

medicaid and the uninsured

A Guide to the Medicaid Appeals Process

Prepared by:

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Kaiser Commission on Medicaid and the Uninsured

The Henry J. Kaiser Family Foundation

March 2012

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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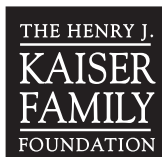


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Executive Summary

A fundamental attribute of health insurance is the existence of enforceable protections to ensure that applicants will get coverage if they meet the eligibility requirements and enrollees with coverage will receive medically necessary services within their benefits package. Beneficiaries' ability to contest an adverse determination is a basic right recognized by law in all types of health insurance, including private insurance, Medicare, and insurance available to federal employees and members of the military, as well as Medicaid. The Medicaid appeals process, however, is different from the appeals processes available through the Medicare program and private health insurance.

The Medicaid program is a vital source of health insurance for nearly 60 million people with low incomes, people with disabilities, and seniors. But, none of the services offered by the Medicaid program are meaningful unless people who are eligible are able to enroll and, once enrolled, can access covered services. Given the number of beneficiaries and the constant fiscal pressure for cost containment, it is inevitable that sometimes coverage is denied and mistakes are made. Resolving these issues fairly and expeditiously is critical to the Medicaid program's ability to achieve its coverage goals. Due to the nature of the program, Medicaid appeal rights have both constitutional and statutory underpinnings. This background paper describes the appeals system available to Medicaid applicants and beneficiaries, including the fair hearing process and the appeals process required for Medicaid managed care organizations (MCOs).

State Agency Appeals Process

Medicaid applicants and beneficiaries are entitled to adequate notice of state agency actions and a meaningful opportunity for a hearing to review those decisions whenever their claim for benefits is denied or not acted upon with reasonable promptness. This includes any action, or inaction, that affects *either* the person's eligibility to be enrolled in Medicaid *or* the person's receipt of a particular medical service covered by the program. The administrative agency hearings in the Medicaid appeals system are often called "fair hearings." The same notice and hearing rights apply to both disputes regarding Medicaid eligibility and to disputes regarding whether an eligible Medicaid enrollee has a medical need for a particular service, whether the benefits are administered through the fee-for-service system or an MCO. The fair hearing process must be accessible to people with limited English proficiency and people with disabilities. State costs of conducting fair hearings are matched by the federal government at 50 percent, while appeals costs incurred by applicants or beneficiaries and their advocates are not.

Example of a Medicaid Eligibility Denial Fair Hearing – Susan's Story, Part 1 – Notice and Hearing Request

Susan is pregnant with her first child and living in a domestic violence shelter. She applied for Medicaid, and the state agency required her to produce information about her own income and that of her estranged husband. The agency notified her that she is ineligible because the couple's combined income exceeds the Medicaid income limit. Susan appealed and asked for an expedited hearing, based on the urgency of her need for prenatal and obstetrical care.

The state Medicaid agency must provide written notice of appeal rights when a person applies for benefits and whenever the state agency takes an action that affects a person's claim for benefits. All notices must advise the person of her right to a hearing, describe the method for requesting a hearing, and explain that the person may represent herself or be represented by legal counsel or someone else. Notice must be provided 10 days before a proposed termination, suspension or reduction of a person's Medicaid eligibility or covered services. Hearings must be requested within a reasonable period of time established by the state agency, not to exceed 90 days from the date that the notice is mailed. Beneficiaries who are currently receiving services generally have the right to request that services continue during an appeal until a hearing decision is issued, by requesting a hearing within the 10 day advance notice period.

Susan's Story, Part 2 – State Fair Hearing

At her fair hearing, the case worker who had handled Susan's Medicaid application testified about how Susan's financial eligibility was calculated. Susan was accompanied by her parents and a former neighbor, all of whom testified that Susan's husband had physically abused her. Each side had the chance to ask questions of the other side's witnesses, and the hearing officer also asked questions. In a written decision mailed after the hearing, the hearing officer ruled that the husband's income should not have been counted when determining Susan's Medicaid eligibility and reversed the state agency's decision to deny coverage. Susan was found eligible retroactive to the beginning of her pregnancy when she had first applied for coverage, and Medicaid reimbursed the clinic for the cost of the visits she already received, in addition to covering her future medical care.

The state Medicaid agency decides whether to offer only an administrative fair hearing or a local level evidentiary hearing with the right to appeal to an administrative fair hearing. Beneficiaries have a number of important procedural rights at hearings. Hearing decisions must be in writing and based exclusively on the evidence introduced at the hearing. If a hearing decision is favorable to the beneficiary, the agency must promptly implement it. The agency also must notify beneficiaries of their right to seek judicial review in state court to the extent it is available. The agency must take final administrative action on appeals within 90 days of the date that the beneficiary asked for a fair hearing.

MCO Appeals Process

In addition to the state fair hearing process, Medicaid MCOs must establish both internal appeal procedures for enrollees to challenge the denial of coverage or payment for medical assistance and a grievance process. A fair and efficient appeals process is especially important in the context of capitated managed care, where there are economic incentives to underserve and the majority of beneficiaries are mandatorily enrolled. Medicaid MCO

Example of an MCO Service Termination Appeal - John's Story, Part 1 - Notice

John is a 15-year-old boy with cerebral palsy and cognitive limitations. He receives Medicaid benefits through an MCO. John's primary care doctor prescribed physical therapy services twice a week to help improve John's mobility and ability to assist in transferring from his wheelchair. John has received physical therapy for several years. Recently, John's Medicaid MCO sent a notice that says John's physical therapy services are no longer considered medically necessary and will be discontinued.

enrollment is expected to grow dramatically in the next few years due to the Affordable Care Act's Medicaid expansion in 2014, and the Centers for Medicare and Medicaid Services' demonstrations to integrate care for people dually eligible for Medicare and Medicaid, both of which will affect populations with complex and costly health care needs.

An MCO notice must contain certain elements. Different timeframes apply to the mailing of MCO notices, depending upon the type of decision. MCOs have flexibility in designing their internal appeals process, provided that enrollees have a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. Federal regulations provide certain rights to enrollees during MCO appeals, govern the timing and content of required notices and the timeframes within which MCOs must resolve appeals, and require MCOs to maintain an expedited appeals review process.

For appeals not resolved wholly in the enrollee's favor, the MCO's written notice of appeal resolution must advise the enrollee about the right to request a state fair hearing and how to do so. The state agency may permit MCO enrollees to request state fair hearings directly in response to MCO notices of action, or the state agency may require MCO enrollees to first exhaust the internal MCO appeal process before requesting a state fair hearing. Federal regulations govern the standard and expedited timeframes within which the state agency must take final administrative action on fair hearing requests by MCO enrollees.

Looking Ahead

The Medicaid appeals process provides important protections for individual applicants and beneficiaries seeking eligibility for the program and coverage of prescribed services.

John's Story, Part 2 – Internal MCO Appeal

John's parents decide to appeal the MCO's denial. Their state requires exhaustion of the MCO appeals process before a state fair hearing. John's parents file a written request for an MCO appeal. Because John's parents ask for the appeal within 10 days of the date of the termination notice, they also are able to ask for John's benefits to continue while the appeal is pending. John's parents receive a letter with a date for them to meet with the MCO. John's parents attend the appeal meeting, which is run by one of the MCO's medical directors who was not involved in the initial decision. The MCO's nurse case manager also is there to explain why the MCO wants to discontinue physical therapy. John's parents have the chance to explain why they think therapy should continue. A few days later, John's parents receive a letter saying that the MCO has upheld its decision to discontinue services.

John's Story, Part 3 – State Fair Hearing

John's parents decide to ask for a state fair hearing. Again, they appeal in time to request that John's benefits continue. They also call the local legal aid office, and an attorney there agrees to take their case and represent John at the hearing. At the fair hearing, the MCO is represented by a lawyer, too. The MCO medical director and nurse case manager testify about why the MCO decided to terminate physical therapy, and John's parents also testify about why John needs services to continue. In addition, John's doctor and physical therapist provide testimony about why they believe physical therapy continues to be medically necessary for John. All witnesses are cross-examined by the opposing lawyers, and the hearing officer also asks questions. The hearing officer takes a couple of months to issue a written decision. The decision finds that the MCO has to continue to authorize physical therapy for John under Medicaid's Early and Periodic Screening Diagnosis and Treatment benefit. Because John's benefits continued while the appeal was pending, his services have not been disrupted during the appeal.

Monitoring of appeals at a systemic level can provide useful management insights into program performance and opportunities for quality improvement. At the same time, the appeals process is multi-layered and can be complex to navigate, with relatively few beneficiaries represented by legal counsel. The features of the Medical appeals system are increasingly significant as health reform is implemented, including challenges in designing an integrated appeals system in new initiatives that seek to integrate Medicare and Medicaid benefits for people who are eligible for both programs and the new single streamlined application process that must assess each person's Medicaid eligibility before considering eligibility for other insurance affordability programs, the denial of which triggers Medicaid notice and appeal rights.

