SMMC Grievance and Appeal System and Fair Hearing Overview

Agency for Health Care Administration (AHCA)

Medical Care Advisory Committee

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Today's Presenters

D.D. Pickle - AHC Administrator for Managed Care Policy and Contract Development

David W. Nam - Chief, Office of Fair Hearings

Purpose

Provide an **overview** of:

- The Grievance and Appeal System requirements for the Statewide Medicaid Managed Care (SMMC) Program
- The requirements for filing complaints and requesting a Medicaid Fair Hearing

Overview

- The **requirements for the grievance and appeal system** are established by the federal government, Florida Statutes, and the SMMC contract.
- **All SMMC health plans must maintain a system for receiving and processing enrollee complaints, grievances, and plan appeals.** Health plans must also provide information to enrollees on requesting a Medicaid fair hearing.
- **Changes in 2016 to Florida law will transition responsibility for some Medicaid fair hearings to the Agency for Health Care Administration (AHCA).**

Terminology

- **Adverse Benefit Determination** - The denial or limited authorization of a requested service, or a reduction, suspension or termination of a previously authorized service.
- **Notice of Adverse Benefit Determination (NABD)** – A written notice sent by the health plan to the enrollee when an adverse benefit determination has been made by the plan.
- **Plan Appeal** – The review by a health plan of an adverse benefit determination.
- **Expedited Appeal** – A plan appeal that must be resolved faster than a standard appeal, due to the enrollee's health condition or other factors requiring expedited resolution.

Terminology (continued)

- **Notice of Plan Appeal Resolution –** A written notice from a plan to an enrollee resolving the enrollee's plan appeal.
- **Complaint** - Any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following business day.
- **Grievance –** An expression of dissatisfaction about any matter other than an adverse benefit determination.
- **Medicaid Fair Hearing** – The opportunity for an enrollee to present his/her case to a reviewing authority if the enrollee feels that the Agency or health plan has made an error in the enrollee's case.

Complaint

- What is a **complaint**?
  - **Any oral or written expression of dissatisfaction by an enrollee submitted to the health plan or to a state agency and resolved by close of business the following business day.**
- A complaint can be filed at any time.

Complaint: Example

- Mrs. Jones receives home delivered meals, but she does not like her home delivered meals provider because she thinks the meals are too salty. She submits this complaint to her SMMC health plan.
- Mrs. Jones' health plan offers to replace her home delivered meals provider with another provider in the network, and Mrs. Jones is satisfied. Her complaint is resolved.
- If the health plan was not able to resolve Mrs. Jones' complaint by close of business the following business day, the complaint automatically becomes a grievance.

Grievance

- What is a **grievance**?
  - **An expression of dissatisfaction about any matter other than an adverse benefit determination**.
- A grievance can be filed at any time.
- Health plans must **resolve a grievance within 90 days.**
- Enrollees do not have to file a complaint before filing a grievance. **If a complaint is filed, but is not resolved by the health plan by close of business the following business day, the complaint automatically becomes a grievance.**

Grievance: Example

- Mr. Smith had an appointment with his cardiologist. The receptionist at the cardiologist's office was new and very rude to him. Mr. Smith filed a grievance with his health plan about the rude encounter he had with the receptionist.
- Mr. Smith's health plan contacted the cardiologist's office to discuss the rude staff member.
- Mr. Smith's health plan contacted Mr. Smith to inform him that they had spoken with the provider, and to counsel him on other cardiologists available in the network.

Adverse Benefit Determination

- Sometimes, a health plan will deny an enrollee's request for a particular service, or will limit, suspend, or terminate a previously authorized service. This is called an adverse benefit determination.
- Health plans must notify enrollees of all adverse benefit determinations in writing.

Notice of Adverse Benefit Determination (NABD)

- The **NABD** is mailed to the enrollee by the health plan for standard authorization decisions **within seven days of the request for service.**
- The **timeframe can be extended up to seven additional days** if the enrollee or the provider requests extension or the health plan justifies how the extension is in the enrollee's interest.
- The **timeframe can be shortened to 48 hours** if the standard timeframe could seriously jeopardize the enrollee.

Notice of Adverse Benefit Determination (NABD) – (continued)

- The **NABD must contain the following components**:
- The adverse benefit determination and the reason it was made.
- The enrollee's right to receive case records and medical necessity criteria free of charge.
- The enrollee's right to request a plan appeal and fair hearing, and the process for exercising those rights.
- The circumstances under which a plan appeal can be expedited and how to request it.
- The enrollee's right to have benefits continue pending resolution of the plan appeal and how to request it, and the circumstances under which the enrollee may be required to pay the cost of those services.

