KanCare (MCO) Appeal Process

The ***KanCare appeal process*** is for KanCare members who are currently ***receiving services*** from a managed care organization (MCO) such as Amerigroup, Sunflower or UnitedHealthcare.

What is an appeal?

An appeal is a request for a review of an ***Adverse Benefit Determination***. An Adverse Benefit Determination is when a managed care organization (MCO) or state agency sends a notice that there has been an adverse decision/determination made regarding the member's benefits/services or regarding a service/benefit the member has requested. A Notice of Adverse Determination is issued for all: terminations, suspensions, reductions, denials, etc. (i.e. MCOs such as Amerigroup, Sunflower or United, or a state agency such as Kansas Department of Health and Environment/KDHE, Kansas Department of Aging and Disability Services/KDADS or Kansas Department of Children and Families/DCF).

The adverse benefit determinations that qualify for an appeal:

- An adverse decision to deny requested benefits or services.
- An adverse change in the amount or type of benefits or services.
- An adverse decision to deny payment (whole or in part) of specific benefits or services.
- A determination by a skilled nursing facility or nursing facility to transfer or discharge a Medicaid resident.

When would I file an appeal?

- The member must complete the MCO's appeal process ***before*** making a request for a fair hearing.
- ***New!*** Submission deadline for member appeals is now 60 calendar days (changed from 30 days), plus an additional 3 calendar days from the date of the notice.
- ***DO NOT WAIT. Turn in the appeal right away.*** You can always withdraw the appeal if you decide not to go forward with the appeal. They do not make exceptions for missed deadlines.
- If the MCO denies this appeal, the member may then file a fair hearing request to the Office of Administrative Hearings (OAH). (see MCO fair hearing process on KanCare website: www.kancare.ks.gov/kancare-ombudsman-office/appeals-information.)

KanCare Ombudsman

How do I file an appeal?

Amerigroup:	**Sunflower:**	**United Healthcare:**
Toll Free: (1-800-600-4441) (TTY: 711); **Direct:** 913-749-5955 (TTY 711) **Mail to:** Central Appeals Processing Amerigroup Kansas, Inc. PO Box 62429 Virginia Beach, VA 23466-2429	**Toll Free:** (1-877-644-4623) (TTY: 1-888-282-6428) **Fax:** 1-888-453-4755 **Mail to:** Sunflower Health Plan Quality Department 8325 Lenexa Dr., Suite 200 Lenexa, KS 66214	**Toll Free:** (1-877-542-9238) (TTY: 711) **Mail to:** United Healthcare Grievance and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364

What documentation do I need?

- Call or write your MCO, as soon as possible, saying you want to appeal. You do not have to state your case yet.
- Follow up with documentation showing why you are appealing the case and disagree with the decision. It can be a letter from yourself and other professionals that can identify all of the following:
    1. the change that has been determined by the managed care organization
    2. why this should not be done and the problems it will cause
    3. the effect it will have short and long-term on the physical, mental and emotional well-being of the member.
- For HCBS member, get a copy of the current Person-Centered Service Plan (previously known as the plan of care or Integrated Service Plan/ISP) and the new one with the changes and compare them by line. State your case based on the changes (line by line) that are of concern. For example, decreasing meal preparation from 8 hours/wk. to 4 hours/wk.; decreasing bathing from 6 hours wk. to 3 hours/wk. How will this impact the member short and long term? How will this impact the member physically, mentally, emotionally? Have healthcare individuals (doctors, nurses, LPN, physical therapists, home attendants, etc.) write something as well as the member. It will be helpful if the professionals know the specific things that are being denied and why. If it is not the *Person-Centered Service Plan hours* being reduced, note what specific services are being reduced so the professionals can help explain why those services are needed based on your issues/concerns.

What happens to my services while I am appealing? (Continuation of Services)

- Non-HCBS Services**:** To request that non-HCBS services continue during the appeals process, you have a ***10-day deadline from the sent date on the "Adverse Decision Notice,"*** or on/before the notice's *effective date*, whichever is later.
- You may have to pay for this care if the appeal decision is not in your favor.
    - ***NEW!*** If services are requested in the 10-day timeframe, the member must continue to receive services without interruption until the conclusion of the appeal.
    - ***NEW!*** Providers may not request continuation of benefits for members even if they are the member's authorized representative. Members must request continuation of benefits.

  - ***NEW!*** MCOs cannot terminate services once the time period or service limits of a previously authorized service have been met while an adverse decision regarding those services is being appealed.
- Home and Community Based Services (HCBS)**:**
  - Those HCBS services must continue without interruption for 63 calendar days following the date of the notice of adverse benefit determination, to allow time for the member to request an appeal.
  - If you file an appeal related to services that are provided as Home and Community Based Services (HCBS), you will automatically keep getting those services while the appeal is being decided.
  - You will ***not*** have to pay for this care even if the appeal decision in not in your favor, unless fraud is present.

What is the timeline?

- *The appeal must be filed within **60 calendar days (NEW)** from the date the letter is **sent** (plus an additional 3 calendar days if the notice was mailed).*
- ***NEW!*** *All* MCO appeals must be resolved within 30 calendar days of when the appeal was received.

