

NOTICE OF INTENT

**Department of Health
Bureau of Health Services Financing**

**Managed Care for Physical and Behavioral Health
Member Grievances and Appeals
(LAC 50:I.Chapter 37)**

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:I.Chapter 37 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing managed care for physical and behavioral health in order to align the current Rule with the *Code of Federal Regulations* and the *Louisiana Administrative Code* which will: 1) revise timeframes for members to initiate state fair hearings and request appeals; 2) revise the timeframe for managed care organizations to resolve grievances; 3) update definitions to align with federal Rule changes; 4) revise record retention requirements; and 5) clarify reporting requirements.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3703. Definitions

Action—Repealed.

1. - 5. Repealed.

Adverse Benefit Determination—any of the following:

1. 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.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the State.
5. The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductible, coinsurance, and other member financial liabilities.

Appeal—a request for review of an adverse benefit determination as defined in this Section.

Grievance—an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to:

1. ...
2. aspects of interpersonal relationships, such as rudeness of a provider or employee;
3. failure to respect the member's rights regardless of whether remedial action is requested; or
4. the member's rights to dispute an extension of time proposed by the MCO to make an authorization decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1589 (June 2011), amended LR 41:939 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3705. General Provisions

A. The MCO must have a system in place for members that includes a grievance process, an appeal process, and access to the state fair hearing process once the MCO's appeal process has been exhausted.

B. Filing Requirements

1. Authority to File. A member, or a representative of his/her choice, including a provider acting on behalf of the member and with the member's written consent, may file a grievance and an MCO level appeal. Once the MCO's appeals process has been exhausted, a member or his/her representative, with the member's written consent, may request a state fair hearing.

a. ...

2. Filing Timeframes. The member, or a representative or provider acting on the member's behalf and with his/her written consent, may file an appeal within 60 calendar days from the date on the MCO's notice of adverse benefit determination.

3. Filing Procedures

a. ...

b. The member, or a representative or provider acting on the member's behalf and with the member's written consent, may file an appeal either orally or in writing. Oral appeals must be followed by a signed, written appeal unless the member requested an expedited appeal.

C. - C.1.b. ...

D. Grievance and Appeal Records

1. The MCO must maintain records of grievances and appeals. A copy of the grievance logs and records of the disposition of appeals shall be retained for 10 years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the 10-year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular 10-year period, whichever is later.

E. All state fair hearing requests shall be sent directly to the state designated entity.

1. - 1.f. Repealed.

F. The MCO will be responsible for promptly forwarding any adverse decisions to the department for further review and/or action upon request by the department or the MCO member.

G. The department may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance or appeal.

H. Information to Providers and Subcontractors. The MCO must provide the information about the grievance system as specified in federal regulations to all providers and subcontractors at the time they enter into a contract.

I. Recordkeeping and Reporting Requirements. Reports of grievances and resolutions shall be submitted to the department

as specified in the contract. The MCO shall not modify the grievance system without the prior written approval of the department.

J. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1590 (June 2011), amended LR 41:939 (May 2015), LR 41:2368 (November 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3707. Handling of Member Grievances and Appeals

A. In handling grievances and appeals, the MCO must meet the following requirements:

1.- 2. ...

3. ensure that the individuals who make decisions on grievances and appeals are individuals who:

a. were not involved in any previous level of review or decision-making, nor a subordinate of any such individual; and

b. if deciding on any of the following issues, are individuals who have the appropriate clinical expertise, as determined by the department, in treating the member's condition or disease:

3.b.i. - B. ...

1. The process for appeals must:

a. provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution;

b. ...

c. provide the member and his/her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records, any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO during the appeals process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals; and

B.1.d. - 3. ...

4. Failure to Make a Timely Decision

a. ...

b. If a determination is not made by the contractual time frames, the member's request will be deemed to have been exhausted and the member may initiate a state fair hearing.

5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1590 (June 2011), amended LR 41:940 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3709. Notice of Adverse Benefit Determination

A. ...

B. Content of Notice. The notice must explain the following:

1. the adverse benefit determination the MCO or its subcontractor has taken or intends to take;

2. the reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination;

3. ...

4. the member's right to request a state fair hearing after the MCO's one-level appeal process has been exhausted;

5. - D.3. ...

E. For service authorization decisions not reached within the timeframes specified in this Section, this constitutes a denial and is thus an adverse action on the date that the timeframes expire.

1. For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request for service.

2. The MCO may extend the 72 hour time period by up to 14 calendar days if the member or provider acting on behalf of the member requests an extension, or if the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

F. The department shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

1. - G. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1591

(June 2011), amended LR 41:940 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3711. Resolution and Notification

A. The MCO must resolve each grievance and appeal, and provide notice as expeditiously as the member's health condition requires, within the timeframes established in this Section. The MCO must provide written notice to all members who filed a grievance whether the grievance was filed with the MCO or the department.

B. Specific Timeframes

1. For standard disposition of a grievance and notice to the affected parties, the timeframe is established as 30 days, or the timeframe established by the department, not to exceed 90 days, from the day the MCO receives the grievance.

