Beyond the Basics

Medicaid Eligibility Appeals

Presented in partnership with the National Health Law Program

May 16, 2023

Webinar Logistics

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Beyond the Basics

National Health Law Program

- NHeLP is a national, non-profit organization that protects and advances the health rights of low-income and underserved individuals and families
- NHeLP advocates, educates and litigates at the federal and state levels
- Find out more: www.healthlaw.org
  → Follow NHeLP on Twitter and on Facebook

Today's presentation provides a general policy overview and does not provide direct legal advice.

Agenda

- PHE Unwinding Overview
- What Determinations Can Be Appealed
  - Pause for questions
- How to Request an Appeal
- Rights During the Appeals Process
- Appeals Process and Implementing Eligibility Decision
  - Pause for questions
- Resources

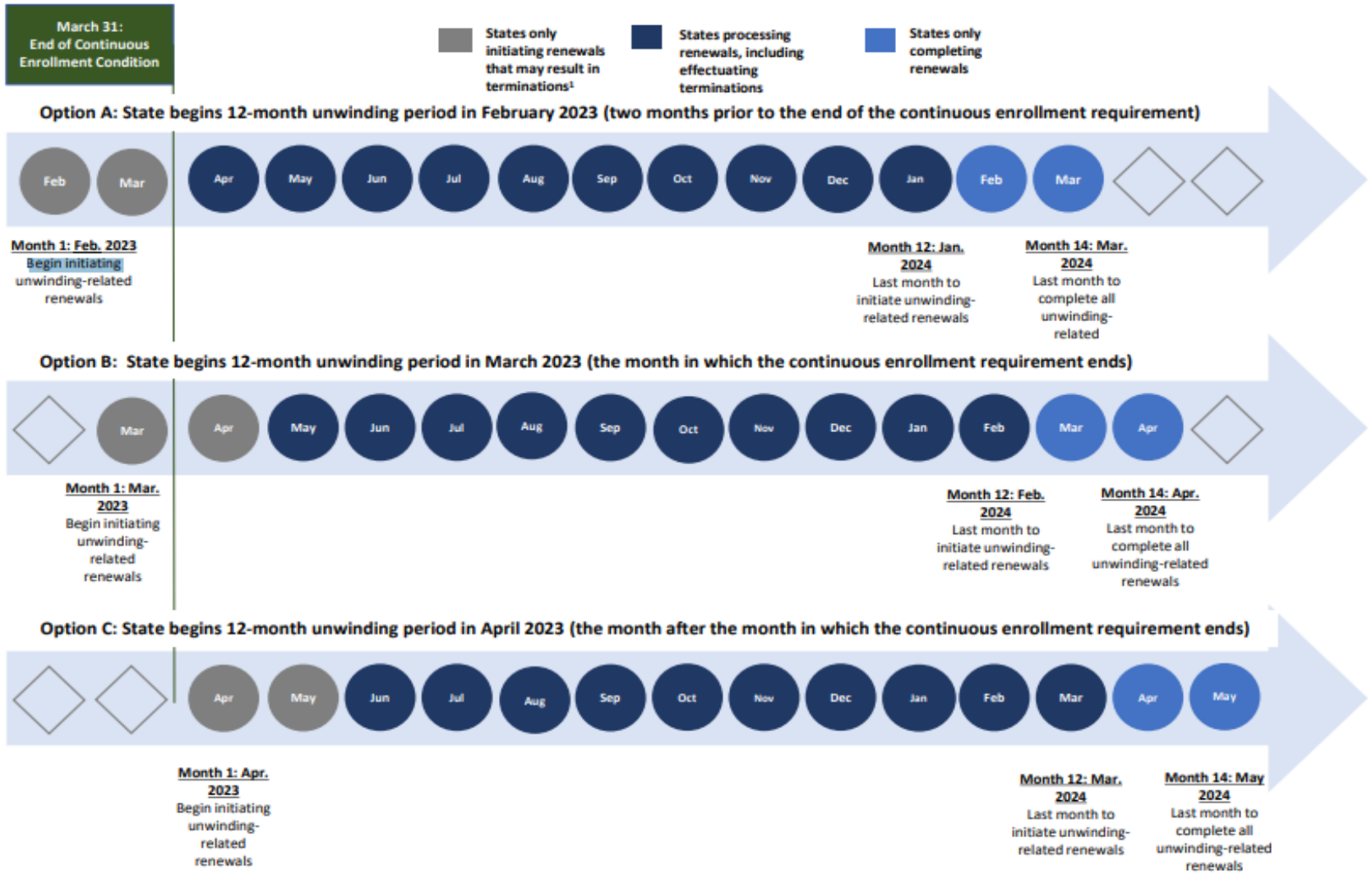
PHE Unwinding Overview

Continuous Coverage End Date

