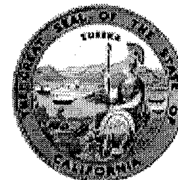
State of California—Health and Human Services Agency

Department of Health Services



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August 27, 2003

MMCD All Plan Letter No. 03009

TO: County Organized Health Systems (COHS)
Geographic Managed Care Plan (GMC)
Prepaid Health Plans (PHP)
Two-Plan Model Plans

FROM: Luis R. Rico, Acting Chief
Medi-Cal Managed Care Division

SUBJECT: Implementation of Expedited State Hearings

Purpose:

The purpose of this All Plan Letter is to provide clarification of Expedited State Hearing (ESH) requirements for enrollees of Managed Care Organizations (MCO) and Prepaid Inpatient Health Plans (PIHP) as required by federal regulations implementing the Balanced Budget Act of 1997 (BBA). Pursuant to the BBA regulations, under Title 42, Code of Federal Regulations (CFR), Section 431.244(f) the Department of Health Services (DHS) is required to implement within three (3) work days a process that resolves disputes which meet the criteria for expedited resolution. An ESH may be required in cases where the enrollee's health plan or the enrollee's provider indicates that taking the time for a standard resolution **could seriously jeopardize the enrollee's life, or health, or ability to attain, maintain or regain maximum function.**

Background:

The Final Rule adopting the BBA regulations was published on June 14, 2002 and became operational on August 14, 2002.

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The BBA regulations impose enhanced enrollee protections in the area of State hearings and under appropriate circumstances require enrollee access to an ESH process. Currently, the State hearing system provides for only a 90-day hearing adjudication process, referred to as a "standard" State hearing request. The regulations also require DHS to monitor MCO and PIHP contractors for compliance with the Final Rule.

The BBA regulations also impose new requirements on MCOs and PIHPs relative to enrollee grievances. For example, Title 42, CFR Section 438.408, requires MCOs and PIHPs to dispose of grievances as expeditiously as the enrollee's health condition requires. In addition to specifying the results of and the basis for the plan's decision, the grievance resolution notice must specify that the enrollee may request further review by the State and how to seek it. For expedited grievances, MCOs and PIHPs must also take reasonable efforts to provide oral notice of their decision to the enrollee.

Policy:

Types of cases subject to ESH

The scope of cases subject to expedited review under the BBA are set forth in Title 42, CFR, Section 431.244(f), which states, in pertinent part:

> "**431.244 Hearing decisions.**
>
> (f) The agency must take final administrative action as follows:
>
> (2) As expeditiously as the enrollee's health condition requires, but no later than three working days after the agency receives from the MCO or PIHP, the case file and information for any appeal of a *denial of a service* (italics added) that, as indicated by the MCO or PIHP----
>
> > (i) Meets the criteria for expedited resolution as set forth in Section 438.410(a) of this chapter, but was not resolved within the timeframe for expedited resolution: or
> > (ii) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the enrollee.
>
> (3) If the State agency permits direct access to a State hearing, as expeditiously as the enrollee's health condition requires, but no later than three working days after the agency receives, directly from an MCO or PIHP enrollee, a hearing request on a decision to *deny a service* that it determines meets the criteria for expedited resolution, as set forth in Section 438.410(a) of this chapter."

As the italicized language in Section 431.244(f) makes clear, **only service denials are subject to ESH.** This includes termination, reduction or suspension of an existing service as well as the denial, in whole or in part, of an initial request for a service. However, the denial of a medical exemption request would **NOT** qualify for an ESH. A medical exemption denial is not a service denial; rather, it is a denial of a request to change the mode (from managed care to fee-for-service) by which the beneficiary will be receiving his/her medical care.

Persons who can request an ESH

Under Title 42, CFR, Section 431.244(f) quoted above, only MCO and PIHP managed care enrollees are eligible for ESHs.

In California, there are three principal managed care models: the Two Plan Model, the Geographic Managed Care (GMC) Model, and the County Organized Health System (COHS) Model. Two-Plan and GMC Health Plans are considered an "MCO" under the BBA. CMS has confirmed that of the five COHS plans in the state, only one (the Health Plan of San Mateo) is subject to the BBA. Accordingly, as of August, 2003 when the BBA regulations take effect, only managed care enrollees (whether mandatory or voluntary) in Two Plan, GMC or COHS plans in the following counties will be eligible for ESHs.