Plan Appeal

- If an enrollee disagrees with an adverse benefit determination, the enrollee may file a plan appeal.
  - **A plan appeal is the review by a health plan of an adverse benefit determination.**
- An enrollee must **file the plan appeal within 60 days** of the date of the adverse benefit determination.
- Health plans must **resolve the plan appeal within 30 days** of the receipt of the plan appeal.

Appeal: Example

- Mrs. Jones' doctor determined that she needs a wheel chair because she has trouble walking and standing after a while.
- Mrs. Jones' health plan denies her request for a wheel chair and sends her a notice of adverse benefit determination.
- Mrs. Jones files a plan appeal. Her health plan reviews and resolves her plan appeal within the 30 day timeframe. Her health plan overturns its original decision and provides the wheel chair.

Expedited Appeal

- Sometimes, an enrollee may need their health plan to review and resolve a plan appeal request more quickly than the standard 30 day review timeframe, because the enrollee's health condition or other factors may require it.
- This **fast review is called an expedited appeal**.
- An enrollee must **file the expedited appeal within 60 days** of the date of the adverse benefit determination.
- The health plan must **resolve the expedited appeal within 72 hours** of the receipt of the expedited appeal.
- If the health plan determines that the appeal does not actually need to be expedited, the request reverts back to a standard plan appeal, and the 30 day resolution timeframe applies.

Example: Expedited Appeal

- Mr. Smith just visited his dentist, and his dentist referred Mr. Smith to an oral surgeon to have his wisdom teeth removed. After his exam with the oral surgeon, the oral surgeon determined that Mr. Smith needs all four wisdom teeth removed, and scheduled his surgery for a week later.
- Five days before his surgery, Mr. Smith's health plan sends him a notice of adverse benefit determination, informing him that the health plan will not cover the wisdom teeth removal surgery.
- Because his surgery is scheduled for five days from now, Mr. Smith files an expedited appeal with his health plan.
- Following his expedited appeal request, his health plan reviews and resolves his appeal within 72 hours. The health plan upholds its original decision, and denies the wisdom teeth removal surgery.

Medicaid Fair Hearing Request

- An enrollee may request a fair hearing when the plan appeal process is completed in the following circumstances:
  - After receiving notice that the health plan is upholding the adverse benefit determination (i.e., **after the plan appeal is denied**)
  - If the health plan **fails to meet the notice and timing requirements** for resolving a plan appeal.
- The **parties** to the Medicaid fair hearing include: the health plan, the enrollee and the enrollee's authorized representative or the representative of a deceased enrollee's estate, and in some cases, the Agency.
- The hearing officer's **final order may be appealed** by the enrollee to the Florida District Courts of Appeal.

Example: Medicaid Fair Hearing

- Mr. Smith just visited his dentist, and his dentist referred Mr. Smith to an oral surgeon to have his wisdom teeth removed. After his exam with the oral surgeon, the oral surgeon determined that Mr. Smith needs all four wisdom teeth removed, and scheduled his surgery for a week later.
- Five days before his surgery, Mr. Smith's health plan sends him a notice of adverse benefit determination, informing him that the health plan will not cover the wisdom teeth removal surgery.
- Because his surgery is scheduled for five days from now, Mr. Smith files an expedited appeal with his health plan.
- Following his expedited appeal request, his health plan reviews and resolves his appeal within 72 hours. The health plan upholds its original decision, and denies the wisdom teeth removal surgery.
- **Mr. Smith can now request a Medicaid Fair Hearing.**

Continuation of Benefits

- If a health plan terminates or reduces a benefit, an enrollee can ask the health plan to continue the benefit while their plan appeal or fair hearing is pending.
- **For benefits to continue during a plan appeal**, the enrollee or the enrollee's authorized representative must file the appeal within the required timeframe and request continuation of benefits **on or before the later of the following**:
  - Within 10 days after the notice of the adverse benefit determination is mailed; or
  - The intended effective date of the proposed adverse benefit determination.
- **For benefits to continue during a fair hearing**, the enrollee must request a fair hearing and continuation of benefits within 10 days of the notice of the adverse plan appeal resolution (i.e., the plan appeal decision).