- Consolidated Appropriations Act of 2023 set the continuous coverage end date!
- End of continuous coverage previously tied to the PHE, but NO MORE! Ended **March 31, 2023**
- Terminations **may have** begun as early as April 1, 2023
  - States have 12 months to initiate all redeterminations pending at the end of the continuous enrollment period, and 14 months to complete them. This is what CMS is referring to as a state's "unwinding period"
    - A state's unwinding period begins when the state initiates the ex parte process for renewals that could result in termination
  - States could begin their unwinding period in February, March, or April 2023.
- This means that states may start terminations anywhere between **April and July** of this year

Unwinding Timelines, 60-Day Renewal

Appendix B1 – Example 1: Unwinding Timeline for States with a 60-day Renewal Process



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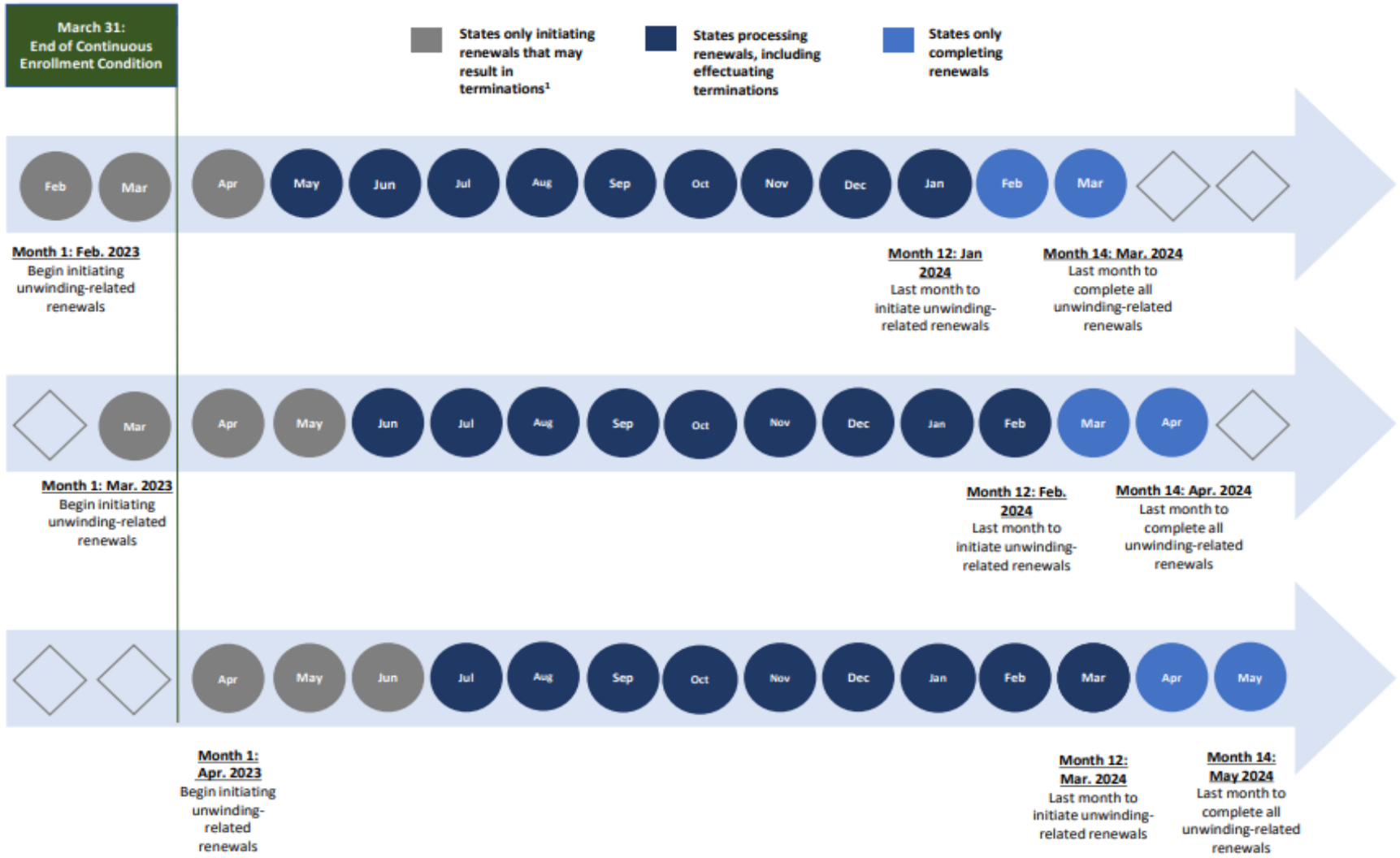
Unwinding Timelines, 90-Day Renewal

