Federal Requirements and State Options: Appeals

State Medicaid programs are required to have a process for beneficiaries to appeal adverse decisions. These include decisions made by the state in determining eligibility for or coverage of specific services under fee for service, or decisions made by a health plan related to coverage of services under managed care arrangements.[1]

The right to appeal is established in federal statute and is based on the constitutional right to due process. These standards were set forth in the U.S. Supreme Court's 1970 decision in *Goldberg v. Kelly*.[2] The decision held that:

- public benefits are a statutory entitlement and due process is applicable in adverse decisions;
- a pre-termination evidentiary hearing is necessary to provide beneficiaries with procedural due process;
- prior to the hearing, beneficiaries must be provided with timely notice detailing reasons for termination;
- beneficiaries must have an opportunity to present arguments in their own behalf and have the right to have a lawyer present; and
- the decision-maker conducting the hearing must be impartial and should not have been involved in making the determination under review.

State responsibilities are outlined in federal statute (§§ 1902(a)(3) and 1932(b)(4) of the Social Security Act (the Act)) and regulation (42 CFR 431.200–250 and 42 CFR 438.400–424). States must provide a fair hearing when a claim for assistance is denied or not acted upon in a timely manner. The right to a hearing is extended to any beneficiary who believes the state Medicaid program or the health plan—including prepaid inpatient health plans (PIHPs) or prepaid ambulatory health plans (PAHPs)—has incorrectly carried out an adverse action or denied a claim for covered benefits or services, or has not acted upon a claim with reasonable promptness (42 CFR 431.220).[3]

The state's hearing system must meet due process standards set forth in *Goldberg v. Kelly* and must be accessible to people who have limited English proficiency and those with disabilities. Each state plan must provide for an appeals process but states retain some flexibility in the design and implementation of the appeals process (discussed in greater detail in Table 1).

The remainder of this fact sheet describes steps each state Medicaid program must take in carrying out its appeals processes for fee for service (FFS) and managed care benefit determinations. Medicaid's FFS appeals process is described in greater detail in MACPAC's state policy compendium, *Elements of the Medicaid Appeals Process under Fee for Service, by State*.

Medicaid and CHIP Payment and Access Commission

1800 M Street NW
Suite 650 South
Washington, DC 20036

www.macpac.gov
202-350-2000
202-273-2452

Notice of Action

The appeals process begins with a notice of intended action from the state Medicaid program or health plan of intended action. Action is defined as a termination, suspension of, or reduction in covered benefits or services (42 CFR 431.201).

Notice must be sent to the beneficiary at least 10 days prior to action on an adverse benefit determination (42 CFR 431.211 and 438.404). The notice must include a statement about the intended action; purpose of the action; a clear statement about the reason for the action; regulations that support the action; beneficiary rights, including the right to an expedited hearing; and the process for continuation of benefits if a hearing or appeal is requested (42 CFR 431.210 and 438.404(b)).[4]

States may offer a timely notice period of greater than ten days. Further, Medicaid programs may be excluded from the timely notice requirement if the agency has proof of the death of the beneficiary or the agency receives a written statement that the beneficiary no longer wishes to receive services (42 CFR 431.213 and 431.214).[5]

For managed care benefit determinations, appeals take place at the health plan level. Following the notice of adverse benefit determination beneficiaries may file an appeal with their health plan. Each plan may only offer one level of appeal. Beneficiaries may file a request an appeal up to 60 days following the notice of adverse benefit determination. States must establish a timeframe for standard resolution of an appeal that is no longer than 30 days from the day the health plan receives the appeal. If the beneficiary requests an expedited resolution—that is, resolution within 72 hours—the health plan may extend the time frame by up to two weeks if the extension is requested by the beneficiary or if the health plan can prove that additional time to gather more information would be in the interest of the beneficiary (42 CFR 438.408).

Optional Evidentiary Hearing

States have the option of offering the beneficiary a local evidentiary hearing prior to a state fair hearing for FFS appeals. These hearings may take place at the local or county level. States may offer these local hearings in selected subdivisions. The agency conducting the hearing must send adequate notice containing information about the hearing. If the local hearing decision is unfavorable to the beneficiary, the state is required to notify the beneficiary in writing of:

- the hearing decision;
- the beneficiary's right to appeal within 10 days after the individual receives the notice of the adverse decision. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows that he or she did not receive the notice within the five-day period (42 CFR 431.232(b));
- the beneficiary's right to request a de novo hearing, restarting the appeals process;[6] and
- the beneficiary's right to discontinue services following adverse decision (42 CFR 431.232)

State Fair Hearing

If a state does not offer local evidentiary hearings, a state fair hearing, if requested, may take place immediately following the notice of intended action. All hearings must be conducted after adequate written notice at a reasonable time and place and by one or more impartial officials (42 CFR 431.240(a)). States may grant authority to the state or federal health insurance exchange to conduct appeals for eligibility determinations as long as beneficiaries are given the option to appeal to the state.[7] States also have the option to review exchange eligibility decisions (42 CFR 431.10(c)(1)(ii) and 431.10(c)(3)(iii)).[8] The state must allow beneficiaries a reasonable time that is not more than 90 days to request a fair hearing following the date the notice of action is mailed (42 CFR 431.221). Beneficiaries must be permitted to request a fair hearing by mail, telephone, in person, or online. An authorized representative may request a fair hearing on behalf of a beneficiary (42 CFR 431.221(a)). Moreover, a state may consolidate individual hearings into a single group hearing if the sole issue involved is one of federal or state law or policy (42 CFR 431.222).

