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 ~~Basic~~ Behavioral Health

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3703. Definitions

Action—~~the denial or limited authorization of a requested service, including:~~Repealed.

~~1. the type or level of service;~~

~~2. reduction, suspension, or termination of a previously authorized service;~~

~~3. denial, in whole or in part, of payment for a service for any reason other than administrative denial;~~

~~4. failure to provide services in a timely manner as specified in the contract; or~~

~~5. failure of the MCO to act within the timeframes provided in this Subchapter.~~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 Repealed.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 ~~action~~ adverse benefit determination as defined in this Section.

Grievance—an expression of dissatisfaction about any matter other than an ~~action as that term is defined in this Section~~adverse benefit determination. ~~The term is also used to refer to the overall system that includes MCO level grievances and access to a fair hearing.~~ ~~Possible subjects for grievances~~ Grievances may include, but are not limited to:

1. ...

2. aspects of interpersonal relationships, such as rudeness of a provider or employee; ~~or~~

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 ~~network~~ 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 ~~30~~60

calendar days from the date on the MCO's notice of ~~action~~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 ~~six~~ 10 years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ~~six~~ 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 ~~six~~10-year period, whichever is later.

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

~~1. The MCO shall provide an electronic report of the grievances and appeals it has received on a monthly basis in~~

~~accordance with the requirements specified by the department, which will include, but is not limited to:~~

~~a. the member's name and Medicaid identification number;~~

~~b. summary of grievances and appeals;~~

~~c. date of filing;~~

~~d. current status;~~

~~e. resolutions; and~~

~~f. resulting corrective action~~1. – 1.f. Repealed.

F. ~~All state fair hearing requests shall be sent directly to the state designated entity~~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 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~~The department may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance or appeal.

H. ~~The department may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance or appeal~~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. ~~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~~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. ~~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~~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 ~~health care professionals~~ 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, ~~and~~ 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 ~~above~~ contractual time frames, the member's request will be deemed to have been ~~approved as of the date upon which a final determination should have been made~~ 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 ~~Action~~Adverse Benefit Determination

A. ...

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

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

2. the reasons for the ~~action~~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. ~~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~~The department shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

~~1. A notice must be furnished as expeditiously as the member's health condition requires, but no later than 72 hours or as expeditiously as the member's health requires, 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.~~

~~G. 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 ~~dispose of a grievance,~~ 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 ~~90~~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 ~~in~~ by the department ~~issued guide~~ to notify a member of the disposition of a grievance.

2. For all appeals, the MCO must provide written notice of ~~disposition~~ 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 ~~request~~ initiate a state fair hearing within ~~30~~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 ~~in accordance with the provisions of this Subchapter~~; 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. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an action or require a notice of action. The member may file a grievance in response to this decision.~~

~~D. Failure to Make a Timely Decision. Appeals shall be resolved no later than the established timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the established timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.~~

~~E. The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution.~~

~~1. The member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required.~~

~~2. The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.~~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 LAC 50:I.3711]

A. *Timely Filing*-filing on or before the later of the following~~, but no greater than 30 days~~:

1. within 10 calendar days of the MCO's mailing of the notice of ~~action~~ adverse benefit determination; or

2. the intended effective date of the MCO's proposed ~~action~~adverse benefit determination.

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

1. – 4. ...

5. member ~~requests~~ 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~~; or~~.

d. ~~the time period or service limits of a previously authorized service has been met~~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