Appendix B2 – Example – Unwinding Timeline for State with a 90-Day Renewal Process



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What Determinations Can Be Appealed

Medicaid Eligibility Appeals

- Beneficiaries who disagree with certain eligibility determinations made by Medicaid have a right to appeal
- Are entitled to notice and hearings when adverse actions take place
  - Due Process Clause of the U.S. Constitution
  - Medicaid statute and regulations
  - Landmark decision *Goldberg v. Kelly*

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When a Beneficiary Can Appeal

- Adverse Actions
  - Application is denied
  - Coverage is terminated
  - Scope of eligibility is reduced or suspended
- Delayed eligibility determinations
  - Claim for assistance not acted upon with “reasonable promptness”
- Not entitled to appeal if “sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients.”
  - Ex. Optional COVID-19 Uninsured Group Program

Notice Requirements

- Written notice at time of application and actions impacting right to benefits
  - Plain language and accessible
  - Provide relevant dates
  - Clear statement of specific reasons supporting the decision
  - Specific regulations that support the action
- Advise of right to a hearing, method of request, right to represent themselves or by an Authorized Representative
  - Including legal services agencies and other sources of representation
- Contain translation for individuals with limited English proficiency and accessible to individuals with disabilities

Notice Requirements, continued

- Circumstances when enrollee can receive continued benefits pending outcome of appeal
  - Sometimes called “Aid Paid Pending”
- Must send **at least 10 days before** the date of the action, **except**:
  - Death
  - Voluntary consent
  - Admitted to an institution where ineligible
  - Whereabouts are unknown and mail returned w/o forwarding address
  - Accepted for Medicaid by another jurisdiction
  - And more (42 CFR § 431.213)

Unwinding of the Medicaid Continuous Coverage Requirement

- Confusing notices & communications
- Bad Notices
  - Insufficient information
    - Failure to include sufficient information on income or basis of eligibility
  - Wrong information
  - Failure to provide notice: bad addresses, bad systems
  - Wrong dates on notices
    - Ex. Notice date is incorrect or totally off from mailing date
- **However**, states must transfer electronic accounts where state assesses potential eligibility
  - Federal Facilitated Marketplace
  - State-Based Marketplace

Scenario 1

- Benito has Medicaid and went to the doctor for a check-up. He provided the doctor's office with his insurance card.
- When the office processed his insurance information, they informed him that his Medicaid terminated the month prior and that he no longer has any insurance coverage. Unable to afford it, Benito puts the charge for the visit on his credit card.
- Benito had no idea that his Medicaid had ended.