Introduction

A fundamental attribute of health insurance is the existence of enforceable protections to ensure that applicants will get coverage if they meet the eligibility requirements and enrollees with coverage will receive medically necessary services within their benefits package. Beneficiaries' ability to contest an adverse determination is a basic right recognized by law in all types of health insurance, including private insurance subject to ERISA, private insurance regulated by states, Medicare, and insurance available to federal employees and members of the military, as well as Medicaid.

Medicaid, the country's publicly financed health and long-term care insurance program, covers a range of people with low incomes, including children and parents, people with a variety of physical and mental health disabilities, and seniors. Beginning in January, 2014, Medicaid's coverage will expand under health reform to include nearly all adults under age 65 with incomes up to 133 percent of the federal poverty level. Medicaid's benefits package includes an array of services, including those typically not offered by private health insurance, such as long-term services and supports for people with disabilities and comprehensive screening, diagnosis and treatment services for children under age 21. None of the services offered by the Medicaid program are meaningful, however, unless individuals who are eligible for Medicaid are able to enroll and, once enrolled, can access covered services. Given the number of beneficiaries and the constant fiscal pressure for cost containment, it is inevitable that sometimes coverage is denied and mistakes are made. Resolving these issues fairly and expeditiously is critical to the Medicaid program's ability to achieve its coverage goals for its nearly 60 million beneficiaries.

The Medicaid appeals process is an important way for applicants and beneficiaries to seek review of decisions about whether a person is eligible for the program and what services will be provided. Due to the nature of the program, Medicaid appeal rights include some specific protections arising from the Due Process Clause of the U.S. Constitution and the federal Medicaid statute. This background paper describes the appeals system available to Medicaid applicants and beneficiaries, including the state agency administrative hearing process and the appeals process required for Medicaid managed care organizations (MCOs).¹

Constitutional Requirements of the Medicaid Appeals Process: Notice and Hearing

Applicants' and beneficiaries' claims to services under the Medicaid Act are protected by the Due Process Clause of the U.S. Constitution.² The two fundamental elements of the constitutionally required Medicaid appeals process are adequate *notice* of state agency actions and a meaningful opportunity for a *hearing* to review those decisions. These foundations of the Medicaid appeals system were articulated by the U.S. Supreme Court in its landmark 1970 *Goldberg v. Kelly* decision, and federal statute and regulations require that the Medicaid appeals system meet the *Goldberg* standards for notice and hearing. In *Goldberg*, the Court acknowledged that beneficiaries rely on programs like Medicaid to meet basic needs, without any other options. The Court observed that "[b]y hypothesis, [such beneficiaries are] destitute, without funds or assets. . . Suffice it to say that to cut off a

[beneficiary] in the face of. . . ‘brutal need’ without a prior hearing of some sort is unconscionable unless overwhelming considerations justify it.”³ Consequently, the Court ruled that “‘the stakes are simply too high for [these beneficiaries], and the possibility for honest error or irritable misjudgment too great, to allow termination of aid without giving the [beneficiary] a chance, if he so desires, to be fully informed of the case against him so that he may contest its basis and produce evidence in rebuttal,’”⁴ thus establishing the essential elements of notice and hearing.

The administrative agency hearings in the Medicaid appeals system often are called “fair hearings.” In addition to the requirements of *Goldberg*, the federal Medicaid Act since its enactment in 1965 has required states that choose to participate in the Medicaid program to offer the opportunity for a state fair hearing to any person whose claim for benefits is denied or not acted upon with reasonable promptness. That includes any action – or inaction – that affects *either* the person’s eligibility to be enrolled in Medicaid during the initial application process or redetermination *or* their receipt of a particular medical service covered by the program. The same notice and hearing rights apply to both disputes regarding Medicaid eligibility and to disputes regarding whether an eligible

Medicaid enrollee has a medical need for a particular service, whether the benefits are administered through the fee-for-service system or a managed care organization. However, as described below, the state may require Medicaid managed care enrollees to first complete the internal managed care organization appeals process before beginning the state fair hearing process.

Generally, there are two broad issues considered at fair hearings: Medicaid applicants can appeal the state agency’s decision to deny their *eligibility* for the program, and Medicaid beneficiaries can seek review of the state agency or a managed care organization’s decision to deny or discontinue coverage of particular *services*. In both contexts, decisions of the state Medicaid agency include actions by its agents and contractors. Beneficiaries also may request a hearing if they believe the state agency or a managed care organization has acted erroneously in suspending, terminating or reducing services. State agencies may not limit or interfere with an individual’s freedom to request a hearing. The instances in which the opportunity for a hearing must be provided are summarized in Text Box 1, and managed care appeals are discussed in more detail below.

Text Box 1:

Required Opportunities for a Fair Hearing

- Applicant’s claim for services is denied or not acted upon with reasonable promptness
- Beneficiary believes that agency has acted erroneously in terminating, suspending or reducing Medicaid eligibility
- Beneficiary believes that agency has acted erroneously in delaying the delivery of, terminating, suspending or reducing Medicaid covered services (e.g., on grounds of medical necessity)
- Nursing facility resident believes that facility’s decision to transfer or discharge is erroneous
- Individual believes that state’s determination regarding preadmission screening and annual resident review is erroneous
- Managed care enrollee wishes to challenge the denial of coverage of, or payment for, services

In addition to the constitutional and statutory underpinnings of Medicaid fair hearings, a variety of sources, listed in Text Box 2, provide further detail about Medicaid appeals procedures.⁵ The Centers for Medicare and Medicaid Services (CMS, the federal agency overseeing the Medicaid program) requires that state Medicaid agencies issue and publicize their hearing procedures and recommends that state hearing procedures be published and widely distributed in the form of rules and

regulations or a clearly stated pamphlet. In addition to federal fair hearing requirements, the Americans with Disabilities Act requires that the Medicaid appeal process afford such accommodations as are reasonably necessary to ensure that the appeal process is accessible to individuals with disabilities.⁶

State costs of conducting fair hearings are matched by the federal government at 50 percent. The costs of applicants or beneficiaries or their advocates or witnesses during appeals are not subject to federal matching. Federal Medicaid matching funds also are available for payments for services continued pending the appeal, to carry out hearing decisions, for corrective action taken prior to a hearing, and for services provided within the scope of the federal Medicaid program and made under court order.

Adequate Notice of State Agency Actions

The Medicaid state agency appeals process typically begins when the agency sends a notice of action to an applicant or beneficiary (see Figure 1, p. 9). Written notice of appeal rights is required at the time of an application for benefits and any time the state agency takes an action that affects a person's claim for benefits. Notice also is required when a nursing facility proposes a resident's transfer or discharge and when the state makes an adverse determination in the preadmission screening and annual resident review process. However, notice is not a prerequisite for an individual to appeal, and individuals can ask for a hearing without waiting to receive a notice. Time limits for an individual to submit an appeal (discussed below) do not begin to run until a required notice has been issued. All notices must advise the individual of the right to a hearing, describe the method for requesting a hearing, and explain that the individual may represent herself or be represented by legal counsel, a relative, a friend, or another spokesperson. CMS recognizes that beneficiaries may have difficulty representing themselves at hearings and directs state agencies to be informed and advise beneficiaries about legal services agencies or other sources of representation.⁷ CMS also directs that written notices of appeal rights should contain a translation in a language understood by beneficiaries who are not familiar with English and that face-to-face interviews should include an oral explanation of appeal rights in understandable language.⁸

Text Box 2:

Sources of Medicaid Appeals Procedures

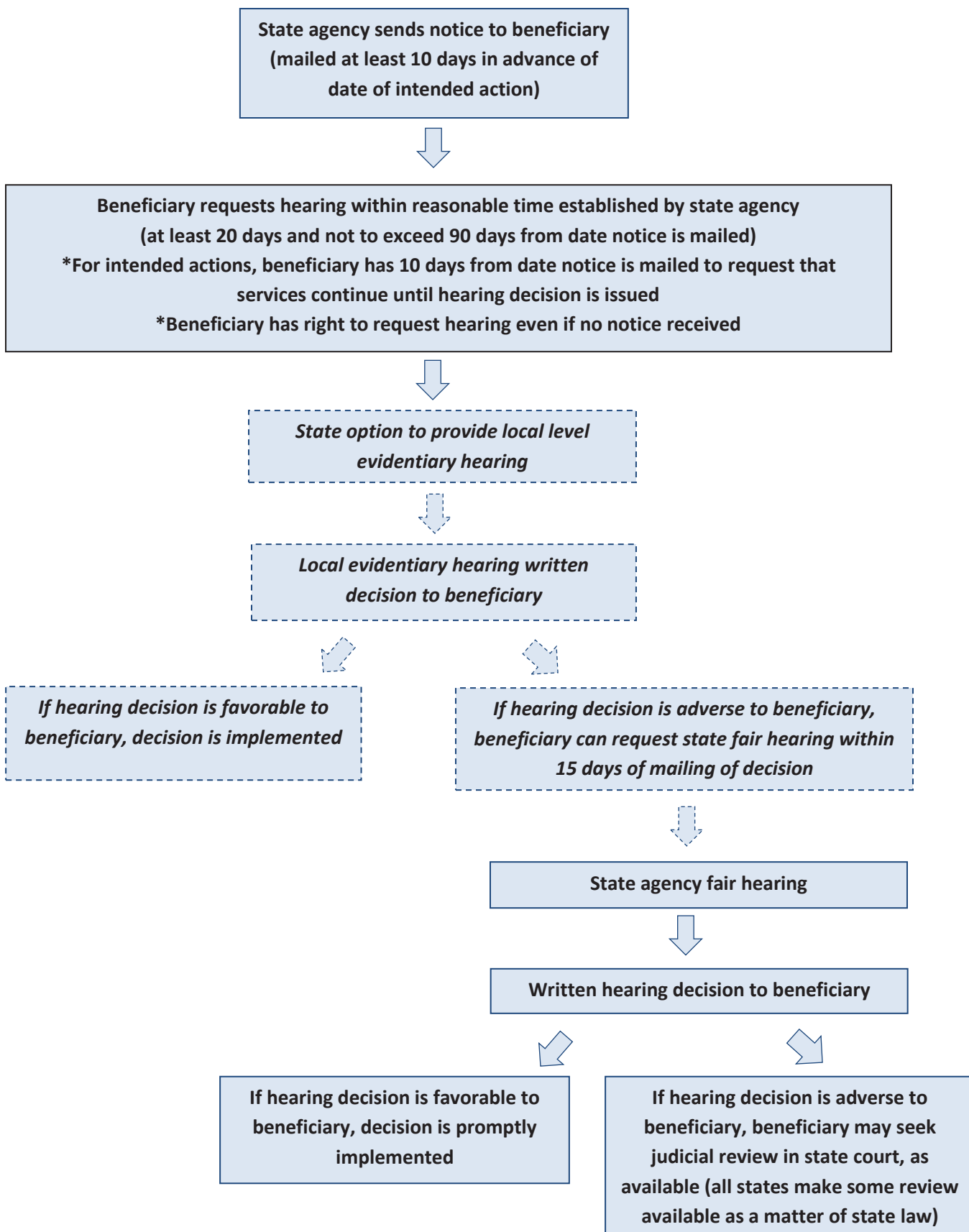
- Federal Medicaid Act, 42 U.S.C. § 1396a(a)(3)
- Federal regulations, 42 C.F.R. § § 431.200-431.246 (state agency appeals) and 42 C.F.R. §§ 438.400-438.424 (managed care appeals)
- CMS State Medicaid Manual, §§ 2900.1 -2904.2
- State statutes, if any
- State regulations and/or policy manuals
- Federal and state court decisions

When a state agency intends to terminate, suspend or reduce an individual’s Medicaid eligibility or covered services, the agency must provide a notice that describes the action the state intends to take, the reasons for the intended action (including *both* the law or policy supporting the proposed action *and* the individual facts that make such law or policy applicable), the specific regulations or law that support or require the action, the individual’s right to request a hearing, and the circumstances under which benefits will continue if a hearing is requested. For intended actions, the state agency generally must mail the notice to the beneficiary at least 10 days before the date of the action, except in limited circumstances.⁹ The required elements and timing of adequate written notice are summarized in Table 1.

**Table 1:
Required Elements and Timing of Written Notice**

	When applying for benefits	When agency intends to take action affecting claim for benefits, such as termination, suspension, or reduction of eligibility or covered services
Statement of intended action		X
Reasons for intended action		X
Citation to specific regulations that support, or change in law that requires, action		X
Explanation of right to request a hearing	X	X
Method by which hearing can be requested	X	X
Right to represent oneself or be represented by legal counsel, relative, friend or other spokesperson	X	X
Explanation of circumstances under which benefits will continue if hearing requested		X

**Figure 1:
State Agency Appeals Process**



Hearing Requests and Continuing Benefits Pending Appeal

The next step in the state agency appeals process is for the beneficiary to request a hearing (Figure 1, p. 9). A case example involving a fair hearing request in response to a Medicaid eligibility denial is described in Text Boxes 3 and 4 below. While a hearing request typically is made in response to a notice of action, it is important to note that a beneficiary has the right to request a hearing in the circumstances listed in Text Box 1 (p. 6), regardless of whether a notice is received. A hearing request is a clear statement by a beneficiary or her authorized representative for the opportunity to present her case to a reviewing authority. The state Medicaid agency may require hearing requests to be in writing and may assist applicants and beneficiaries in submitting hearing requests. Hearings must be requested within a reasonable period of time established by the state agency, not to exceed 90 days from the date that the notice of action is mailed. CMS considers time periods of less than 20 days from the date of mailing of the notice to be unreasonable. Hearing requests may be denied or dismissed by the state agency only if the individual withdraws the request in writing or if she fails to appear at a scheduled hearing without good cause. The state agency must be able to document that an individual's decision to withdraw a hearing request, or to waive any other due process right (e.g., to a decision within specified time limits) is voluntary and is informed by an awareness of the person's rights and the consequences of the decision.

Beneficiaries who are currently receiving services have the right to request that services continue during an appeal until a hearing decision is issued. This is often called "aid paid pending" or "continued benefits." To invoke this right, a beneficiary must request a hearing before the date of the state agency's intended action, within the 10 day advance notice period. However, aid pending an appeal is not available if the sole issue at the hearing is one of federal or state law or policy, as opposed to issues of fact or judgment such as the proper application of state law or policy to the facts of an individual's case. For example, if the federal law were to change and no longer provide Medicaid benefits for people with incomes above an amount that is currently covered, continued benefits would not be available because the termination of benefits resulted from a change in federal law.

After the 10 day advance notice period expires, a beneficiary still may ask for a hearing, until the expiration of the time period to do so, but the state agency may implement its decision to reduce or discontinue services while the appeal is pending. The state agency may reinstate and continue services until a hearing decision is issued, if a beneficiary requests a hearing within 10 days after the date of action. Services also must be reinstated if the state agency takes action without issuing the required notice. If a beneficiary receives

Text Box 3:

Example of a Medicaid Eligibility Denial Fair Hearing – Susan's Story, Part 1 – Notice and Hearing Request

Susan is pregnant with her first child and living in a domestic violence shelter. She applied for Medicaid, and the state agency required her to produce information about her own income and that of her estranged husband. The agency notified her that she is ineligible because the couple's combined income exceeds the Medicaid income limit. Susan appealed and asked for an expedited hearing, based on the urgency of her need for prenatal and obstetrical care.

continued services while the appeal is pending, and the state agency’s decision ultimately is upheld at the hearing, the agency may seek to recoup from the beneficiary the cost of any services provided while the appeal was pending. The availability of aid pending appeal is summarized in Table 2.

**Table 2:
Availability of Aid Pending Appeal**

	State agency <u>must</u> continue benefits pending appeal	State agency <u>may</u> continue benefits pending appeal
Beneficiary requests hearing within 10 day advance notice period, before date of agency’s intended action, unless sole issue of federal or state law or policy	X	
Beneficiary requests hearing within 10 days after date of agency action		X
State agency takes action without issuing required notice	X	

State Agency Hearing Process and Decisions

The state Medicaid agency decides whether to offer only an administrative fair hearing, as required by *Goldberg*, or a local level evidentiary hearing with the right to appeal to an administrative fair hearing (Figure 1, p. 9). State agencies may offer local level evidentiary hearings only in some political subdivisions and not in others. A local evidentiary hearing may provide an additional opportunity to obtain relief more quickly than a fair hearing, or it may be an additional hurdle, delaying beneficiary access to a fair hearing. If a beneficiary loses at a local level evidentiary hearing, the state agency must provide a written hearing decision that summarizes the facts and identifies the regulations supporting the decision. A beneficiary has the opportunity to request a state fair hearing in writing within 15 days of the mailing of an adverse evidentiary hearing decision. The beneficiary also has the option to request that the state fair hearing be *de novo*, meaning that the state fair hearing will begin anew with the opportunity to present testimony and evidence. If the beneficiary does not request a *de novo* hearing, the state fair hearing may consist only of a review of the local evidentiary hearing record to determine whether that decision is supported by substantial evidence, without considering any new testimony or evidence.