Filing and Resolution Time Frames

Type of Action	Filing Time Frame	Resolution Time Frame
Plan Appeal	60 days from the date of the adverse benefit determination	30 days from the day the health plan receives the plan appeal
Expedited Appeal	60 days from the date of the adverse benefit determination	72 hours after the health plan receives the expedited appeal
Grievance	Can be filed at any time	90 days from the day the health plan receives the grievance
Fair Hearing	120 days after the enrollee receives notice that the health plan is upholding the adverse benefit determination (i.e., after the plan appeal is decided)	90 days from the date the enrollee filed the plan appeal (with some exceptions)

Other Requirements

- The enrollee is entitled to a free copy of his/her case file.
- Limitations exist regarding which health plan staff can make decisions on grievances and plan appeals.
- There are certain times when an enrollee may request a fair hearing before the health plan finishes its appeals process.
- The health plan is required to notify the enrollee of any delays or extensions in processing grievances or plan appeals.
- A record with required information on each grievance and plan appeal must be kept by the health plan and be accessible to the Agency.
- Health plans are required to use standard, mandatory notice templates for the NABD and notice of plan appeal resolution provided by the Agency.

Changes in the Medicaid Fair Hearing Process

Presenter:

David W. Nam - Chief, Office of Fair Hearings

Section 409.285(2), Florida Statutes - Opportunity for Hearing and Appeal

"Appeals related to Medicaid programs directly administered by the Agency for Health Care Administration, including appeals related to Florida's Statewide Medicaid Managed Care program and associated federal waivers, filed on or after March 1, 2017, must be directed to the agency in the manner and form prescribed by the agency. The department and the agency shall establish a transition process to ***transfer administration of these appeals from the department to the agency by March 1, 2017****.(a) The hearing authority for appeals heard by the Agency for Health Care Administration may be the Secretary of Health Care Administration, a panel of agency officials, or a hearing officer appointed for that purpose. The hearing authority is responsible for a final administrative decision in the name of the agency on all issues that have been the subject of a hearing. A decision of the hearing authority is final and binding on the agency. The agency is responsible for ensuring that the decision is promptly carried out."*

AHCA's New Office of Fair Hearings

- **Beginning March 1, 2017, most Medicaid Fair Hearing requests must be filed with AHCA** (when requesting a fair hearing, the notice of hearing rights provides important instructions specifying whether AHCA or the Department of Children and Families (DCF) is responsible for providing a Medicaid Fair Hearing).
- Notices of Medicaid Fair Hearing rights issued prior to March 1, 2017 identify DCF as the agency responsible for providing a Medicaid Fair Hearing.
- Notices of Medicaid Fair Hearing rights issued on or after March 1, 2017 identify AHCA as the agency responsible for providing a Medicaid Fair Hearing. (**DCF will have some limited Medicaid Fair Hearing responsibilities after March 1, 2017**).
- AHCA will be filing a Notice Of Proposed Rule related to Medicaid Fair Hearings that delineates AHCA's jurisdiction for fair hearings.

Medicaid Fair Hearings and DCF

- **On or after March 1, 2017, DCF's Office of Appeal Hearings will administer and conduct** the following Medicaid fair hearings**:**
  - All fair hearings arising from **Medicaid financial eligibility** determinations made by DCF
  - All fair hearings arising from eligibility determinations or service denials, reductions, terminations or suspensions pertaining to the **iBudget Waiver** administered by the Florida Agency for Persons with Disabilities.
  - All fair hearings arising from the **Pre-admission Screening and Resident Review,** as mandated by Section 1917(e)(7) of the Social Security Act and Title 42, Code of Federal Regulations (CFR), Sections 483.100 through 483.138, Subpart C.
  - All fair hearings resulting from **resident transfers or discharges** as those terms are defined in Section 400.0255, Florida Statutes.

Medicaid Fair Hearings and AHCA

- **On or after March 1, 2017, the AHCA Office of Fair Hearings will administer and conduct** the following Medicaid fair hearings:
  - Medicaid fair hearings directly related to **Medicaid programs directly administered by AHCA.**
  - Medicaid fair hearings related to Florida's Statewide Medicaid Managed Care **(SMMC) program and associated federal waivers, filed on or after March 1, 2017**.

