 WL 3498494, *4 (E.D. Tex. Dec. 4, 2006). The court decided the case in favor of Jonathan. The court found "no [prior authorization] exception" to a federal Medicaid regulation that requires the state to mail written notice at least ten days prior to the adverse action and to maintain benefits if a hearing is requested. *Id.* at *8 (citing 42 C.F.R. §§ 431.211, 431.230); *see also id.* at *14 (refusing deference to an old federal agency letter). The court also held the Medicaid agency ran afoul of *Goldberg's* constitutional requirements to provide enrollees with a pre-termination hearing—noting that right must operate in the prior authorization context so that a favorable decision will actually result in the claimant's benefits being restored. Finding it a "distinction without a difference," the Court rejected the state's argument that Jonathan's situation was distinguishable from *Goldberg* because he was not entitled to future services that had not yet been authorized. *Id.* at *12 (discussing *Goldberg* and citing *Ladd,* 962 F. Supp. 284).

IV. Recommendations for assuring due process

When across-the-board or individual service reductions or restrictions occur, the state Medicaid agency and its contractors must adhere to the due process protections outlined above. As noted, *McCartney v. Canlser* was filed in federal district court in North Carolina on April 7, 2008, in part to address DM's problems, which were described above in Section II. The parties recently entered into a settlement agreement that includes a detailed set of procedures the state Medicaid agency will implement. *See McCartney*, Civ. No. 7:08-cv-57-H (Settlement Agreement filed Oct. 14, 2010 and approved Nov. 10, 2010). As noted in the agreement, the goal of these procedures is to

> provide uniformity across the Medicaid program, eliminate situations where a Medicaid recipient experiences an inadvertent break in service, and ensure that Medicaid recipients are provided with due process to which they are entitled under federal and state law.

Id. at Exh. B (*North Carolina Dep't of Health and Human Services Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures* at 1). While the procedures are tailored to the Medicaid program in North Carolina, they are recommended for other state programs as well. They include:

1. *Notice of adverse decisions.* Adverse decisions on initial requests for services, continuation requests and request for prior approval will be made in writing and mailed to the Medicaid recipient or his/her parent or legal guardian.

To assure that the required information is provided uniformly to all actions, form notices will be used by the Medicaid agency and contractors. The parties developed six notices:

- Notice of Decision on Initial Request for Medicaid Services—Adult
- Notice of Decision on Initial Request for Medicaid Services—Child**
- Notice of Change in Services—Adult
- Notice of Change in Services—Child**

- Notice of Denial of Services Request—Additional information previously requested and not received
- Notice of Change in Services—Additional information previously requested and not received

** The notice is for recipients under age 21 and provides additional explanation about coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

Among other things, all of the notices will provide the specific reason(s) for the intended action, citation to the specific legal authority for the action, and, where applicable, an explanation of the right to continued benefits. Instructions clearly inform the individual who is preparing the notice that "[a] statement that medical necessity was not met or the EPSDT standard was not met is not a sufficient explanation." *Id.* at 9. The notices of action contain a Medicaid Services Hearing Request Form to request a hearing,

2. *Avoiding discouragement and intimidation*. Prior to the decision on a request for prior approval, contacts with the requesting provider or recipient (including telephone and e-mail contacts) will be limited as needed to obtain more information about the service request and/or to provide education about Medicaid-covered services. The provider or recipient will not be asked to withdraw or modify a request for prior approval, to accept a lesser number of hours, less intensive type of services, or to modify a clinical assessment. Neither the state nor its agents will provide misinformation to or intimidate providers or recipients so as to discourage them from requesting Medicaid services, the continuation of Medicaid services, or the filing or prosecuting of an administrative appeal. Scripted language will be read to or provided in writing at the beginning of contacts with a provider or recipient. For example, the following script will be used when speaking with providers:

> We have received a prior authorization request for [NAME OF RECIPIENT] and would like to discuss it with you. Nothing in this conversation is intended to discourage you from continuing with the request you have submitted. Your patient has the right to a written notice and a hearing if we deny the request and to authorization for payment for services during the appeal process if this request involves a service your patient is currently receiving. I cannot ask you to withdraw the request you have submitted or to modify the request to accept a lower amount, level, or type of service. I am calling because, at this time, we do not have enough information to approve this request. If you have additional information that you have not submitted that you think would support your request, please tell me about it now.