All hearings must be conducted at a reasonable time, date and place and only after adequate written notice of the hearing is provided. CMS directs state agencies to make special provisions for the convenience of beneficiaries, such as holding hearings at client homes for people who are homebound or live far away from the usual hearing site.¹⁰ If beneficiaries are unable to attend hearings in person, telephone hearings are permissible provided that due process rights, such as those listed in Text Box 5 (p. 14), are observed. If a hearing involves medical issues, such as a diagnosis, an examining physician’s report, or a medical review team decision, the state agency must pay for a medical assessment other than the assessment performed by the individual who made the original decision, if the hearing officer considers such an assessment necessary. CMS directs that medical sources in these assessments shall

be satisfactory to the beneficiary.¹¹ Independent medical assessments become part of the hearing record either through a written report or expert testimony.

Applicants, beneficiaries and their representatives have a number of important procedural rights associated with state fair hearings. They must have the opportunity to examine the contents of their case file and all documents and records to be used by the agency at the hearing, both at a reasonable time before the hearing date and during the hearing. The state agency also must make available the specific policy materials necessary for an applicant, beneficiary or her representative to determine whether to request a hearing and to prepare for a hearing. At the hearing, applicants and beneficiaries must be allowed to bring witnesses, establish all pertinent facts and circumstances, present an argument without undue interference, and question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses. CMS advises state agencies to refrain from using the rules for the conduct of the hearing to suppress beneficiaries' claims.¹² State agencies must make provisions to secure an interpreter for beneficiaries with limited English proficiency.¹³ The state Medicaid agency may respond to a series of individual hearing requests by conducting a group hearing in cases in which the sole issue is one of federal or state law or policy, provided that each person is able to present her own case.

Hearing officers need not be lawyers but must be impartial individuals who have not participated in the initial determination of the action in question. Hearing decisions must be in writing. Decisions must be based exclusively on the evidence introduced at the hearing, which means that the hearing officer cannot be influenced by *ex parte* communications received outside the hearing. (This ban on *ex parte* communications may pose challenges for hearing officers who are not lawyers, because they must resolve issues of law or evidence without resort to legal counsel outside of the hearing.) The hearing record consists of only the transcript or recording of the testimony and exhibits, or an official report of the substance of what happened at the hearing, all papers and requests filed in the proceeding, and the hearing officer's recommendation or decision. Hearing decisions may be made by the highest executive officer of a state agency, a panel of agency officials, or the hearing officer. Beneficiaries must have access to the hearing record at a convenient time and place. *De novo* state fair

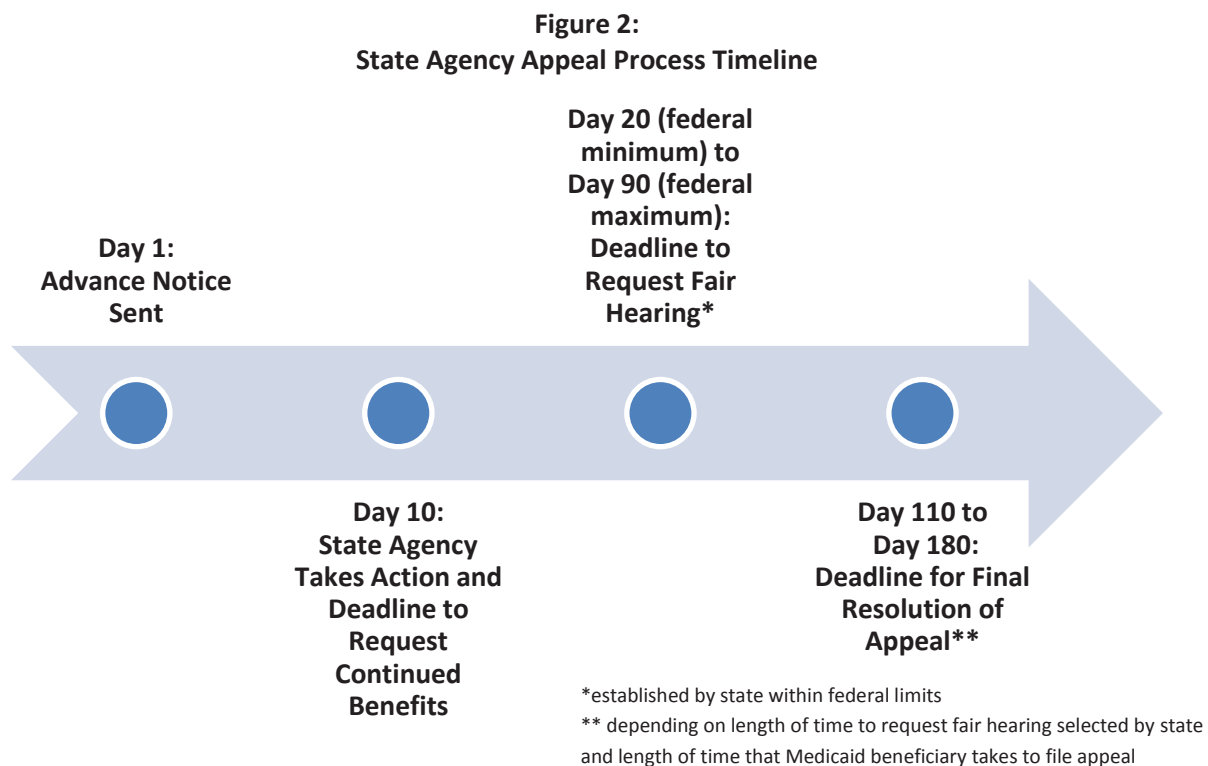
Text Box 4:

Susan's Story, Part 2 – State Fair Hearing

At her fair hearing, the case worker who had handled Susan's Medicaid application testified about how Susan's financial eligibility was calculated. Susan was accompanied by her parents and a former neighbor, all of whom testified that Susan's husband had physically abused her. Each side had the chance to ask questions of the other side's witnesses, and the hearing officer also asked questions. In a written decision mailed after the hearing, the hearing officer ruled that the husband's income should not have been counted when determining Susan's Medicaid eligibility and reversed the state agency's decision to deny coverage. Susan was found eligible retroactive to the beginning of her pregnancy when she had first applied for coverage, and Medicaid reimbursed the clinic for the cost of the visits she already received, in addition to covering her future medical care.

hearing decisions (after local evidentiary hearings) must specify the reasons for the decision and identify the supporting evidence and regulations.

Hearing decisions are binding on state agencies. If a hearing decision is favorable to the beneficiary, or if the agency decides in the beneficiary's favor before the hearing, the agency must promptly make corrective payments, retroactive to the date the incorrect action was taken. If the hearing decision is not favorable, the agency also must notify beneficiaries of their right to seek judicial review in state court to extent it is available (all states make some judicial review of administrative hearing decisions available as a matter of state law). The agency must take final administrative action on appeals within 90 days of the date that the beneficiary asked for a fair hearing. However, the hearing officer has the discretion to grant delays up to 30 days at the beneficiary's request or if necessary medical evidence cannot be obtained within 90 days. The timeline for an appeal of a state Medicaid agency decision through the fair hearing process is illustrated in Figure 2.



CMS advises state agencies that they may reopen and revise final eligibility determinations upon the written request of an applicant, beneficiary, or her representative alleging good cause within one year or when the state agency has information that the prior determination is incorrect or there is other good cause.¹⁴ Good cause means the existence of new and material evidence that was not considered at the time of the prior determination and that demonstrates facts that may result in a different conclusion, even though the prior determination was reasonable when made; or clerical error in mathematical computations; or error apparent from the face of the evidence. State agencies may reopen prior decisions at any time if there is evidence of fraud.

The public must have access to all agency hearing decisions, although confidential beneficiary information must be safeguarded. Applicant and beneficiary rights associated with state fair hearings are summarized in Text Box 5.

Text Box 5:
Applicant/Beneficiary Appeal Rights

- To a state fair hearing, if requested within applicable time limits
- To receive adequate written notice of state agency decisions
- To represent oneself or be represented by legal counsel, a relative, friend or other spokesperson
- To request that services continue until a hearing decision, if requested within applicable time limits
- To receive written notice of the hearing, which is to be scheduled at a reasonable time, date and place
- To have appeals decided by an impartial hearing officer
- To examine the case file and all documents and records to be used by the agency at the hearing, before and during the hearing
- At the discretion of the hearing officer, to obtain an independent medical assessment, at the program's expense, of the medical issues presented by the appeal
- To bring witnesses
- To establish all pertinent facts and circumstances
- To present argument without undue interference
- To question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses
- To receive a written hearing decision based exclusively on the evidence at the hearing
- To access the hearing record at a convenient time and place
- To receive corrective payments retroactive to the date of an incorrect action
- To seek judicial review as available

Medicaid Managed Care Appeals Process

A fair and efficient appeals process is especially important in the context of capitated managed care, where there are economic incentives to underserve and where the majority of beneficiaries is mandatorily enrolled and realistically cannot “vote with their feet.” States are increasingly administering their Medicaid programs through capitated managed care delivery systems, and Medicaid managed care enrollment is expected to grow dramatically in the next few years due to the Affordable Care Act's Medicaid expansion in 2014, and CMS's demonstrations to integrate care for people dually eligible for Medicare and Medicaid, both of which will affect populations with complex and costly health care needs.

