DISABILITY RIGHTS CENTER - NH
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# KNOW YOUR RIGHTS

# New Hampshire Medicaid Managed Care Health Plans

# Your Right To Appeal Or File A Grievance

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**What is Medicaid Managed Care?**

In a Medicaid managed care system, Medicaid recipients are provided health care coverage from a company under contract with the state. Managed care companies, or MCOs, agree to provide Medicaid benefits to recipients in exchange for a monthly payment from the state. The State of New Hampshire originally contracted with three MCOs to provide health care coverage for most New Hampshire Medicaid recipients; one (Meridian) has withdrawn as a provider. The remaining MCOs are NH Healthy Families and Well Sense Health Plan.

**What can I do if I disagree with a decision made by my MCO or if I am unhappy with the services they provide?**

As a member of a Medicaid managed care plan, you have the right to file a ***grievance*** or an ***appeal*** if you are dissatisfied with your plan in any way. More information on the grievance and appeal process is provided below. Each MCO has its own internal grievance and appeal process. New Hampshire requires that you appeal to your MCO before requesting a fair hearing with the State. Each MCO has a member handbook with information about its grievance and appeal process. You can find a link to the two MCO member handbooks below.

## APPEALS

**What is an appeal?**

Whenever an MCO takes an "***action***" that you disagree with you can file an appeal. If you are a member of a Medicaid managed care plan, there are two levels of appeal. The first level of appeal is a request for the MCO to review any "***action***" it has taken. When an MCO

takes an ***"action"***, you must go through the MCO's appeal process before requesting a fair hearing with the State.

**What type of "*actions*" can I request an appeal for?**

You may file an appeal if you disagree with any of the following MCO "actions:"

- A decision to deny or provide only limited authorization of a requested health care service.
- A decision to reduce health care services that you are getting.
- A decision to limit health care services that you are getting.
- A decision to suspend a health care service that you are getting.
- A decision to end a health care service that you are getting.
- Not receiving health care services in a timely manner.
- The failure of your MCO to act within the timeframes required for resolution of a grievance, standard resolution of an appeal, or expedited resolution of an appeal.

**Will I be notified of MCO "actions"?**

If your MCO denies, reduces, limits, suspends or ends health care services, the MCO is required to send you a written notice telling you about this decision. MCOs are required to give you a written notice if it takes any of the above actions, at least 10 days in advance of the action. The written notice must contain certain elements, including explaining the action the MCO has taken or intends to take, the reasons for the action, and the specific legal basis that supports it. It must also include information about the appeal process. It is very important to review the notice carefully and follow the deadlines for the appeal process.

**How do I file an appeal with the MCO?**

You may file your appeal over the phone or in writing. An oral request for an appeal must be followed by a written and signed appeal request unless the request is for an expedited resolution. You may also designate someone to file the appeal for you, including your provider. You must give written permission to name another person to file an appeal for you. Each MCO has its own appeal process. The chart below contains information about how to file an appeal with each MCO, and links to permission forms if you want to name another person to file for you. You must file your appeal with the MCO within 30 days of the date of the MCO's written notice. To ensure your services continue pending your appeal to the MCO, you must specifically

request continuation of benefits and appeal **within 10 calendar days from the date you *receive* the notice of action**.

You may lose your right to appeal an MCO action or your right to continued services if you do not file within these timeframes. You have the right to file an appeal even if no notice was sent.