2. - D. ...

E. Format of Notice

1. The MCO shall follow the method specified by the department to notify a member of the disposition of a grievance.

2. For all appeals, the MCO must provide written notice of the resolution.

3. For notice of an expedited resolution, the MCO must provide written notice of the resolution and also make reasonable efforts to provide oral notice.

F. - F.2.c. ...

G. Requirements for State Fair Hearings

1. ...

2. If the member has exhausted the MCO's one-level appeal procedures, the member may initiate a state fair hearing within 120 days from the date of the MCO's notice of appeal resolution.

3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:941 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§3713. Expedited Resolution of Appeals

A. ...

B. If the MCO denies a request for expedited resolution of an appeal, it must:

1. transfer the appeal to the timeframe for standard resolution; and

2. make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice of the reason for the decision to

extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with the decision.

C. - E.2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:941 (May 2015), amended by the Department of Health, Bureau of Health Services Financing LR 44:

§3715. Continuation of Services during the Pending MCO Appeal or State Fair Hearing

[Formerly IAC 50:I.3711]

A. *Timely Filing*-filing on or before the later of the following:

1. within 10 calendar days of the MCO's mailing of the notice of adverse benefit determination; or
2. the intended effective date of the MCO's proposed adverse benefit determination.

B. Continuation of Benefits. The MCO must continue the member's benefits if the:

1. - 4. ...
5. member timely files for continuation of benefits.

C. ...

1. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

a. the member withdraws the appeal or request for state fair hearing;

b. 10 calendar days pass after the MCO mails the notice providing the resolution of the appeal against the member, unless the member has requested a state fair hearing with continuation of benefits, within the 10-day timeframe, until a state fair hearing decision is reached; or

c. a state fair hearing entity issues a hearing decision adverse to the member.

d. Repealed.

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1591 (June 2011), amended LR 41:942 (May 2015), amended by the Department of Health, Bureau of Health Services Financing LR 44:

§3717. Effectuation of Reversed Appeal Resolutions

[Formerly LAC 50:I.3713]

A. ...

1. If the MCO or the state fair hearing entity reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the decision.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1592 (June 2011), amended LR 41:942 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this

proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, December 28, 2017 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge,

LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

Person
Preparing
Statement: Yolanda Ellis Dept.: Health
Phone: 342-5042 Office: Bureau of Health Services
Financing

Return P.O. Box 91030
Address: Baton Rouge, LA Rule Title: Managed Care for Physical and
Behavioral Health
Member Grievances and Appeals

Date Rule Takes Effect: February 20, 2018

SUMMARY

In accordance with Section 953 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a fiscal and economic impact statement on the rule proposed for adoption, repeal or amendment. The following summary statements, based on the attached worksheets, will be published in the Louisiana Register with the proposed agency rule.

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (SUMMARY)

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 17-18. It is anticipated that \$1,728 (\$864 SGF and \$864 FED) will be expended in FY 17-18 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no effect on revenue collections other than the federal share of the promulgation costs for FY 17-18. It is anticipated that \$864 will be collected in FY 17-18 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NON-GOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing managed care for physical and behavioral health in order to clarify and ensure that the proposed revisions align with the Code of Federal Regulations and the Louisiana Administrative Code which will: 1) revise timeframes for members to initiate state fair hearings and request appeals; 2) revise the timeframe for managed care organizations to resolve grievances; 3) update definitions to align with federal Rule changes; 4) revise record retention requirements; and 5) clarify reporting requirements. It is anticipated that these changes will benefit the member by allowing them additional time to file for appeal and state fair hearing. There may be an indeterminable cost increase to the managed care organizations due to increased records retention requirements. All other changes are technical in nature are not anticipated to have costs or benefits to managed care providers or members in FY 17-18, FY 18-19 and FY 19-20.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Don Deery
Signature of Agency Head
or Designee

Shrey V. Acharya
Legislative Fiscal Officer
or Designee

Ben Steele, Medicaid Director
Typed name and Title of
Agency Head or Designee

11/8/2017
Date of Signature

Bhaskar Jod
LDH/BHSF Budget Head

11/08/17
Date of Signature

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

The following information is required in order to assist the Legislative Fiscal Office in its review of the fiscal and economic impact statement and to assist the appropriate legislative oversight subcommittee in its deliberations on the proposed rule.

- A. Provide a brief summary of the content of the rule (if proposed for adoption or repeal) or a brief summary of the change in the rule (if proposed for amendment). Attach a copy of the notice of intent and a copy of the rule proposed for initial adoption or repeal (or, in the case of a rule change, copies of both the current and proposed rules with amended portions indicated).

This proposed Rule amends the provisions governing managed care for physical and behavioral health in order to clarify and ensure that the proposed revisions align with the Code of Federal Regulations and the Louisiana Administrative Code which will: 1) revise timeframes for members to initiate state fair hearings and request appeals; 2) revise the timeframe for managed care organizations to resolve grievances; 3) update definitions to align with federal Rule changes; 4) revise record retention requirements; and 5) clarify reporting requirements.