In addition to the state fair hearing process described above, supplementary appeal procedures are available to Medicaid managed care enrollees. These additional appeals procedures apply only to Medicaid managed care organization (MCO) enrollees and not to beneficiaries enrolled in primary care case management models. The MCO's obligations regarding appeal procedures should be specified in the MCO's contract with the state Medicaid agency, which should be available as a matter of public record. Enrollees can learn about their MCO's specific process through their member handbook, the MCO's website, or by calling the MCO's customer service department.

The federal Medicaid Act requires MCOs to establish internal appeal procedures for enrollees to challenge the denial of coverage or payment for medical assistance. These internal appeal procedures may provide an additional opportunity to obtain relief more quickly than a fair hearing, or they may be an additional hurdle, delaying beneficiary access to a fair hearing. MCO actions subject to appeal include the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner as defined by the state agency; the failure of an MCO to resolve grievances and appeals within the required timeframes; and for residents of rural areas with only one MCO, the denial of an enrollee's request to obtain services outside the network. MCOs also must provide access to the state fair hearing system and establish a grievance process. MCO enrollees may file grievances to express dissatisfaction about matters that are not subject to appeal, such as the quality of care or services provided or a provider or employee's rudeness or failure to respect enrollee rights. It is important to note that many actions, or inactions, that might be characterized as "quality" issues, such as delays in treatment, are in fact adverse actions affecting Medicaid benefits and thus are subject to the notice and hearing requirements of appeals. The types of review available to MCO enrollees in various circumstances are summarized in Table 3 below.

**Table 3:
Types of Review Available to Managed Care Enrollees**

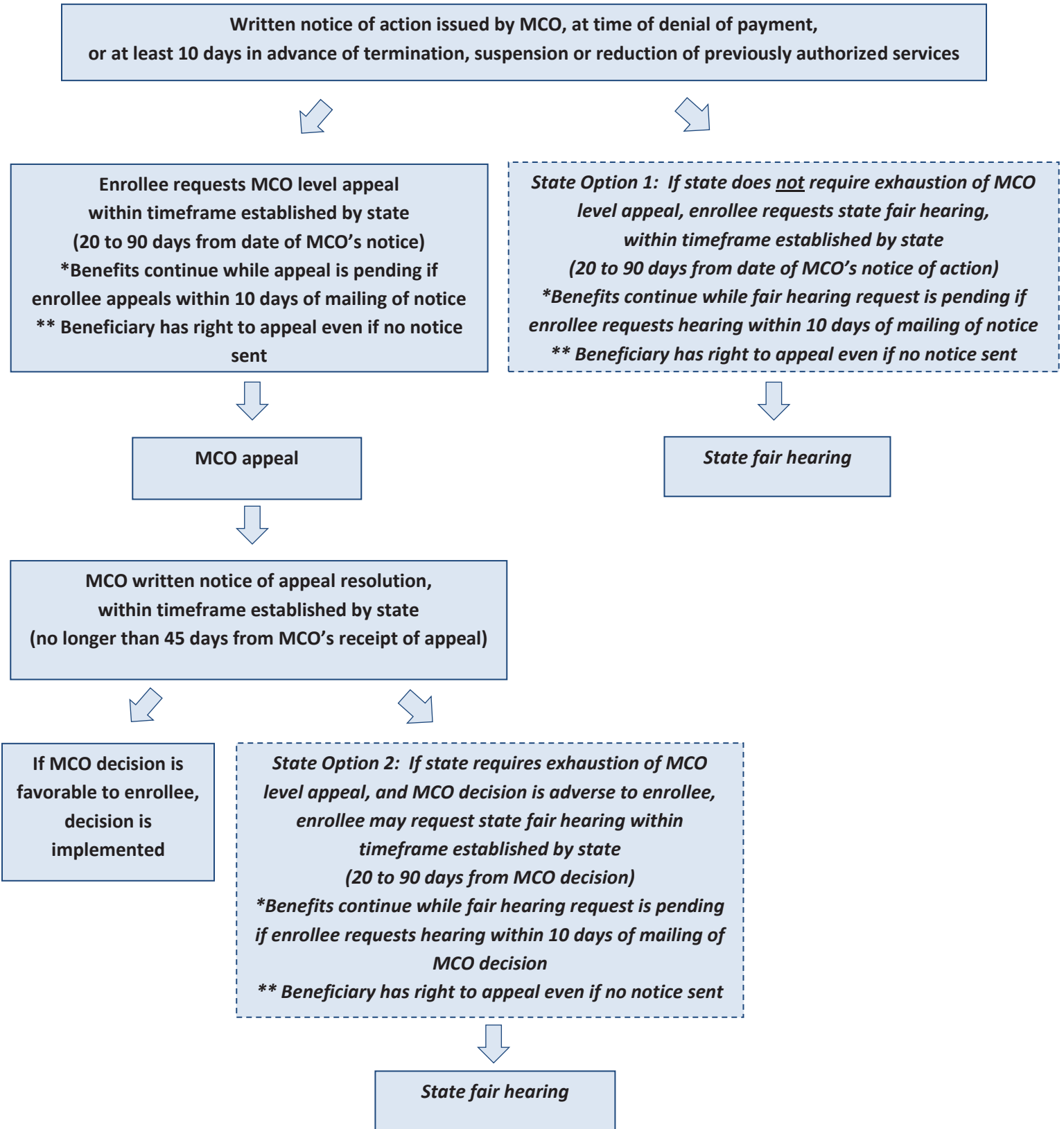
	MCO Appeal	State Fair Hearing	MCO Grievance
MCO denial or limited authorization of requested service	X	X	
MCO reduction, suspension or termination of previously authorized service	X	X	
MCO denial of payment for a service in whole or in part	X	X	
MCO failure to provide services in timeframe established by state	X	X	
MCO failure to resolve grievances or appeals in timeframe established by state	X	X	
MCO denial of request to obtain services outside network for enrollees in rural areas with only 1 MCO	X	X	
Enrollee dissatisfaction about quality of care or services provided			X
Provider or MCO employee failure to respect enrollee rights			X
MCO denial of enrollee request for expedited appeal			X
Other matters about which enrollee is dissatisfied that are not subject to MCO appeal			X

MCO Notices of Action

The MCO appeals process begins with a written notice of action (Figure 3, p. 17). MCO notices must use easily understood language and formats, must be available in the prevalent non-English languages spoken by enrollees in the MCO service area, as determined by the state, and must be available in alternative formats, such as those appropriate for people with visual limitations or with limited reading proficiency. An MCO notice must explain the action the MCO has taken or intends to take, the reasons for the action, the enrollee or provider’s right to file an appeal, the enrollee’s right to request a state fair hearing if the state does not require exhaustion of MCO appeals first, the procedures for exercising MCO appeal rights, the circumstances under which expedited resolution is available and how to request it, and the enrollee’s right to continued benefits pending appeal, how to request continued benefits, and the circumstances under which enrollees may be required to pay the costs of continued benefits. The required contents of MCO notices of action are summarized in Text Box 6. As in the state fair hearing context, notice is not a prerequisite for an individual to appeal, and individuals can ask for a hearing without waiting to receive a notice.

<p>Text Box 6: Required Contents of MCO Notices of Action</p> <ul style="list-style-type: none"> • Explanation of the action • Reasons for the action • Right to file MCO appeal • Right to request state fair hearing (if exhaustion of MCO appeal process not required first) • Procedures for exercising MCO appeal rights • When expedited resolution is available and how to request it • Right to continue services pending appeal, how to request it, and when enrollee liable to repay

**Figure 3:
Managed Care Appeals Process**



Different timeframes apply to the mailing of MCO notices, depending upon the type of decision. Notices of decisions to terminate, suspend or reduce previously authorized services generally must be mailed at least 10 days before the date of the action, except in limited circumstances.¹⁵ Notices of denial of payment must be mailed at the time of any action affecting the beneficiary's claim. Notices regarding decisions to deny or limit services in response to standard service authorization requests must be mailed as expeditiously as the enrollee's health condition requires and within state-established timeframes that may not exceed 14 calendar days of receipt of the service request. However, decisions on service authorization requests must be expedited if a provider indicates, or the MCO determines, that the standard decision timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. In such cases, notice of the MCO's decision must be provided as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the service request. Both the standard and expedited service request timeframes may be extended by 14 additional calendar days if requested by the enrollee or provider or if the MCO justifies (to the state agency upon its request) a need for additional information and how the extension is in the enrollee's interest. If the MCO extends the decision timeframe, it must provide written notice to the enrollee and inform the enrollee of her right to file a grievance about its decision to extend the timeframe. Service authorization decisions that are not made within the required timeframes are treated as denials. The timeframes required for mailing notices of various types of MCO decisions are illustrated in Figure 4 (p. 19).