What are Benito's rights?

Scenario 1

- Benito has Medicaid and went to the doctor for a check-up. He provided the doctor's office with his insurance card.
- When the office processed his insurance information, they informed him that his Medicaid terminated the month prior and that he no longer has any insurance coverage. Unable to afford it, Benito puts the charge for the visit on his credit card.
- Benito had no idea that his Medicaid had ended.

What are Benito's rights?

- Benito's state Medicaid agency was obligated to send him an advance notice about the negative action on his coverage.
- Since he never received any such notice, he has the right to appeal (and should).
- The state Medicaid agency is also obligated to reinstate his coverage since they failed to provide any notice and fewer than 90 days have passed since coverage was terminated.
- Once reinstated (and assuming he prevails at his appeal), he is also entitled to reimbursement for the medical bill.

Scenario 2

- Taylor and Chris are both enrolled in Medicaid. They receive a 1-page letter from their state Medicaid agency that says their coverage will end in 10 days. None of their information has changed since they were last renewed. There is no other information in the letter.
- Confused, Taylor and Chris attempt to reach their eligibility worker, but they have not been able to reach them.

What are Taylor and Chris' rights?

Scenario 2

- Taylor and Chris are both enrolled in Medicaid. They receive a 1-page letter from their state Medicaid agency that says their coverage will end in 10 days. None of their information has changed since they were last renewed. There is no other information in the letter.
- Confused, Taylor and Chris attempt to reach their eligibility worker, but they have not been able to reach them.

What are Taylor and Chris' rights?

- The notice is insufficient: it needs to provide the reasoning for the termination and cite the authority that supports their reasoning in the notice. The notice must also advise of the couple's appeal rights.
- Since the couple's eligibility information has not changed since when they were first enrolled, they should definitely appeal.
- The agency should resend the notice with all of the required information and immediately reinstate their Medicaid coverage.

Questions?

How to Request an Appeal

Requesting a Medicaid Eligibility Appeal

- Online
- Telephone
- U.S. mail
- In person
- Other commonly available electronic means
- State agencies can require hearing requests be in writing
- State agencies may not limit or interfere with freedom to request a hearing

Where To Get Help

- Assisters **do not** have a duty to:
  - Represent a consumer in an appeal
  - Sign an appeal request
  - File an appeal on the consumer's behalf
- What assisters can do to help beneficiaries:
  - Go over notices to make sure beneficiaries understand (or that the agency has informed them of) their right to an appeal. Go over deadlines, including APP
  - Connect with local legal aid organization

    https://www.lsc.gov/about-lsc/what-legal-aid/get-legal-help
  - For beneficiaries without access to phone or internet, help them contact the agency to request an appeal (make sure you are clear that you are not representing)
  - Help request if they need an interpreter, alternative format/accommodations

Timeframes for Requesting Appeals

- Individual must be given a reasonable time to request
- Timeframe is established by the state agency
- Not to exceed **90 days** from the date the notice is mailed
- Must be requested by the individual impacted or by designated authorized representative
- **Note**: If 90 days has passed since the eligibility decision, individuals may ask for an extension of time to file for a "good cause" exception if mitigating circumstances exist for why they did not file during the 90-day period.
- During "unwinding" some states have temporarily extended request timeframes

Scenario 3

- Cynthia receives a Notice of Action about her Medicaid coverage. The notice states that her coverage will end on the last day of the month, because she is over the income limits to qualify. However, Cynthia's income has not changed and she remains under the limits.
- The notice contains the contact information for her eligibility worker and nothing else.
- Cynthia tries to reach her eligibility worker several times to remedy the proposed termination, but cannot reach the worker. After several months, her Medicaid has terminated.
- After calling several numbers, she reaches her state Medicaid agency to discuss her termination. The agency informs her that she has to reapply because she is past the state's 60-day appeal deadline.

