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VAYA HEALTH PROVIDER ADVISORY COUNCIL

Due Process Overview

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DMA WAIVER CONTRACT AMENDMENT

- Requires Vaya to inform providers about Enrollee grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR §438.400 through 42 CFR §438.424.

Grievance Process and Timeline

- Member can file grievance about any matter other than a SAR decision
- No Wrong Door – telephone, care coordinator, email, EthicsPoint, 24/7 Hotline
- Vaya has 90 days to resolve grievance, can be extended by 14 days
- We strive to resolve or refer for investigation within 30 days
- Providers must cooperate with Vaya grievance process and must have their own grievance process
- Member not required to use provider grievance process first

- *Alexander* (DSS wait times)
- *Antrican* (Dental Access)
- *McCartney* (Behavioral Health)
- *Pashby* (PCS)
- *L.S. v. Wos* (Cardinal Innovations)

WHY DOES DHHS CARE SO MUCH ABOUT ENROLLEE APPEAL RIGHTS?

WHEN IS MEDICAID BENEFICIARY ENTITLED TO APPEAL?

- Whenever Vaya Health issues Adverse Benefit Determination (used to be called “Action”)
- You know, because “Adverse Benefit Determination” is so much simpler

WHAT IS AN ADVERSE BENEFIT DETERMINATION?

- Denial (in whole or in part) of request for Medicaid (including b3) services
- Reduction, suspension, or termination of a previously authorized service
- Payment denial
- Failure to provide services in a timely manner, as defined by the State
- Failure to issue decision in 14 calendar days
- Denial of a request to obtain out of network services (only applies if member lives in rural area)

AUTHORITY TO REVIEW 42 CFR § 438.210(a)(4)

- Vaya can place appropriate limits on services
  - based on established criteria such as medical necessity
  - not budget or cost-cutting goals (no incentives to deny)
- Utilization review is a safeguard against unnecessary and inappropriate medical care. It allows managed care organizations to review member care from perspectives of medical necessity, quality of care, and other factors
- **Provider responsibility to document medical necessity**

WRITTEN NOTICE OF ADVERSE BENEFIT DETERMINATION

- Must include the basis and clinical reasons for decision, appeal rights and appeal form
- If decision is to deny, reduce/ or terminate “previously authorized” service, must give 10 days’ advance notice
- **Previously authorized means there is a current active auth**
- Provider receives electronic or mailed notification – does not receive appeal form

MAILING NOTICES

- Date of notice must be date of mailing
- Mailed to member or guardian within 1 business day of decision
- Sent via certified mail
- Sent to address on file with DSS (NCFAST may not have accurate information)
- Member Appeals Team always researches guardian information and strives to mail guardian directly
- Critical for care coordinator and provider to work with member to keep address current

HOW AND WHEN DOES MEMBER APPEAL?

- Member has 60 (***used to be 30***) calendar days to request reconsideration with MCO
- Can request orally to preserve filing date but must follow with written confirmation
- Vaya acknowledges receipt of appeal in writing
- Provider can only file appeal with written consent of member or guardian
- Cannot go straight to State, must go through MCO reconsideration process

- An appeal of a denial or partial approval (limited authorization) of a service does not prevent the provision of other authorized services during the appeal
- Enrollee can always make new requests for services during the appeal