MCO Appeal Requests and Continued Benefits Pending Appeal

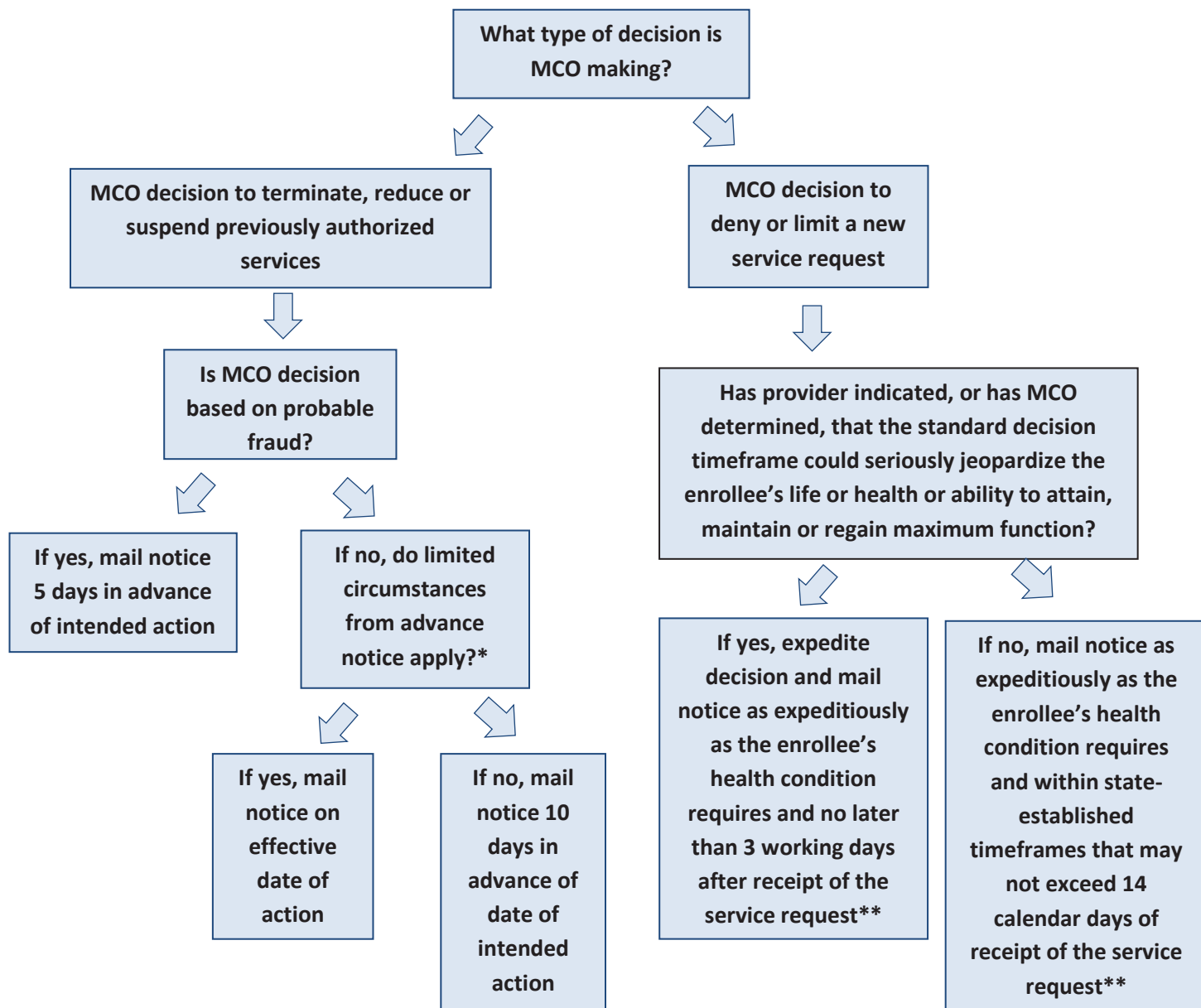
An MCO enrollee, or a provider acting on her behalf and with her written consent, may file an MCO appeal (Figure 3, p. 17). A case example of an MCO service termination appeal is described in Text Boxes 7, 8, and 9. Providers also may file grievances or state fair hearing requests on behalf of enrollees, if the state agency permits the provider to do so. MCOs must ensure that punitive action is not taken against providers who support an enrollee's appeal or who request expedited resolution of appeals. MCO appeals may be filed orally or in writing. Oral inquiries seeking to appeal an action must be treated as appeals to establish the earliest possible filing date. Oral appeals must be followed with a written signed appeal, unless the enrollee requests expedited resolution of the appeal (described below). MCO appeals must be filed within a reasonable timeframe established by the state agency, within 20 to 90 days from the date of the MCO's notice of action. MCOs must give enrollees any reasonable assistance with completing appeal forms and taking other procedural steps, such as providing interpreter services and toll-free numbers with adequate TTY and interpreter capability, and must acknowledge receipt of appeals.

Text Box 7:

Example of an MCO Service Termination Appeal - John's Story, Part 1 - Notice

John is a 15-year-old boy with cerebral palsy and cognitive limitations. He receives Medicaid benefits through an MCO. John's primary care doctor prescribed physical therapy services twice a week to help improve John's mobility and ability to assist in transferring from his wheelchair. John has received physical therapy for several years. Recently, John's Medicaid MCO sent a notice that says John's physical therapy services are no longer considered medically necessary and will be discontinued.

**Figure 4:
Timeframes for Mailing MCO Notices of Action**



*Limited circumstances from advance notice include the agency’s receipt of factual information confirming a beneficiary’s death, a beneficiary’s clear written statement declining services, a beneficiary’s admission to an institution where she is no longer eligible for services, returned mail with no forwarding address, the beneficiary’s acceptance for services by another jurisdiction, a change in the level of care prescribed by beneficiary’s physician, and an adverse preadmission screening determination.

** Time period may be extended by 14 additional calendar days if requested by the enrollee or provider or if the MCO justifies (to the state agency upon its request) a need for additional information and how the extension is in the enrollee’s interest; if MCO extends time period, it must provide written notice to the enrollee and inform the enrollee of her right to file a grievance about the decision to extend the decision timeframe.

The MCO must continue the enrollee's benefits while an appeal is pending in cases involving the termination, suspension or reduction of a previously authorized course of treatment ordered by an authorized provider, if the period covered by the original authorization has not expired and if the enrollee or provider files an appeal within 10 days of the mailing of the notice of action, or by the effective date of a proposed action, and requests that services continue. In these cases, benefits must continue until the enrollee withdraws the appeal; 10 days after the mailing of the MCO notice of appeal resolution, unless the enrollee timely requests that services continue while a state fair hearing request is pending; the issuance of a state fair hearing decision adverse to the enrollee; or the expiration of the time period or service limits of a previously authorized service. If the final resolution of the MCO appeal upholds the MCO's initial decision, the MCO may recover the cost of services furnished to the enrollee while the appeal was pending.

MCO Appeals Process and Decisions

MCOs have flexibility in designing their internal appeals process, provided that enrollees have a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The MCO must afford the enrollee and her representative the opportunity before and during the appeals process to examine the enrollee's case file, including medical records, and any other documents and records considered during the MCO appeals process. Individuals who decide MCO appeals must not have been involved in any previous review and must be health care professionals with appropriate clinical expertise in treating the enrollee's condition, as determined by the state, in appeals of denials based on lack of medical necessity, grievances regarding denials of expedited appeal resolution, and cases that involve clinical issues. The state agency must require MCOs to maintain records of grievances and appeals and must review that information as part of the state quality strategy. The MCO must resolve each appeal as expeditiously as the enrollee's health situation requires and within state-established timeframes no longer than 45 days after the MCO receives the appeal in standard appeals and no longer than 3 working days after the MCO receives the appeal in expedited appeals. These timeframes may be extended by the MCO by up to 14 calendar days at the enrollee's request or if the MCO shows (to the state agency's satisfaction upon its request) the need for additional information and how the delay is in the enrollee's interest. The MCO must provide written notice to the enrollee of the reason for any extensions. The MCO must maintain an expedited appeals review process for cases

Text Box 8:

John's Story, Part 2 – MCO Internal Hearing

John's parents decide to appeal the MCO's denial. Their state requires exhaustion of the MCO appeals process before a state fair hearing. John's parents file a written request for an MCO appeal. Because John's parents ask for the appeal within 10 days of the date of the termination notice, they also are able to ask for John's benefits to continue while the appeal is pending. John's parents receive a letter with a date for them to meet with the MCO. John's parents attend the appeal meeting, which is run by one of the MCO's medical directors who was not involved in the initial decision. The MCO's nurse case manager also is there to explain why the MCO wants to discontinue physical therapy. John's parents have the chance to explain why they think therapy should continue. A few days later, John's parents receive a letter saying that the MCO has upheld its decision to discontinue services.

where the MCO determines from an enrollee’s request, or the provider indicates, that the standard appeal resolution timeframe could seriously jeopardize the enrollee’s life or health or ability to attain, maintain or regain maximum function. If the MCO denies a request for expedited resolution, it must resolve the appeal within the standard timeframe, make reasonable efforts to provide the enrollee with prompt oral notice of the denial of expedited review and follow up with written notice of the denial of expedited review within 2 calendar days. The timeframes within which MCOs must take final action on appeals are illustrated in Figures 5 and 6 (pp. 22 and 23).