What are Cynthia's rights?

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Scenario 3

- Cynthia receives a Notice of Action about her Medicaid coverage. The notice states that her coverage will end on the last day of the month, because she is over the income limits to qualify. However, Cynthia's income has not changed and she remains under the limits.
- The notice contains the contact information for her eligibility worker and nothing else.
- Cynthia tries to reach her eligibility worker several times to remedy the proposed termination, but cannot reach the worker. After several months, her Medicaid has terminated.
- After calling several numbers, she reaches her state Medicaid agency to discuss her termination. The agency informs her that she has to reapply because she is past the state's 60-day appeal deadline.

What are Cynthia's rights?

- Insufficient notice – no appeal rights included! The agency must reinstate her coverage.
- Can she still request an appeal?
  - **Yes.** She can argue "good cause" and the insufficiency of the notice even if her request is past the appeal timeline (and request APP). It is the agency's obligation to have informed her of the appeal timelines, her appeal rights, and where/how to request an appeal.

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Rights During The Appeals Process

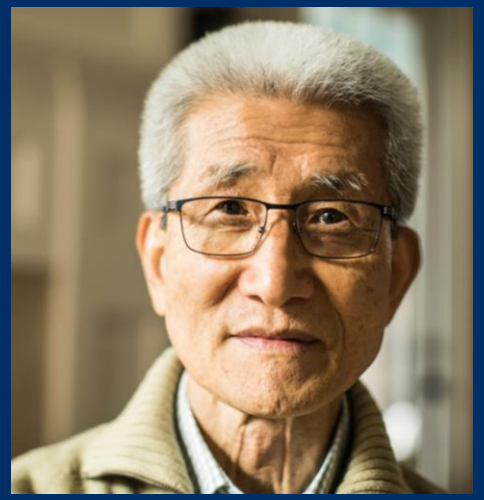
Prior to State Fair Hearing

- Individuals have the right to review their case file
- Examine all policies and documents that form the basis for the decision
- Agencies must arrange for interpreters for individuals with LEP
- May request an **expedited hearing** if waiting for hearing would otherwise jeopardize life, health, or ability to attain/maintain, regain maximum function
  - Must ask on the appeal request
  - If denied, agency must provide notice and will proceed as a standard hearing

At the State Fair Hearing

- Must be fair: occurs at a reasonable time, date, and place
- Conducted by an impartial hearing officer
- Must have opportunity to bring witnesses, establish pertinent facts, present argument without interference, confront and question adverse witnesses
- In-person hearing is not necessarily guaranteed, many states are shifting to telephonic and video hearings

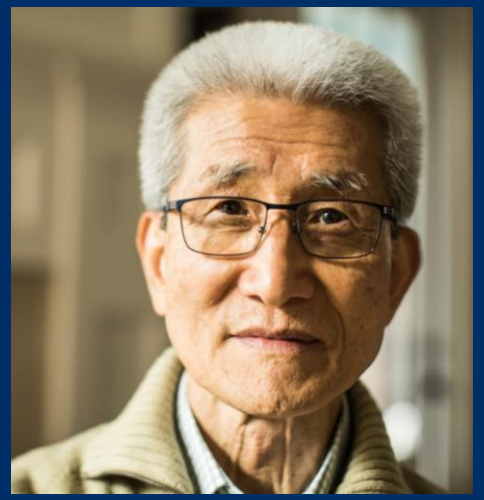
Scenario 4



- Kim receives a notice stating that his Medicaid coverage will terminate by the end of the month because he is now eligible for Medicare.
- Kim does not speak English and this is documented in his case file from when he first applied. He calls his eligibility worker to get more information about the proposed termination and to review his case file. Kim asks for an interpreter.
- Kim's case worker tells him in English that there is nothing he can do about the proposed termination at this point, but informs Kim that he can request an appeal. The worker ends the call.