Policies for the Appeal process

- You should not be treated differently by your MCO or MCO Care Coordinator if you file an appeal.
- A **Notice of Adverse Benefit Determination** is sent to tell a KanCare member that there has been an adverse decision/determination made regarding in their current KanCare services or requested services. It will tell the member that there is an option to appeal the action. *The appeal must be filed within **60 calendar days (NEW)** from the date the letter is **sent** (plus an additional 3 calendar days if the notice was mailed).*
- ***NEW!*** *All* MCO appeals must be resolved within 30 calendar days of when the appeal was received.
- ***NEW!*** Member can have access to and copies of all documents relevant to the adverse benefit determination free of charge and sufficiently in advance of resolution timeframes for appeals (if requested).
- ***NEW!*** Member may include testimony in addition to evidence and legal and factual arguments when appealing.
- Once an appeal has been submitted, the Managed Care Organization (Amerigroup, Sunflower or Untied) will assign a new team to review your case information and any new documentation you send, to determine if they agree with you or with the original decision.
- If the MCO fails to issue service authorization decisions for standard and expedited service authorizations, such untimely authorizations constitute a denial and is considered an "adverse determination." (Members can appeal an "adverse determination." If that appeal is denied, they then have the right to file a fair hearing.)
- ***NEW:*** If the MCO fails to meet appeal resolution timeframes for standard and expedited

appeals the member is deemed to have exhausted the MCO's appeal process, so the member now has the right to file a fair hearing.

Expedited Appeals

For an appeal related to services that put your health at immediate risk, you may file an expedited appeal with your MCO.

- The MCO will issue a notice regarding the resolution of an expedited appeal within 72 hours of the receipt of the request for an expedited appeal.
- The member can submit an appeal in writing or verbally (by phone).
- A member must file an expedited appeal first, if that is denied, the member can then file an expedited fair hearing.

If it is not approved as an expedited appeal, it will become a standard MCO appeal and go through the standard MCO appeal process.

The KanCare Ombudsman recommends: Within 24-48 hours of submitting an expedited appeal to your MCO, contact the MCO to confirm whether or not it qualifies as a standard or expedited appeal.

Appeal Worksheet (on page 6)

- **For HCBS MEMBERS: State the case based on the changes line by line.** Get a copy of the "current" Person Centered Service Plan (plan of care) and the "new" Person Centered Service Plan and compare them line by line to show the unwanted changes and help providers to identify what issues and risks may be involved.
- For example: (1) Decreasing meal planning & preparation from 8 hours/week to 4 hours/week, (2) Decreasing dressing/grooming from 7 hours/week to 3 hours/week. Write out how each of these will impact the member (1) short term, (2) long term.
- Have the professionals write something as well as the member.
- The letter(s) would be about why this should not be done and problems it will cause, stating the short and long-term effects it will have on the physical, mental and emotional well-being of the member.
- Note: It will be helpful for healthcare individuals (doctors, nurses, LPN, physical therapists, home attendants, etc.) to know the specific things that are being denied and why. If it is not the Person-Centered Service Plan *hours* being reduced, tell the professionals which services specifically are being reduced or suspended, so they can help explain why those services are needed based on your issues/concerns.

MCO (Managed Care Organization) Appeals Worksheet

- To avoid missing critical deadlines, the KanCare Ombudsman's office recommends that the member contacts their MCO by phone immediately to inform them of their (1) request to appeal and (2) request to keep *non-HCBS services* during the appeals process (HCBS services will automatically continue during the appeals process). Then follow up with appeal letter or worksheet as well any additional documentation that supports the member's case.
- ***This is not a legal form or document*** and is intended to help the KanCare consumer to organize important information needed to request an appeal with their Managed Care Organization (MCO). The KanCare member can file an appeal without using this document.

A. Contact Information & Important Dates:

1. Name (KanCare member):
   _____
2. Mailing Address:
   _____
3. Phone: _____ Medicaid ID#: _____
4. *Sent Date* on Adverse Benefit Determination Letter from MCO/State Agency: _____
5. Make a copy of the Adverse Determination Letter and send the copy in with your appeal letter or this worksheet. If you are appealing by phone, have the Adverse Determination Letter in front of you when you make the call.
6. Date member requested appeal (by phone or in writing): _____ (**63 calendar days deadline from *sent date* on Adverse Determination Letter**).
7. **If Applicable** (If requesting **Continuation of Non-HCBS related services** during appeals process): Date member requested *Non-HCBS related services* to continue during the appeals process (by phone or in writing): _____.
   - **10 calendar days deadline from *sent date* on Adverse Determination Letter** (to ask for Non-HCBS related services to continue throughout the appeals process)
   - Please keep in mind that the member may have to pay for *Non-HCBS related services* if they lose the appeal.
8. Date member sent copy of the appeal letter (or this worksheet) and any additional documentation from KanCare member that supports member's case: _____
9. **Optional:** Date member sent copies of any additional documentation from healthcare individuals (doctors, therapists, etc.) that supports member's case: _____

B. State your case by answering the following questions for each change on your benefits/services:

1. What service(s)/benefit(s) are being changed?
   _____
   _____
2. How will this impact your physical/mental/emotional well-being short term (up to 6 months)?
   _____
   _____
3. How will this impact your physical/mental/emotional well-being long term (over 6 moths)?
   _____
   _____