| **MCO APPEAL CONTACT INFORMATION** | |
|---|---|
| **Well Sense** | **New Hampshire Healthy Families** |
| Well Sense Health Plan<br>2 Copley Place, Suite 600<br>Boston, MA 02116<br>Attention: Member Appeals<br><br>Fax: 617-897-0805<br>Phone: 877-957-1300<br>TTY: 866-765-0055<br><br>Here is the authorized representative form for Wellsense:<br>http://wellsense.org/app_assets/personal-rep-designation-request-form-12-03-13_20140117t121330_en_web_14f2cd1c3d084df2bfb10f85f8fa47fa.pdf<br><br>Well Sense contracts with Beacon Health Strategies, LLC, to manage behavioral health services. ***For appeals related to mental health or behavioral health services***, call or submit appeal in writing to:<br><br>Appeal Coordinator<br>Beacon Health Strategies, LLC<br>500 Unicorn Park Drive, Suite 401<br>Woburn, MA 01801<br><br>Fax: 781-994-7636<br><br>Phone: 855-834-5655<br>Here is the authorized representative form for Beacon Health Strategies:<br>http://drcnh.org/BeaconAuthRepForm.pdf | New Hampshire Healthy Families<br>Grievance and Appeal Coordinator<br>2 Executive Park Drive<br>Bedford, NH 03110<br><br>Fax: 1-866-270-9943<br>Phone: 866-769-3085<br>Relay NH: 855-742-0123<br><br>Here is the authorized representative form for NHHF:<br>http://www.nhhealthyfamilies.com/files/2014/01/NHHF-Auth-Rep-Form-Post-20140129.pdf<br><br>New Hampshire Healthy Families contracts with Cenpatico to manage behavioral health and specialty therapy services. ***For appeals related to mental health or behavioral health services and specialty therapy services***, call or submit appeal in writing to:<br><br>Cenpatico<br>Appeals Department<br>12515-8 Research Boulevard, Suite 400<br>Austin, Texas 78759<br><br>Fax: 866-714-7991<br><br>Phone: 888-282-7767 |

**What are my rights during my appeal to the MCO?**

After your appeal is filed, the MCO must provide a reasonable opportunity for you to present evidence, and allegations of fact or law, in person as well as in writing. Additionally, the MCO must allow you to review your case file, including medical records and any other documents and records the MCO considered as part of your appeal. You have the right to receive a copy of your records upon request, although you may be charged a reasonable amount for the copies.

**When will I receive a response from the MCO to my appeal?**

MCOs are required to issue a written decision within 30 calendar days after receipt of your appeal request. The MCO is permitted to request an extension of up to 14 calendar days if 1) you request the extension, or 2) if the MCO shows that there is a need for additional information and the MCO can show that the extension is in your best interest.

**Can I request an expedited appeal?**

If taking the time for standard resolution of your appeal would seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function, you may request expedited resolution of your appeal. If the MCO accepts your request for an expedited appeal, they must resolve it as "expeditiously as the member's health condition requires," but no later than 3 calendar days after the MCO received your request.

**Can I appeal the MCO's decision to deny my request for an expedited appeal?**

If the MCO denies your request for an expedited appeal, it must make "reasonable efforts" to give you prompt verbal notice of the denial and then must provide written notice of the denial within 2 calendar days . You have the right to file a grievance with the MCO if it denies your request for an expedited appeal. It is important to note that if the MCO denies your request for an expedited appeal, it must then treat your appeal as part of the standard appeal process.

**Do I have the right to receive continued benefits pending my appeal to the MCO?**

Whenever you appeal an MCO's decision to deny, reduce, limit, suspend or end health care services, you have a right to continued benefits pending the resolution of your appeal to the

MCO so long as: 1) you specifically request continuation of benefits **and** 2) you appeal within 10 calendar days from the date you ***receive*** the notice of action. The date on which you ***receive*** the notice is considered to be 5 days after the date on the notice, unless you can show that you did not receive the notice within the 5–day period.

**Can I appeal to the State?**

If you are unhappy with the MCO's resolution of your appeal, you may appeal that decision to the State by requesting a fair hearing. **This is the second level of appeal.** You cannot request a fair hearing without first going through the MCO's appeal process. You must file your request for a fair hearing with the State within 30 days of the date of the MCO's written decision on your appeal. To ensure services continue pending your appeal to the State, you must specifically request continuation of benefits **and** request a fair hearing within 10 calendar days from the date you ***receive*** the MCO's decision on your appeal.