What are Kim's rights?

Scenario 4



- Kim receives a notice stating that his Medicaid coverage will terminate by the end of the month because he is now eligible for Medicare.
- Kim does not speak English and this is documented in his case file from when he first applied. He calls his eligibility worker to get more information about the proposed termination and to review his case file. Kim asks for an interpreter.
- Kim's case worker tells him in English that there is nothing he can do about the proposed termination at this point, but informs Kim that he can request an appeal. The worker ends the call.

What are Kim's rights?

- First, Medicare does not mean that a person cannot have Medicaid. Kim should definitely appeal.
- The case worker should have gotten an interpreter for Kim upon his request.
- The worker also should have explained in further detail the basis for the proposed termination (especially since it is incorrect) to try to remedy the proposed termination.
- The worker was incorrect to say that there was nothing he can do about the proposed action and was supposed to arrange for Kim to review his case documents.

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Appeals Process & Implementing Eligibility Decision

Aid Paid Pending/Continuing Benefits

- Individuals can request that their Medicaid benefits continue during the appeals process until a decision is issued
- Must request a hearing within the 10-day notice period, before the agency's proposed action
  - May request after the 10-day period, but agency's discretion to grant APP
  - Agency must reinstate continued benefits/services if they take action without providing required notice
  - During "unwinding" **some states** automatic with no deadline
- Agency may recoup payments from individual if APP granted but the agency's decision is upheld after hearing
  - During "unwinding" period, **some states** are prohibited from recoupment!

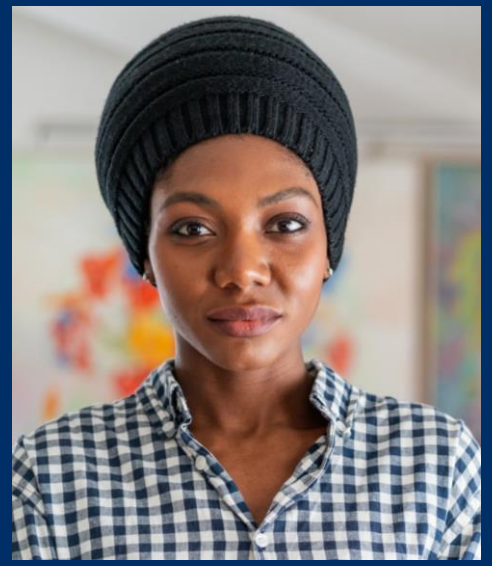
Hearing Decision

- Must be based solely on the legal rules and evidence presented
- Must be provided to individual in writing within 90 days of the hearing request
- Must summarize the facts and regulations supporting the decision
- Must inform about additional administrative or court review options
- Decision is final and binding but may be subject to judicial review

Key Points to Remember

- Individuals can submit an appeal in the following ways:
  - Submit a form online
  - Complete an appeal request form and mail or fax the request to the state Medicaid agency
  - Write a letter
  - Request by telephone
- The agency or county Medicaid office will try to resolve eligibility appeals informally
- Individuals have a right to a hearing if they remain dissatisfied with the informal resolution
- Decisions are mailed within 90 days of receipt of the appeal request