- B. Summarize the circumstances that require this action. If the action is required by federal regulations, attach a copy of the applicable regulation.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing managed care for physical and behavioral health in order to align the current Rule with the Code of Federal Regulations and the Louisiana Administrative Code which will: 1) clarify timeframes for members to initiate state fair hearings and request appeals; 2) revise the timeframe for managed care organizations to resolve grievances; 3) update definitions to align with federal Rule changes; 4) revise record retention requirements; and 5) clarify reporting requirements.

- C. Compliance with Act 11 of the 1986 First Extraordinary Session.

- (1) Will the proposed rule change result in any increase in the expenditure of funds? If so, specify amount and source of funding.

No. It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 17-18. In FY 17-18, \$864 is included for the state's administrative expense for promulgation of this proposed rule and the final rule.

- (2) If the answer to (1) above is yes, has the Legislature specifically appropriated the funds necessary for the associated expenditure increase?

- (a) _____ If yes, attach documentation.
(b) _____ If no, provide justification as to why this rule change should be published at this time.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

I. A. COST OR SAVINGS TO STATE AGENCIES RESULTING FROM THE ACTION PROPOSED

1. What is the anticipated increase or (decrease) in cost to implement the proposed action?

COST	FY 17-18	FY 18-19	FY 19-20
PERSONAL SERVICES			
OPERATING EXPENSES	\$1,728	\$0	\$0
PROFESSIONAL SERVICES			
OTHER CHARGES			
REPAIR & CONSTR.			
POSITIONS (#)			
TOTAL	\$1,728	\$0	\$0

2. Provide a narrative explanation of the costs or savings shown in "A.1.", including the increase or reduction in workload or additional paperwork (number of new forms, additional documentation, etc.) anticipated as a result of the implementation of the proposed action. Describe all data, assumptions, and methods used in calculating these costs.

In FY 17-18, \$1,728 is included for the state's administrative expense for promulgation of this proposed rule and the final rule.

3. Sources of funding for implementing the proposed rule or rule change.

Source	FY 17-18	FY 18-19	FY 19-20
STATE GENERAL FUND	\$864	\$0	\$0
SELF-GENERATED			
FEDERAL FUND	\$864	\$0	\$0
OTHER (Specify)			
Total	\$1,728	\$0	\$0

4. Does your agency currently have sufficient funds to implement the proposed action? If not, how and when do you anticipate obtaining such funds?

Yes, sufficient funds are available to implement this rule.

B. COST OR SAVINGS TO LOCAL GOVERNMENTAL UNITS RESULTING FROM THIS PROPOSED ACTION.

1. Provide an estimate of the anticipated impact of the proposed action on local governmental units, including adjustment in workload and paperwork requirements. Describe all data, assumptions and methods used in calculating this impact.

This proposed rule has no known impact on local governmental units.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

2. Indicate the sources of funding of the local governmental unit that will be affected by these costs or savings.

There is no known impact on the sources of local governmental unit funding.

II. EFFECT ON REVENUE COLLECTIONS OF STATE AND LOCAL GOVERNMENTAL UNITS

- A. What increase or (decrease) in revenues can be expected from the proposed action?

REVENUE INCREASE/DECREASE	FY 17-18	FY 18-19	FY 19-20
STATE GENERAL FUND			
AGENCY SELF-GENERATED			
RESTRICTED FUNDS*			
FEDERAL FUNDS	\$864	\$0	\$0
LOCAL FUNDS			
Total	\$864	\$0	\$0

**Specify the particular fund being impacted*

- B. Provide a narrative explanation of each increase or decrease in revenue shown in "A". Describe all data, assumptions, and methods used in calculating these increases or decreases.

In FY 17-18, \$864 will be collected for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

III. COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NON-GOVERNMENTAL GROUPS

- A. What persons or non-governmental groups would be directly affected by the proposed action? For each, provide an estimate and a narrative description of any effects on costs, including workload adjustments and additional paperwork (number of new forms, additional documentation, etc.)

This proposed Rule amends the provisions governing managed care for physical and behavioral health in order to clarify and ensure that the proposed revisions align with the Code of Federal Regulations and the Louisiana Administrative Code which will: 1) revise timeframes for members to initiate state fair hearings and request appeals; 2) revise the timeframe for managed care organizations to resolve grievances; 3) update definitions to align with federal Rule changes; 4) revise record retention requirements; and 5) clarify reporting requirements. It is anticipated that these changes will benefit the member by allowing them additional time to file for appeal and state fair hearing.

- B. Also, provide an estimate of any revenue impact resulting from this rule or rule change to these groups.

There may be an indeterminable cost increase to the managed care organizations due to increased records retention requirements. All other changes are technical in nature and are not anticipated to have costs or benefits to managed care providers or members in FY 17-18, FY 18-19 and FY 19-20.

IV. EFFECTS ON COMPETITION AND EMPLOYMENT

Identify and provide estimates of the impact of the proposed action on competition and employment in the public and private sectors. Include a summary of any data, assumptions and methods used in making these estimates.

This rule has no known effect on competition and employment.