DURING THE APPEAL

CONTINUATION OF BENEFITS

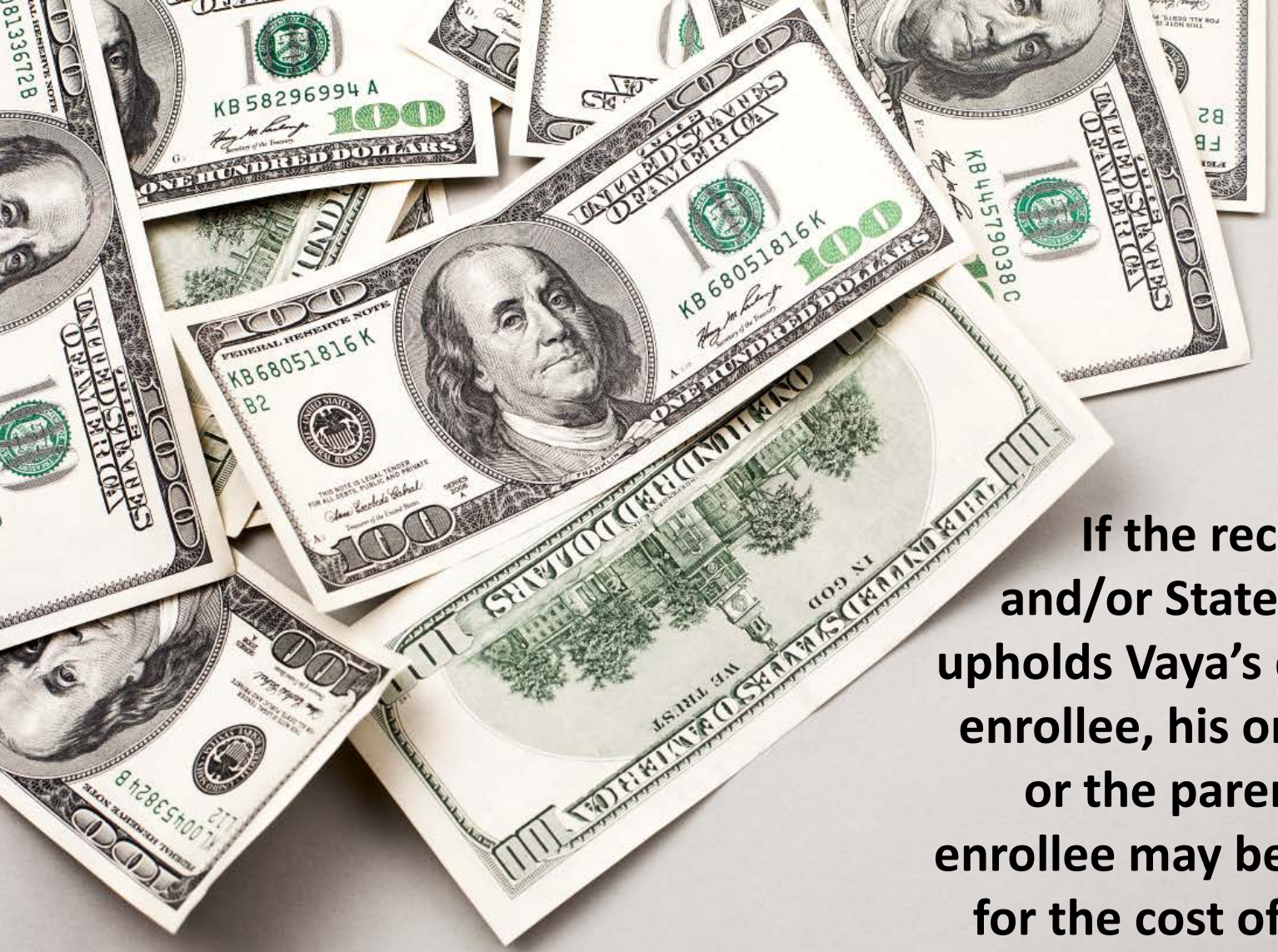
- Member can request continuation of benefits within 10 days of notice of adverse benefit determination
- MCO must continue benefits if ALL of the following are met:
  - Enrollee files timely request for an appeal
  - The appeal involves the termination, suspension, or reduction of previously authorized services;
  - Services were ordered by an authorized provider;
  - **Period covered by the original authorization has not expired;** AND
  - Enrollee timely files for continuation of benefits.

CONTINUATION OF BENEFITS

*****REVISED*****

Benefits must continue until either:

- Enrollee withdraws the appeal; OR
- Enrollee fails to request a state fair hearing and COB within 10 calendar days after Vaya sends notice of an adverse resolution; OR
- State fair hearing office issues a hearing decision adverse to the enrollee.



If the reconsideration and/or State Fair Hearing upholds Vaya's decision, the enrollee, his or her spouse, or the parent of a minor enrollee may be responsible for the cost of the services furnished during the reconsideration and/or State Fair Hearing

- Member has right to review medical record and documents relied on in making decision
- Can submit any additional information, even if information dates prior to decision and was not included in material submitted by provider
- Reviewed by clinician who was not involved in original decision, and who is not a subordinate of person who made decision

RECONSIDERATION REVIEW PROCESS

RECON REVIEW TIMEFRAME AND DECISION

- MCO has 30 calendar days to issue decision, unless expedited
- Decision mailed to member or guardian
- Date of notice must be date mailed
- If original decision upheld, must include appeal rights and Office of Administrative Hearings (OAH) appeal form
- Provider receives electronic or mailed notification (does not receive appeal form)

STATE FAIR HEARING (OAH)

- Member or provider with permission has 120 (***used to be 30 days***) from date of decision to file appeal
- First step: Voluntary Mediation conducted by Mediation Network of NC
- If not resolved at mediation, hearing will be scheduled before ALJ
  - Usually conducted by telephone
  - Can submit new evidence
- OAH has 55 days to issue final decision
- If either party dissatisfied, can file appeal to Superior Court within 30 days

NON-MEDICAID APPEALS

- Vaya processes timely appeals filed by members who contest denials of non-Medicaid funded service requests
- Must be received within 15 business days of adverse notice
- Non-Medicaid services and funding not an entitlement
- EPSDT does not apply
- No right to go to OAH – can appeal to DMH if disagree with MCO, but MCO makes final decision

LET'S RECAP

- Due Process is the right of Medicaid beneficiaries to receive notice and a hearing if Vaya issues adverse benefit determination (denial, reduction, termination of service authorization)
- Vaya has 14 days to make standard authorization decisions, and 72 hours for expedited decisions
- Members who disagree with ABD issued by Vaya now have 60 days to file request for reconsideration
- If Vaya decision upholds original action in whole or in part, member now has 120 days to appeal to OAH