For managed care benefit determinations, individuals may initiate a state fair hearing if they have exhausted the appeals process or if they received notice that the health plan is upholding the adverse benefit determination (42 CFR 438.408(f)(1))[9]. States have the option to allow providers or authorized representatives to request an appeal or state fair hearing on behalf of enrollees (42 CFR 438.402(c)(1)(ii)). Managed care beneficiaries may request a fair hearing up to 120 days after the health plan has issued the appeals resolution notice (42 CFR 438.408(f)(2)). The health plan may extend the time frame for appeals by up to two weeks if it is requested by the enrollee or if the plan can show the state agency a need for the additional time (42 CFR 438.408(c)). Further, the state may offer an external medical review at the enrollee's option if:

- the review is not used as a deterrent to proceed to a state fair hearing;
- it is conducted as independent of the state and health plan;
- it is free to the enrollee; and
- the review does not extend the time frame of the appeals process or disrupt the continuation of benefits (42 CFR 438.402(c)(1)(i)(B))

Receipt of Decision

Typically, the state must take final administrative action within 90 days following the request for a fair hearing. If the beneficiary was granted an expedited fair hearing, the decision must be issued no later than three working days after the request for expedited fair hearing (42 CFR 431.244(f)). Decisions must be in writing and must be based only on evidence introduced in the hearing. In the case of an evidentiary hearing, decisions must summarize facts and identify regulations that support the decision. In the case of a de novo hearing, the decision must specify the reasons for the decision and identify supporting evidence. State hearing decisions must be made publicly available. The notice of decision must notify beneficiaries of their right to seek rehearing or judicial review (42 CFR 431.244–245).

Continuation of Benefits

If the state sends timely notice and the beneficiary requests a hearing before the effective date of the action, the state may not terminate or reduce services until a decision is reached and may reinstate services if a beneficiary requests a hearing not more than 10 days after the date of action (42 CFR 431.231). The state may terminate services if it is determined that the sole issue is one of federal or state law or if the state informs the beneficiary that services are to be terminated or reduced pending the hearing decision (42 CFR 431.230).

For managed care benefit determinations, the health plan must continue an enrollee's benefits if:

- the request for appeal is filed by the enrollee or the provider within 60 days from the date on the adverse benefit determination notice;
- the appeal involves an adverse determination resulting in termination, suspension, or reduction of services; the services in question were ordered by a provider;
- the originally authorized timeline for coverage has not expired; and
- the enrollee files the request for continuation of benefits within 10 calendar days of the notice of adverse benefit determination or before the intended effective date of the proposed adverse benefit determination, whichever is later (42 CFR 438.420).

TABLE 1. Federal Requirements and State Options: Summary of State Flexibilities Related to Appeals

Stages of appeals process	Federal statutory and regulatory requirements	State plan options
Notice of action	• The state or local agency must send a notice at least 10 days before the date of action (42 CFR 431.211 and 438.404).	• None available
Optional level of appeals	• If the state elects to offer a local evidentiary hearing, the state must inform the applicant or beneficiary in writing of the right to appeal within 10 days after receiving notice of an adverse decision (42 CFR 431.232).	• The state retains the option to offer a local evidentiary hearing with the ability to appeal to the Medicaid agency (42 CFR 431.205(b)(2)). • The state may offer local evidentiary hearings in some localities and not others (42 CFR 431.205(c)).
Requesting a fair hearing	• The state must allow the applicant or beneficiary a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing (42 CFR 431.221). • The state must permit the beneficiary to request a fair hearing by mail, telephone, in person, or online (42 CFR 431.221(a)). • The state must permit the beneficiary to request an expedited appeal (42 CFR 438.408). • If the state has delegated hearing procedure authority to the health insurance exchange for program eligibility determinations the state must provide beneficiaries with the choice to have the fair hearing conducted by the state (42 CFR 431.10(c)(1)(ii)).	• The state chooses the time frame but it cannot exceed 90 days. The state may delegate hearing procedure authority to the state or federal exchange or exchange appeals entity (42 CFR 431.10(c)(1)(ii)). If so, the state may choose to establish a review process to oversee exchange appeals decisions (42 CFR 431.10(c)(3)(iii)).

