

A quick guide for Managed Care appeal processes

All contracted managed care organizations (MCOs) in Washington State that provide Medicaid benefits must have an appeal process for their enrollees. This is formally documented in WACs 182-538-110 (managed care) or 182-538A-110, 182-538B-110, and 182-538C-110 (integrated managed care) as the Grievance and Appeal System for Enrollees. Each MCO is required to document enrollee appeal rights, per their Health Care Authority (HCA) contracts. See definitions and links to MCO appeals and grievances at the end of this fact sheet.

Right to an Appeal

When a benefit/service is denied, suspended, terminated, or reduced, the enrollee receives a notice of adverse benefit determination detailing why the MCO came to their decision. The enrollee has the right to appeal this decision. Only an enrollee, the enrollee's authorized representative, or a provider with the enrollee's or authorized representatives' written consent may request an appeal. The enrollee may request the appeal orally or in writing; however, an oral appeal must be followed with a signed consent to appeal form. This written requirement is not required for expedited appeals, which are appeals that are handled urgently due to the enrollee's health being in jeopardy.

The MCO is required to send a notice of resolution, which must include the enrollee's right to request an agency administrative hearing. This includes:

- The right to request and receive benefits while an agency administrative hearing is pending, and how to make the request;
- That the enrollee may be held liable for the cost of those benefits received for the first 60 days after the agency, or the Office of Administrative Hearings (OAH) receives an agency administrative hearing request, if the hearing decision upholds the MCO's adverse benefit determination.

There is only one level of review in the MCO appeal process. The MCO remains an independent party and is responsible for its own representation in any agency administrative hearing, appeal to the board of appeals, and any subsequent judicial proceedings.

If the Enrollee Disagrees With the Resolution of the Appeal

If the enrollee does not agree with the resolution of the appeal, the enrollee or the enrollee's authorized representative may request a hearing. The hearing must be requested within 120 days of the date of the notice of the resolution of the appeal. Appeal rights must be exhausted before a hearing is granted.

If the hearing is not in favor of the enrollee, and the hearings process is exhausted, the enrollee has the right to request an independent review in accordance with RCW 48.43.535 and chapter 182-538 WAC.

Continuation of Benefits

Benefits/services the enrollee is receiving at the time of the adverse benefit determination can be continued during the appeal process, as long as all of the following apply:

- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The original period covered by the original authorization has not expired.
- The enrollee requests the continuation of benefits within 10 days of the date of the adverse benefit determination or date of the notice of the resolution of the appeal.

If the benefits/services are continued while the appeal, hearing, or independent review is pending, they will be continued until one of the following occurs:

- The enrollee withdraws the appeal, hearing, or independent review request.
- The enrollee has not requested continuation of services within 10 calendar days of the date of the adverse benefit determination.
- OAH has issued a decision to uphold the denial decision.

If the MCO or a final order entered by the HCA Board of Appeals, or an independent review organization reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MCO must authorize or provide the disputed services no later than 72 hours from the date it receives notice reversing the determination. If the MCO's decision to deny is reversed during the appeal, the disputed services must be paid for by the MCO.

Payment responsibility if the denial is upheld

If the final resolution of the appeal, independent review, or final order from OAH upholds the MCO's adverse benefit determination, the MCO may recover from the enrollee the amount paid for the services provided to the enrollee for the first 60 days during in which the appeal was pending.

Definitions

"Administrative hearing" means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by chapter 34.05 RCW, the agency's hearings rules found in Titles 388 or 182 WAC, or other law.

"Adverse benefit determination" means any of the following (42 C.F.R. §438.400(b)):

(a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial, in whole or in part, of payment for a service;

(d) The denial of request for "good cause" designation that would preclude usual third-party liability procedures;

(e) The failure to provide services or in a timely manner, including failure to issue an authorization or denial within required timeframes;

(f) The failure of a managed care organization (MCO) to act within the timeframes for resolution and notification of grievances and appeals;

(g) The denial of a client's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other client financial liabilities

(h) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside the network under 42 C.F.R. Sec. 438.52

(b)(2)(ii).

"Appeal" means a review by the MCO of an adverse benefit determination.

"Enrollee" means a person enrolled in managed care with an MCO that has a contract with the state.

"Enrollee's representative" means a person with a legal right or written authorization from the enrollee to act on behalf of the enrollee in making decisions.

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

"Grievance and appeal system" means the processes the MCO implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

"Timely" concerning the provision of services, means an enrollee has the right to receive medically necessary health care as expeditiously as the enrollee's health condition requires. Concerning authorization of services and grievances and appeals, "timely" means according to the agency's managed care program contracts and the time frames stated in WACs 182-538-110, 182-538A-110, 182.538B-110 and 182-538C-110.

Links:

Amerigroup - myamerigroup.com/wa/wawa_apple_health_mhb_eng.pdf

Community Health Plan of Washington - chpw.org/for-members/grievances-and-appeals/

Coordinated Care - coordinatedcarehealth.com/providers/resources/grievance-process.html

Molina HealthCare - molinahealthcare.com/members/wa/en-us/mem/medicare/quality/gna/Pages/gna.aspx

United HealthCare - uhcprovider.com/en/admin-guides/administrative-guides-manuals-2019/capitation-delegation-guide-supp-2019/cad-appeals-grievances-guide-supp-2019.html

Health Care Authority - hca.wa.gov/assets/free-or-low-cost/19-046.pdf