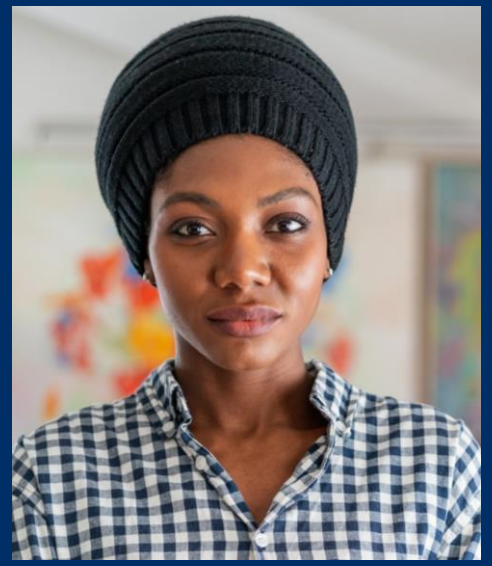
Scenario 5



- Keyshia has Medicaid and receives a 10-day notice stating that her coverage will terminate at the end of the month, because she is over the asset limit. However, Keyshia's assets are exempted. The notice contains all of the required appeal information.
- The next day, Keyshia calls the state Medicaid agency and requests an appeal. Her appeal is entered into the system and the agency informs her that she will receive confirmation letters and more information about the hearing in the next couple of weeks.
- After three weeks, she receives confirmation letters and a hearing date. However, she learned that her Medicaid coverage effectively terminated.

What are Keyshia's rights?

Scenario 5



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- After three weeks, she receives confirmation letters and a hearing date. However, she learned that her Medicaid coverage effectively terminated.

What are Keyshia's rights?

- Keyshia called the state Medicaid agency the day after she received her 10-day notice. While the agency correctly processed her hearing request, they failed to give her APP even though she requested prior to the effective termination.
- The agency must reinstate her coverage while she is pending her appeal.

Scenario 6

- On April 20th, Danny and his family receive a 10-day Notice of Action stating that their Medicaid coverage will end after the last day of the month. The family's income has increased since their last renewal, but Danny believes some of their income is exempt and therefore, he wants to appeal.
- Danny calls the agency to ask for an appeal first thing in the morning on May 2nd. The request is processed and the family receives confirmation letters that they will receive a hearing date in the next couple of weeks.
- The next week, Danny goes to a follow up visit for his cancer treatment with his doctor. He receives a bill for the visit and learns that his Medicaid coverage was terminated at the start of the month. Danny and his family are still waiting for their hearing date.

What are Danny and his family's rights?

Scenario 6

What are Danny and his family's rights?

- Danny requested the appeal after the 10-day notice period, so him and his family are not automatically entitled to APP.
- They can still request APP for good case, but it's up to the agency to grant it. They might argue that his cancer is a serious health condition where loss of coverage would jeopardize his life and well-being.
- As for the income issue which is the basis for the hearing, that will depend if some of the household income is exempt that would keep them under the income limit.
- If the household prevails, Danny can also get the medical bill covered by Medicaid since his coverage should not have terminated. However, if the hearing is not favorable then it would not be covered.
- **What if Danny got APP and the bill was covered by Medicaid pending an unfavorable hearing decision?** The agency technically has the right to recoup payment for the bill.

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Questions?

Resources

Resources

- NHeLP "Consumer Protections & Due Process" fact sheet:

  https://healthlaw.org/wp-content/uploads/2023/04/Highlights-Protect-Medicaid-Series-Due-Process.pdf