4. *Continued benefits.* Procedures will be implemented and followed to ensure that medically necessary services will continue uninterrupted across authorization periods and that, if a re-authorization request is denied or reduced, the individual can exercise their right to continued benefits pending an appeal. The procedures are set forth in *North Carolina Dep't of Health and Human Services Medicaid Recipient Due Process Rights and Prior Approval Policies and Procedures* (Settlement Agreement, Exh. B)

The prior authorization procedures place the first responsibility upon the recipient's provider and treating clinicians to demonstrate medical necessity. As in most states, North Carolina's Medicaid program makes heavy use of electronic processing. Whenever possible, providers are to submit requests for prior approval of outpatient/community-based/ambulatory services electronically, using the forms and fields provided by the

utilization reviewer. Providers can supplement the information if they believe the form is insufficient (for example with evaluation reports, treatment records, or letters of explanation).

Utilization reviewers will consider all relevant information that is submitted. So that prior authorization requests will be considered using ascertainable standards, utilization reviewers will make "individualized medical necessity decisions based on the individual representations of each prior authorization request and the applicable law and policy, will use publicly available utilization review and best practice guidelines, and will allow case-by-case exceptions to those guidelines and policies as required by EPSDT." *Id.* at 3.

The system is designed to allow benefits to be reauthorized without interruption so long as the provider submits the request for continuation of the service at least 10 calendar days *prior to* the end of the current authorization period. If the request for reauthorization is submitted after the end of the current authorization period, the request is treated as initial request.

> Example: DM is authorized to receive 8 units of service each week for a 90-day period running June 1-August 31. A request for reauthorization of the 8 units is submitted on August 15. The utilization reviewer issues a decision approving the request on September 4. Authorization will be entered into the system retroactive to September 1.
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> Example: DM is authorized to receive 8 units of service each week for a 90-day period running June 1-August 31. A request for reauthorization of the 8 units is submitted on August 28. The utilization reviewer issues a decision approving the request on September 4. Authorization will be entered into the system September 4 for 90 days, but the service will not be authorized from September 1-3.

The procedure is also designed to provide continued benefits to recipients who appeal the termination or reduction of a previously approved service. Importantly, this right does not depend on whether the provider submitted the authorization request 10 days before the end of the authorization period *so long as* that request was made before the end of the authorization period.

> Example: DM is authorized to receive 8 units of service each week for a which the authorization ends on August 31. On July 20, the provider submits a request for 8 units of the service per week to continue for 90 more days. The utilization reviewer issues a notice of decision denying the request on September 4. Authorization for 8 units per week will be entered into the system effective retroactive to September 1 through September 14 (10 days from the date of the notice). If an appeal is requested within 10 calendar days of the notice of decision, authorization for 8 units will continue until the final agency decision.
>
> Example: DM is authorized to receive 8 units of service each week for a 90-day period running June 1-August 31. A request for reauthorization of the 8 units is submitted on August 28. On September 4, the utilization reviewer issues a decision approving only 4 units of service. Authorization for 8 units of service will be entered into the system effective September 4 for 10 days, and authorization for 4 units per week for 90 days will be entered effective September 15. The service will not be authorized from September 1-3. If an appeal is requested within 10 calendar days of

the notice of decision, authorization for 8 units will be reinstated until there is a final agency decision.

Example: DM was authorized to receive 8 units per week of a service for which the authorization ends on July 31. On July 31, the provider submits a request for 8 units of the service per week to continue for 90 more days. The request is denied in a notice dated August 10 to be effective 10 days later on August 20. The recipient appeals on August 20. Maintenance of services must be authorized for 8 units per week, effective August 20.

Example: DM is authorized to receive 8 units of service each week for a 90-day period running June 1-August 31. A request for reauthorization is submitted on September 3. The utilization reviewer issues a decision reducing the authorization to 4 units of service. Authorization for the service at the new level will beginning with the effective date of the notice. If an appeal is requested, services will continue at the new level pending appeal.

4. *Impartial hearings.* Administrative hearings will occur *de* novo, thus allowing the claimant to present evidence that was not necessarily considered when the initial coverage decision was made by the agency or its contractors. The right to a *de novo* hearing is addressed in the written notices of decision with the following statement:

> At the hearing, you may present new evidence, including medical records and testimony from doctors and other providers about why you need the requested services (even if you obtained it after Medicaid made its decision).

The North Carolina legislature has authorized telephone/videoconference hearings unless the individual requests an in-person hearing, so that process is also explained in the notices. The Medicaid Services Hearing Request Form includes requesting an in-person hearing.

5. *Implementation of the final decision.* When an appeal is taken and decided in whole or in part for the claimant, the final decision will be authorized for at least 20 prospective calendar days after the date of decision. The final agency decision will include a notification that a new request for prior authorization must be received by the utilization reviewer within 15 calendar days of the decision in order to avoid interruption in services.