I) Two Plan counties—Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare
II) GMC counties—Sacramento, San Diego
III) COHS county—San Mateo

Additionally, enrollees in the following specialty plans will be eligible for ESHs: Kaiser Prepaid Health Plan (covering a small number of enrollees in Marin and Sonoma Counties), AIDS Healthcare Foundation (in Los Angeles), Family Mosaic (in San Francisco), Senior Care Action Network, aka SCAN (covering a limited number of enrollees in Los Angeles, Riverside and San Bernardino Counties), and Programs of All Inclusive Care of the Elderly (PACE), including On Lok, Sutter Senior Care, Center for Elders and Alta Med.

Enrollees in **managed care dental plans will NOT be entitled to ESHs**, since those plans are considered Prepaid Ambulatory Health Plans (PAHPs), not MCOs or PIHPs. Additionally, enrollees in the COHS plans operating in Monterey, Napa, Orange, Santa Barbara, Santa Cruz, Solano and Yolo Counties will not be eligible for ESHs. As noted above, the BBA does not apply to those COHS plans.

Aside from enrollees, a provider may request an ESH on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so (Title 42, CFR, Section 438.402(a)(ii)). As interpreted by DHS, Welfare & Institutions Code Section 10950 gives providers this authority, since there is no limitation on who may be an authorized representative in this statute. Welfare and Institutions Code Section 10950 reads, "If any applicant for or recipient of public social services is dissatisfied with any action, he or she shall, in person or through an authorized representative...upon filing a request...be accorded an opportunity for a state hearing." Although the BBA regulations are silent on the issue, it seems beyond dispute that an emancipated minor, a parent on behalf of his/her minor child, and a duly-appointed guardian or conservator of an enrollee may also request an ESH. By their nature, ESHs should never involve deceased enrollees or the estate of a deceased enrollee.

Criteria for an ESH

Under Title 42, CFR, Section 431.244(f), a case may qualify for an ESH under the following circumstances:

i) If an eligible enrollee bypasses the plan's internal grievance/appeal process and proceeds directly to State hearing or the claimant files for a State hearing concurrently with filing an internal plan grievance/appeal, an ESH would be available if the enrollee's condition meets the criteria under Title 42, CFR, Section 438.410(a)—that is, where the enrollee's health plan, or the enrollee's provider, indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. "Provider" means the provider requesting the service(s), since that provider is in the best position to evaluate the enrollee's need for the service(s). (BBA Final Rule, published June 14, 2002, Federal Register at page 41062.)

ii) If the enrollee files for a State hearing after filing an expedited grievance/appeal with the plan, an ESH is available under the following circumstances:
    a) The plan does not resolve the grievance within 72 hours, but the plan indicates the matter meets the criteria for expedited resolution as set forth in Title 42, CFR, Section 438.410(a); or
    b) The plan does resolve the grievance in expedited fashion within 72 hours, but the decision is wholly or partially adverse to the enrollee.

The plan is **NOT** required to automatically forward the case file to the Department of Social Services (DSS) with a request that the matter be scheduled for an ESH under any of the circumstances described above (BBA Final Rule, published June 14, 2002, Federal Register at page 41062). Rather, it is incumbent on the managed care enrollee to request an ESH. Again, only service denials are subject to ESH.

Commencement of the three day timeframe for an ESH

In accordance with Title 42, CFR, Section 431.244(f), supra, in cases where the enrollee files for an ESH after first going through the plan's expedited internal grievance process and the grievance was resolved by the plan in expedited fashion, but denied in whole or in part or the grievance was not acted upon by the plan within 72 hours, but the grievance meets the criteria for expedited resolution, the three day timeframe begins to run when the Department of Social Services (DSS) receives the case file from the MCO or PIHP (Title 42, CFR, Section 431.244(f)(2)). As a practical matter, this means that the three day timeframe does not begin on the day the enrollee makes the request for an ESH, since it may take one to two business days for the health plan to transmit the case file to DSS.