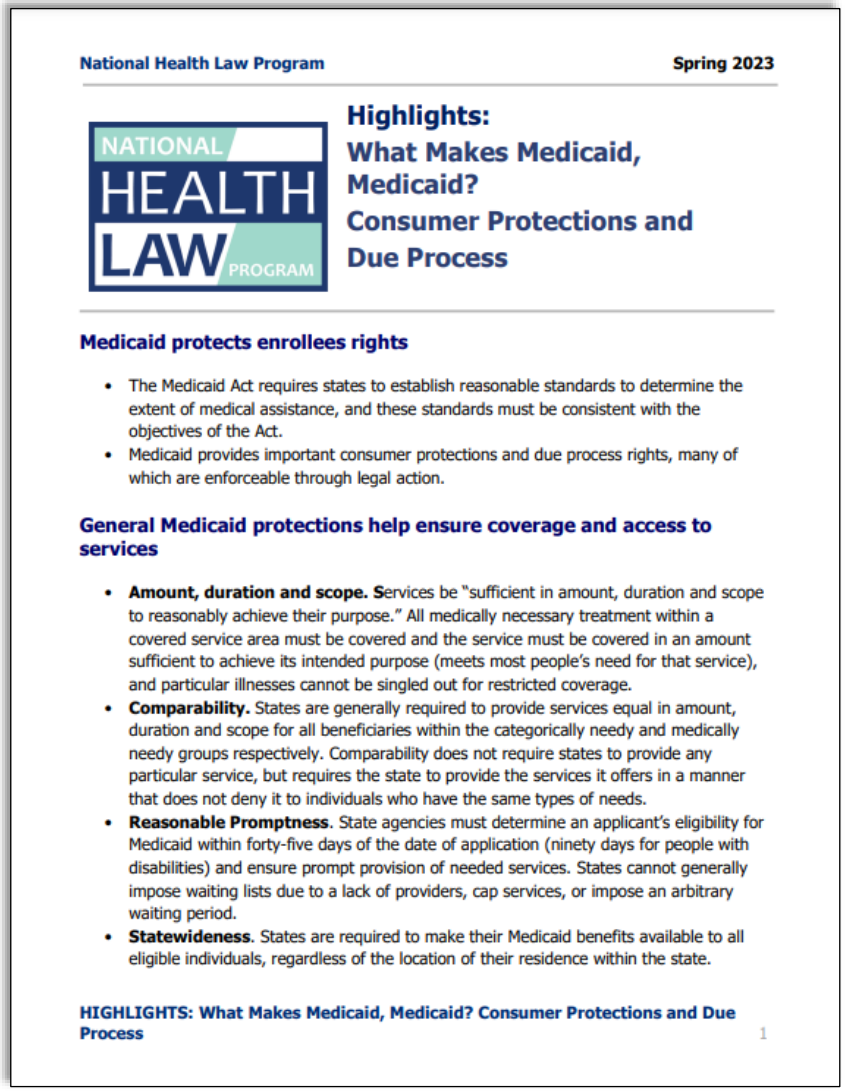
- NHeLP "What Makes Medicaid, Medicaid?" Series, "Consumer Protections & Due Process":

  https://healthlaw.org/resource/what-makes-medicaid-medicaid-series/

- NHeLP, COVID-19 PHE and Continuous Coverage Unwinding Page:

  https://healthlaw.org/unwinding/

- Beyond the Basics and NHeLP webinar: Marketplace Appeals Process (April 2022)



National Health Law Program Spring 2023

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Highlights: What Makes Medicaid, Medicaid? Consumer Protections and Due Process

Medicaid protects enrollees rights

- The Medicaid Act requires states to establish reasonable standards to determine the extent of medical assistance, and these standards must be consistent with the objectives of the Act.
- Medicaid provides important consumer protections and due process rights, many of which are enforceable through legal action.

General Medicaid protections help ensure coverage and access to services

- **Amount, duration and scope. S**ervices be "sufficient in amount, duration and scope to reasonably achieve their purpose." All medically necessary treatment within a covered service area must be covered and the service must be covered in an amount sufficient to achieve its intended purpose (meets most people's need for that service), and particular illnesses cannot be singled out for restricted coverage.
- **Comparability.** States are generally required to provide services equal in amount, duration and scope for all beneficiaries within the categorically needy and medically needy groups respectively. Comparability does not require states to provide any particular service, but requires the state to provide the services it offers in a manner that does not deny it to individuals who have the same types of needs.
- **Reasonable Promptness**. State agencies must determine an applicant's eligibility for Medicaid within forty-five days of the date of application (ninety days for people with disabilities) and ensure prompt provision of needed services. States cannot generally impose waiting lists due to a lack of providers, cap services, or impose an arbitrary waiting period.
- **Statewideness**. States are required to make their Medicaid benefits available to all eligible individuals, regardless of the location of their residence within the state.

HIGHLIGHTS: What Makes Medicaid, Medicaid? Consumer Protections and Due Process 1

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For more information and resources, please visit
www.healthreformbeyondthebasics.org