The MCO must provide written notice of the disposition of all appeals and must make reasonable efforts to also provide oral notice of decisions in expedited appeals. The written notice of appeal resolution must contain the MCO’s decision and the date the appeals process was completed, and for appeals not resolved wholly in the enrollee’s favor, must advise the enrollee about the right to request a state fair hearing and how to do so, the right to request that benefits continue while the fair hearing is pending and how to do so, and that the enrollee may be held liable for the cost of continued benefits if the state agency ultimately upholds the MCO’s decision. If the MCO or a state fair hearing officer reverses an MCO 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 enrollee’s health condition requires. If the MCO or a state fair hearing officer reverses an MCO decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the state must pay for those services in accordance with state policy and regulations.

State Fair Hearing Requests by MCO Enrollees

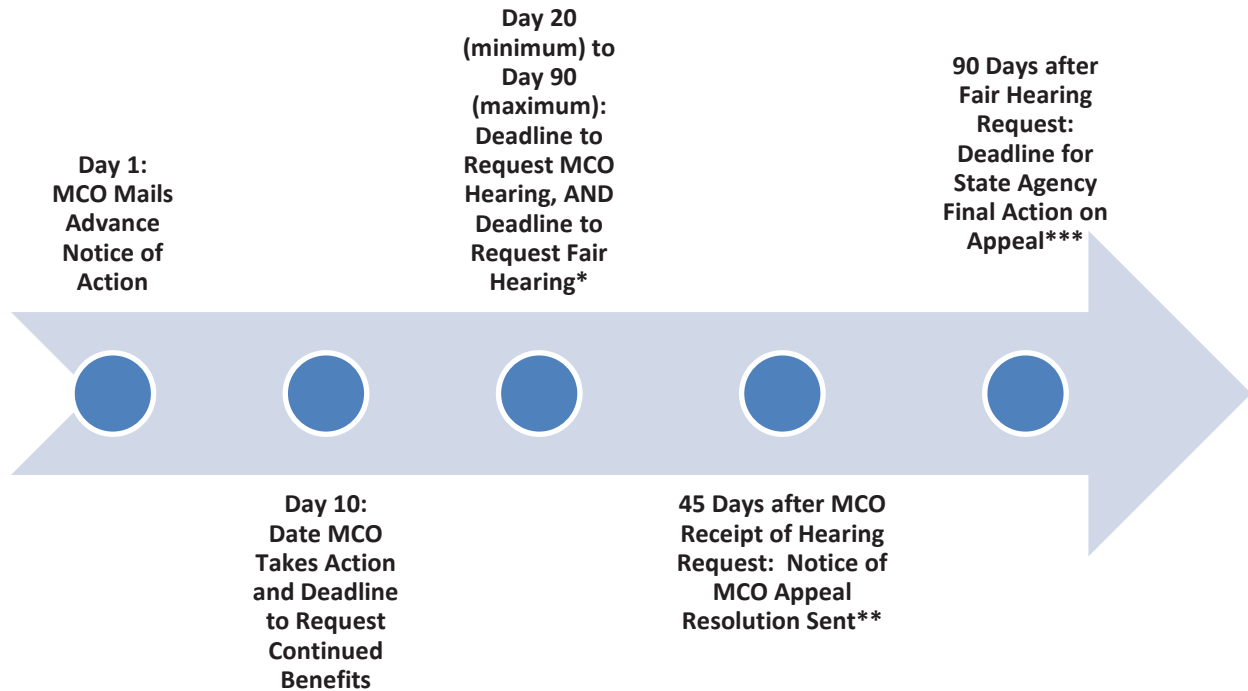
The state agency may permit MCO enrollees to request state fair hearings directly in response to MCO notices of action, or the state agency may require MCO enrollees to first exhaust the internal MCO appeal process before requesting a state fair hearing (Figure 3, p. 17). Figures 5 and 6 (pp. 22 and 23) compare the timelines for each option. State fair hearing requests must be filed within a reasonable time specified by the state within 20 to 90 days from the date of the MCO’s notice of appeal resolution if the state requires exhaustion of the MCO appeal procedures, or within 20 to 90 days from the date of the MCO’s notice of action if the state permits direct access to a fair hearing.

Text Box 9:

John’s Story, Part 3 – State Fair Hearing

John’s parents decide to ask for a state fair hearing. Again, they appeal in time to request that John’s benefits continue. They also call the local legal aid office, and an attorney there agrees to take their case and represent John at the hearing. At the fair hearing, the MCO is represented by a lawyer, too. The MCO medical director and nurse case manager testify about why the MCO decided to terminate physical therapy, and John’s parents also testify about why John needs services to continue. In addition, John’s doctor and physical therapist provide testimony about why they believe physical therapy continues to be medically necessary for John. All witnesses are cross-examined by the opposing lawyers, and the hearing officer also asks questions. The hearing officer takes a couple of months to issue a written decision. The decision finds that the MCO has to continue to authorize physical therapy for John under Medicaid’s Early and Periodic Screening Diagnosis and Treatment benefit. Because John’s benefits continued while the appeal was pending, his services have not been disrupted during the appeal.

**Figure 5:
Timeline for Managed Care Appeal Process with
State Option for *Simultaneous* Fair Hearing**

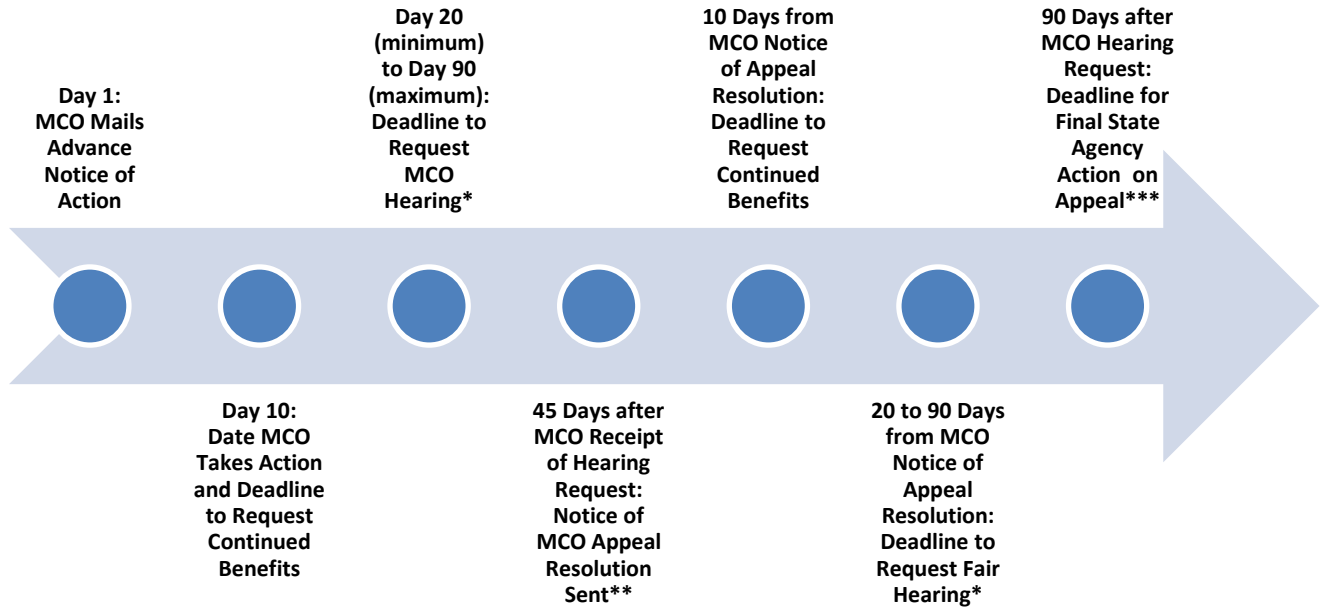


*Established by state within federal limits

**Except that expedited appeals must be resolved within state-established timeframe no later than 3 working days of MCO’s receipt of appeal. Timeframes may be extended by the MCO by up to 14 calendar days if the enrollee requests or if the MCO shows (to the state agency’s satisfaction upon its request) the need for additional information and how the delay is in the enrollee’s interest, with written notice to the enrollee of the reason for any extensions. If the MCO denies a request for expedited resolution, it must resolve the appeal within the standard timeframe, make reasonable efforts to provide the enrollee with prompt oral notice of the denial of expedited review and follow up with written notice of the denial of expedited review within 2 calendar days.