In cases where the enrollee bypasses the plan's internal grievance process and proceeds directly to State hearing, or in cases where the enrollee files for State hearing concurrently with filing an internal plan grievance, CMS has confirmed that the three day timeframe in Title 42, CFR, Section 431.244(f)(3) begins to run when the State, in this case the DSS State Hearings Division (SHD), receives information from the MCO or provider sufficient to establish that the case meets the criteria for expedited resolution under 42 CFR Section 438.410(a). Once again, this may or may not be the same day the claimant requests an ESH. For example, if an enrollee requests an ESH, but the request does not include a written statement from the enrollee's health plan or provider that establishes an entitlement to expedited resolution, the matter should be set for a State hearing on the standard hearing calendar. As soon as the DSS, Public Inquiry and Response (PIAR) receives evidence/information sufficient to establish the enrollee's right to an expedited resolution, the matter should be rescheduled for an expedited State hearing.

Telephonic requests for ESHs

Under Title 42, CFR, Section 438.410(a), either the claimant's health plan or provider must indicate that taking the time for a standard resolution could seriously jeopardize the claimant's life or health or ability to attain, maintain or regain maximum function. This certification by the plan or provider must be in writing. Accordingly, if a claimant calls DSS-PIAR requesting an ESH as to a service denial, the matter should be placed on the standard State hearing calendar.

The claimant should be told that the matter will be rescheduled for an ESH, once DSS-PIAR receives by mail, facsimile or otherwise written information sufficient to satisfy the criteria in Title 42, CFR, Section 438.410(a). Similarly, if the claimant and/or his or her provider call requesting an ESH on a service denial, the matter should be placed on the standard calendar and immediately rescheduled for expedited status once DSS-PIAR receives (by mail, facsimile or otherwise) written confirmation that the case satisfies the criteria for expedited resolution under Title 42, CFR, Section 438.410(a).

Submission of Required Documents for ESHs

Within two (2) business days of being notified by DHS or the DSS-PIAR that the enrollee has filed a request for a State hearing which meets the criteria for expedited resolution, the plan (MCO/PIHP) shall deliver or cause to be delivered directly to the designated/appropriate DSS administrative law judge all information and documents which the plan considered in connection with the action which is the subject of the ESH, whether or not those documents support the plan's decision. This includes, but is not limited to, copies of the relevant treatment authorization request and notice of action (NOA), plus any pertinent grievance resolution notice. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DSS-PIAR along with copies of the original NOA and grievance resolution notice. One or more plan representatives with knowledge of the enrollee's condition and the reason(s) for the action which is the subject of the ESH shall be available by phone during the State hearing proceedings.

Written Certification Request

A request for an ESH may be made orally or in writing. However, before the matter can be scheduled for expedited hearing, either the provider requesting the service or the plan must indicate, in writing, that the enrollee's condition satisfies the criteria for expedited resolution. The notice must contain, at a minimum, the following information:

- Enrollee's First Name, Middle Initial and Last Name;
- Enrollee's Address, City, State, Zip and/or E-mail;
- Enrollee's Telephone Number;
- Date of Birth;
- Name of Managed Care Organization or Health Plan;
- Beneficiary Identification Code Number (BIC);
- Social Security Number;
- First Name, Middle Initial and Last Name of Provider/Physician requesting the service at issue;
- Identification Number of Provider/Physician requesting the service at issue;

- Address, City, State, Zip and /or e-mail of Provider requesting the service at issue;
- Telephone Number of Provider/Physician requesting the service at issue;
- A description of the enrollee's medical condition and diagnosis, explaining why this condition meets the criteria for expedited resolution under Title 42 CFR, Section 438.410(a);
- The specific Medical Treatment or Service being requested;
- The specific resolution sought by the enrollee;
- If the enrollee has a condition that is a serious threat to his/her health, include a statement of explanation in support of such a conclusion;
- The reason provided by the Managed Care Organization or Health Plan for denying, modifying or delaying services, treatment or reimbursement, (not medically necessary, experimental and investigation, or other) along with a copy of the relevant Treatment Authorization Request which was denied or modified;
- If submitted by the plan, include a list of the physicians who have treated the enrollee for the condition. Include their contact information and note whether they were within or outside of the plan network; and
- Dated signatures from the provider/physician making the request, the enrollee if available, and the plan representative if applicable.

Requests for all ESHs should be directed to:

Expedited Hearing Unit
State Hearings Division
744 P Street, MS 19-65
Sacramento, CA 95814
FAX: (916) 229-4267

For general information or questions concerning expedited state hearings, you may contact the Department of Health Services, Medi-Cal Managed Care Division, Office of the Ombudsman at 1(888) 452-2609.