Requesting a Medicaid Fair Hearing from AHCA

- Requesting a Medicaid fair hearing from AHCA will utilize AHCA's new fair hearing intake process. A **Medicaid fair hearing may be requested from AHCA's Medicaid Hearing Unit intake** by contacting:

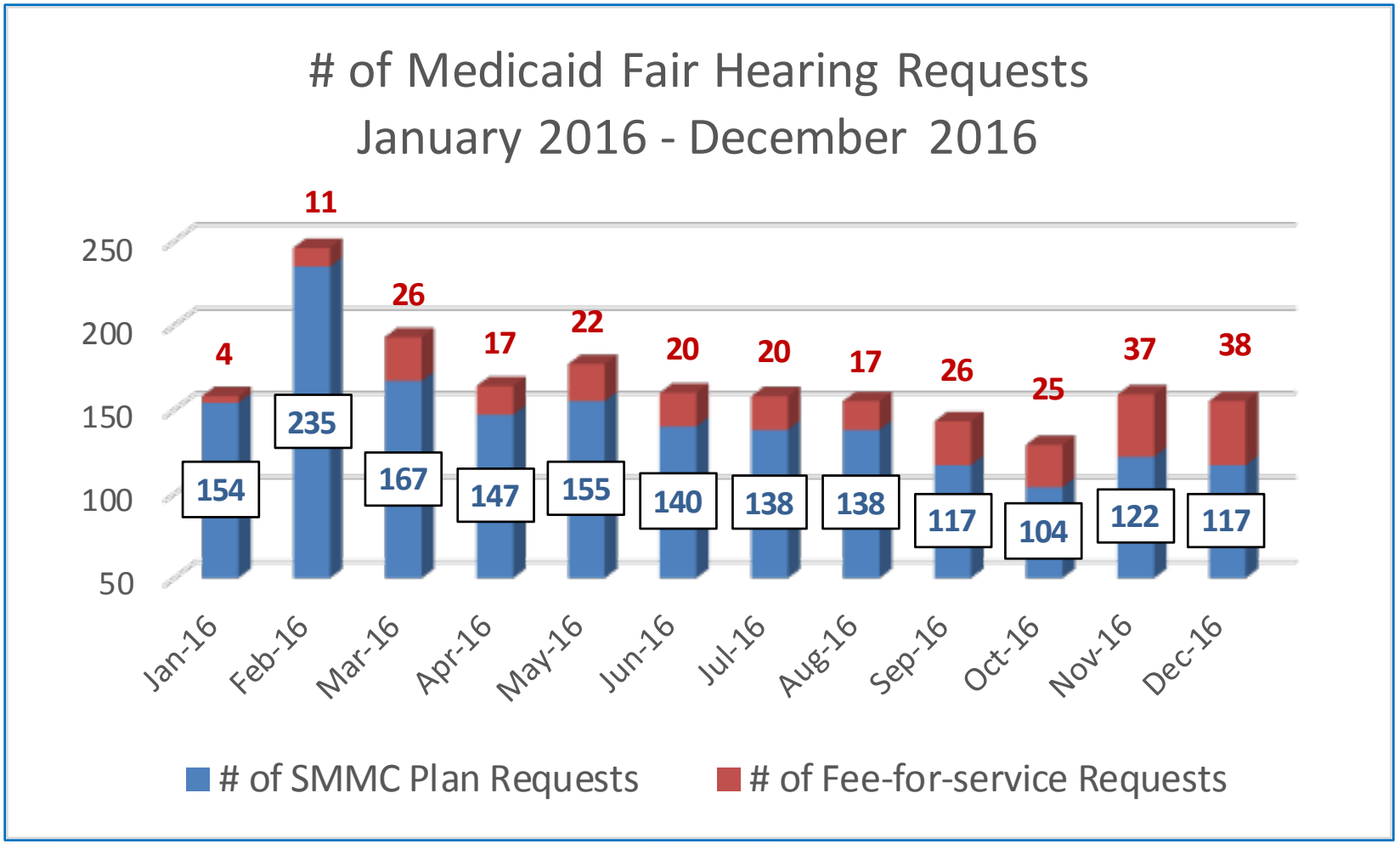
Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
Telephone:(877)254-1055 (toll-free)
Fax: (239)338-2642
E-mail: MedicaidHearingUnit@ahca.myflorida.com

AHCA Office of Fair Hearings

- AHCA's Office of Fair Hearings (OFH or Office), is responsible for acknowledging Medicaid fair hearing requests filed with AHCA. The Office will assign a Hearing Officer who will schedule a hearing, or take other appropriate action on the hearing request pursuant to Rule 59G-1.100, F.A.C. **Contact information for the AHCA's Office of Fair Hearings is:**

  Agency for Health Care Administration
  Office of Fair Hearings
  2727 Mahan Drive, MS#11
  Tallahassee, Florida 32308
  Email: OfficeOfFairHearings@ahca.myflorida.com

Florida Medicaid State Fair Hearing Requests received during 2016
Statewide Medicaid Managed Care and Fee-for-service



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Questions?