*** Except that expedited appeals must be resolved within 3 working days after state agency receives case file and information from MCO that expedited criteria are met, but appeal was not resolved within that timeframe or was resolved within that timeframe but wholly or partially adverse to enrollee. Criteria for expedited resolution are if resolution in standard timeframe could seriously jeopardize enrollee’s life or health or ability to attain, maintain or regain maximum function.

**Figure 6:
Timeline for Managed Care Appeal Process with
State Option for *Subsequent* Fair Hearing**



*Established by state within federal limits

** Except that expedited appeals must be resolved within state-established timeframe no later than 3 working days of MCO’s receipt of appeal. Timeframes may be extended by the MCO by up to 14 calendar days if the enrollee requests or if the MCO shows (to the state agency’s satisfaction upon its request) the need for additional information and how the delay is in the enrollee’s interest, with written notice to the enrollee of the reason for any extensions. If the MCO denies a request for expedited resolution, it must resolve the appeal within the standard timeframe, make reasonable efforts to provide the enrollee with prompt oral notice of the denial of expedited review and follow up with written notice of the denial of expedited review within 2 calendar days.

***Not including number of days enrollee subsequently took to request fair hearing. Expedited appeals must be resolved within 3 working days after state agency receives case file and information from MCO that expedited criteria are met, but appeal was not resolved within that timeframe or was resolved within that timeframe but wholly or partially adverse to enrollee. Criteria for expedited resolution are if resolution in standard timeframe could seriously jeopardize enrollee’s life or health or ability to attain, maintain or regain maximum function.

If an MCO enrollee requests a state fair hearing, the state agency must take final administrative action within 90 days of the date the enrollee requested an MCO appeal, not including the number of days the enrollee took to subsequently request a state fair hearing, or within 90 days of the date the enrollee filed for direct access to a state fair hearing if the state does not require exhaustion of MCO appeals. In expedited appeals, the state agency must take final administrative action as expeditiously as the enrollee's health condition requires and no later than 3 working days after the agency receives from the MCO the case file and information about any appeal of a service denial that, as indicated by the MCO, meets the criteria for expedited resolution (i.e., resolution in standard timeframe could seriously jeopardize enrollee's life or health or ability to attain, maintain or regain maximum function) but was not resolved within that timeframe or was resolved within that timeframe but wholly or partially adverse to the enrollee. If the state agency permits direct access to state fair hearings, the state agency must take final administrative action as expeditiously as the enrollee's health condition requires but no later than 3 working days after the agency receives directly from an MCO enrollee a fair hearing request on a decision to deny services that the state agency determines could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function if resolved within the standard timeframe. The timeframes for final administrative action by the state Medicaid agency in fair hearings for MCO enrollees are illustrated in Figures 5 and 6 (pp. 22 and 23), and MCO enrollees' appeal rights are summarized in Text Box 10 below.

**Text Box 10:
MCO Enrollee Appeal Rights**

- To request an MCO appeal, within applicable time limits
- To request a state fair hearing, within applicable time limits
- To file an MCO grievance
- To receive adequate timely written notice of MCO decisions
- To have oral inquiries about appeals treated as appeals
- To receive reasonable assistance from the MCO in completing appeal forms and other procedural steps
- To request that services continue until an appeal decision, within applicable time limits
- To request expedited review of appeals
- To have a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing
- To have the opportunity before and during the appeals process to examine the enrollee's case file, including medical records, and any other documents and records considered during the MCO appeals process
- To have MCO appeal decided by individual who was not involved in any previous review and in certain circumstances, who is a health care professional with appropriate clinical expertise
- To receive written notice of the MCO appeal decision
- To have services authorized or provided promptly and as expeditiously as the enrollee's health condition requires, and to have services received while the appeal was pending paid, if the enrollee wins her appeal

Looking Ahead

The Medicaid appeals process provides important protections for individual applicants and beneficiaries seeking eligibility for the program and coverage of prescribed services. Monitoring of appeals at a systemic level also can provide useful management insights into program performance and opportunities for quality improvement. At the same time, the appeals process is multi-layered and can be complex to navigate. While Medicaid state agency and managed care employees become familiar with the process as repeat players and typically have access to lawyers through the state attorney general's office or private law firms, relatively few applicants and beneficiaries are represented by legal counsel in Medicaid appeals. A report issued by the Legal Services Corporation found that "[o]nly a small fraction of the legal problems experienced by low-income people (less than one in five) are addressed with the assistance of either a private attorney (pro bono or paid) or a legal aid lawyer."¹⁶ Similarly, the National Center for Medical-Legal Partnership estimates that "every low-income family has an average of three unmet legal needs" and that "publicly funded legal aid agencies turn away three out of every five applicants for assistance."¹⁷

The features of the Medicaid appeals system are increasingly significant as health reform is implemented. The Medicaid appeals process is different from the appeals processes available through the Medicare program and private health insurance. Recent health reform initiatives encourage the integration of Medicare and Medicaid benefits for people who are eligible for both programs, raising questions about how appeals in integrated systems must be handled to ensure conformity with constitutional due process requirements. In addition, as of January, 2014, new health insurance affordability programs, such as premium tax credits through insurance exchanges and basic health plans provided at state option, will be available. The health reform law requires a single streamlined application for Medicaid, CHIP and benefits available through the exchanges that must assess every applicant's Medicaid eligibility before considering eligibility for other programs. Unless an individual is approved for Medicaid, every application or redetermination of an individual's eligibility for a state health subsidy will therefore trigger notice and a right, if requested, to a fair hearing. The appeals system for benefits available through the exchanges is still being developed. In addition, disputes about covered services will inevitably arise when the estimated 16 million childless adults obtain new coverage through the Medicaid expansion, many of whom will enroll at state option in Medicaid managed care organizations. Consequently, the Medicaid appeals process will continue to play an important role in ensuring that applicants and beneficiaries receive the services to which they are entitled.

This background paper was prepared by MaryBeth Musumeci of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Endnotes:

¹ This paper is based largely on the applicable federal Medicaid regulations; significant judicial precedent governing Medicaid appeals is beyond its scope. It also does not address applicants' and beneficiaries' right to sue to enforce the Medicaid Act in federal court, which may be appropriate in circumstances where beneficiaries seek a determination that state action violates federal law and/or injunctive relief, neither of which are available in the fair hearing context.

² The Fifth Amendment to the U.S. Constitution, applicable to the federal government, in pertinent part provides "No person shall. . . be deprived of life, liberty, or property, without due process of law." The Fourteenth Amendment to the U.S. Constitution in pertinent part provides ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law. . . ."

³ *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970) (quoting *Kelly v. Wyman*, 294 F. Supp. 893, 899, 900 (S.D.N.Y. 1968)).

⁴ *Id.*, 397 U.S. at 266 (quoting *Kelly v. Wyman*, 294 F. Supp. at 904-05).

⁵ See also National Health Law Program, *The Advocate's Guide to the Medicaid Program*, 2.23-2.25 (May 2011). The CMS State Medicaid Manual is available at

<http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10>.

⁶ See 42 U.S.C. § § 12131 *et seq.*; 28 C.F.R. Part 35.

⁷ CMS State Medicaid Manual, § 2900.3, available at

<https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

⁸ *Id.*, § 2900.4, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

⁹ Exceptions to the 10 day advance notice requirement include the agency's receipt of factual information confirming a beneficiary's death, a beneficiary's clear written statement declining services, a beneficiary's admission to an institution where she is no longer eligible for services, returned mail with no forwarding address, the beneficiary's acceptance for services by another jurisdiction, a change in the level of care prescribed by beneficiary's physician, and an adverse preadmission screening determination. Cases of probable fraud require 5 days advance notice.

¹⁰ CMS State Medicaid Manual, § 2902.6, available at

<https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

¹¹ *Id.*, § 2902.8, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

¹² *Id.*, § 2902.9, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

¹³ *Id.*, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

¹⁴ *Id.*, § 2904.1, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

¹⁵ The same exceptions as listed in note 9 above apply here.

¹⁶ Legal Services Corporation, "Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans" (2009), available at

http://www.lsc.gov/pdfs/documenting_the_justice_gap_in_america_2009.pdf.

¹⁷ Ellen Lawton *et al.*, "Disparities in Health, Disparities in Law: The Global Potential of Individual Advocacy," in *Health Capital and Sustainable Socioeconomic Development* (Patricia A. Cholewka & Mitra M. Motlagh eds., 2008).

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