TABLE 1. (continued)

Stages of appeals process	Federal statutory and regulatory requirements	State plan options
Conducting a fair hearing	• All hearings must be conducted after adequate written notice of hearing, at a reasonable time and place, and by one or more impartial officials (42 CFR 431.240(a)).	• Optional group hearings (42 CFR 431.222)
Receipt of decision	• In general, the appeal must be resolved within 90 days (42 CFR 431.244(f)). An expedited hearing decision must be issued within 3 working days after the request for an expedited hearing (42 CFR 431.244(f)(2)). • The agency must notify the applicant or beneficiary in writing of the decision and their right to seek judicial review (42 CFR 431.245).	• None available
Continuation of benefits	• Typically, if the beneficiary receives the timely notice as required under 42 CFR 431.211 or 431.214 and requests a hearing before the date of action, the agency may not terminate or reduce services until after the hearing decision is final (42 CFR 431.230).	• The state may reinstate benefits if the beneficiary requests a hearing not more than 10 days after the action (42 CFR 431.231).
Managed care benefit determination	• In managed care benefit determinations, the appeal process begins at the plan level following the notice of action. Each health plan may have only one level of appeal (42 CFR 438.402(b)). • For standard resolutions, the state must establish a time frame that is no longer than 30 days from the day the health plan receives the appeal (42 CFR 438.408(b)(2)).	• The state may allow a provider or authorized representative to request an appeal or state fair hearing on behalf of enrollees (42 CFR 438.402(c)(1)(ii)). • The appeals time frame may be extended if requested by the enrollee or if the health plan can prove that additional time would be beneficial to the enrollee (42 CFR 438.408(c)). • The state may offer and arrange for an external medical review (42 CFR 438.402(c)(1)(i)(B)).

TABLE 1. (continued)

Stages of appeals process	Federal statutory and regulatory requirements	State plan options
	• An enrollee may request a state fair hearing only after receiving notice that the health plan is upholding the adverse benefit determination or through deemed exhaustion of the appeals processes. • For the health plan to continue benefits, in addition to filing for continuation before the date of action or within 10 days, beneficiaries must meet the following criteria: – beneficiaries or providers must file an appeal within 60 days from the date on the adverse benefit determination notice; – the appeal must involve an adverse determination resulting in termination, suspension, or reduction of services; – services in question must have been ordered by a medical professional; and – the originally authorized timeline for coverage must not have expired (42 CFR 438.420).	

Note: Information is current as of May 8, 2018.
Source: MACPAC analysis of the *Code of Federal Regulations*, and CMS 2016a and 2016b.

Endnotes

[1] This brief does not cover services provided in nursing facilities.

[2] *Goldberg v. Kelly*, 397 U.S. 254 (1970).

[3] A PAHP is an entity without a comprehensive risk contract that provides services (other than inpatient hospital services and institutional services) to enrollees under a contract with the state on the basis of payment arrangements that do not follow state plan rates. A PIHP is an entity without a comprehensive risk contract that provides inpatient hospital or institutional services to enrollees under a contract with the state on the basis of payment arrangements that do not follow state plan rates (42 CFR 438.2).

[4] Beneficiaries are entitled to have their benefits continued until the hearing decision is final if they receive timely notice and request a state fair hearing or appeal at the plan level before the date of action (42 CFR 431.230 and 438.404(b)).

[5] Other examples of exception from advance notice on the part of the Medicaid agency include: the beneficiary is admitted to an institution disqualifying them from services; the beneficiary's whereabouts are unknown and no forwarding address is known; the beneficiary is accepted for services by another Medicaid jurisdiction; a physician prescribes a change in medical care; or the agency has facts indicating an action should be taken due to probable fraud (42 CFR 431.213–214).

[6] A de novo hearing is a hearing that starts over from the beginning as if it has not been previously heard (42 CFR 431.201).

[7] The term "exchange" means a federal or state health benefit exchange. Exchanges are governmental agencies or nonprofit entities (established by the state or federally by the U.S. Department of Health and Human Services to facilitate the purchase of qualified health plans (45 CFR 155.20).

[8] States that choose to delegate the authority to conduct fair hearings to the exchange or exchange appeals entity must provide individuals with a choice to have the fair hearing conducted by the state (42 CFR 431.10(c)(1)(ii)). Further, states have the option to establish a review process to oversee decisions made under that delegation (42 CFR 431.10(c)(3)(iii)). For example, if a state has delegated eligibility determinations and appeals to the exchange, a beneficiary may apply for Medicaid at the exchange and if they are deemed ineligible they may file an appeal directly with the exchange with whom they have had contact rather than going to the Medicaid agency (CMS 2013). Massachusetts is one example of a state that delegates some authority to the health insurance exchange to conduct eligibility appeals and fair hearings (Code of Mass. Regulations tit. 130 § 515.004 (2014)).

[9] Deemed exhaustion of the appeals process means (1) the beneficiary received a resolution notice from the health plan or (2) the health plan failed to operate within the notice and timing requirements set forth by the appeals regulations (42 CFR 438.408).

References

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