You may lose your right to appeal or your right to continued services if you do not file within these timeframes. You have the right to request a fair hearing even if the MCO failed to provide a written decision on your appeal.

To request a fair hearing with the State, write to:

Administrative Appeals Unit
Office of Operations Support
NH Department of Health & Human Services
105 Pleasant Street
Concord, NH 03301
1-800-852-3345 extension 4292
Fax: 603-271-8422

**Can I contact Disability Rights Center - NH for advice or assistance?**

Yes. Call Disability Rights Center - NH at 1-800-834-1721.

**What happens when I appeal the MCO's decision to the State?**

In New Hampshire, Medicaid fair hearings are usually held at the Administrative Appeals Unit in Concord or at your local District Office. A hearing officer from the Administrative Appeals Unit will conduct the hearing. Medicaid beneficiaries have a number of important procedural rights associated with fair hearings. You can learn more about those rights here.

**When will I receive a decision from the State following my fair hearing?**

Pursuant to federal law, the State is required to issue a written decision within 90 days of the date you first requested your appeal to the MCO. This does not include the number of days it took for you to request a fair hearing with the State.

**Do I have the right to receive continued benefits pending resolution of my fair hearing?**

Whenever you appeal an MCO's decision to deny, reduce, limit, suspend or end health care services, you have a right to continued benefits pending the resolution of your fair hearing appeal so long as: 1) you specifically request continuation of benefits **and** 2) you appeal within 10 calendar days from the date you ***receive*** the MCO's written decision on your appeal. The date on which you ***receive*** the decision is considered to be 5 days after the date on the decision, unless you can show that you did not receive the decision within the 5–day period. Even if you requested continued benefits during your appeal to the MCO, you must request it again to have continued benefits pending resolution of your fair hearing.

If you lose your fair hearing, you may be responsible for the cost of continued benefits provided pending the appeal.

**Ombudsman's Office**

In addition to filing a grievance or appeal, you can contact the Department of Health and Human Services Ombudsman's Office at 603-271-6941, 603-271-5573, or 1-800-852-3345 ext. 6941 to discuss your issues. While the Office of the Ombudsman cannot overturn the decision of an MCO, it may be able to provide information on how to file an appeal or grievance or intervene on your behalf to resolve any conflict. It is important, however, that you file your appeal and/or grievance first, then contact the Office of the Ombudsman so you do not miss any deadlines and lose your right to appeal.

## GRIEVANCES

**What is a grievance?**

A grievance is like a complaint. A grievance can be filed if you are dissatisfied with your Medicaid managed care plan for any reason ***other*** than the "actions" listed in the appeals section. You can file a grievance if you are dissatisfied with the quality of care or services provided, the way you are treated by your plan's employees, providers or contractors, or if you believe the MCO is not respecting your rights.

**How do I file a grievance?**

You may make your grievance over the phone or in writing. Writing is preferred, and keep a copy for your records. You may also designate someone to make the grievance for you. Each MCO has its own internal grievance process. The chart below contains information about how to file a grievance with each MCO.

| **MCO GRIEVANCE CONTACT INFORMATION** | |
|---|---|
| **Well Sense** | **New Hampshire Healthy Families** |
| Well Sense Health Plan<br>2 Copley Place, Suite 600<br>Boston, MA 02116<br>Attention: Member Grievances<br><br>Fax: 617-897-0805<br>Phone: 877-957-1300<br>TTY: 866-765-0055 | New Hampshire Healthy Families<br>Grievance and Appeal Coordinator<br>2 Executive Park Drive<br>Bedford, NH 03110<br><br>Fax: 1-866-270-9943<br>Phone: 866-769-3085 or<br>Relay NH: 855-742-0123 |
| Well Sense contracts with Beacon Health Strategies, LLC, to manage Behavioral Health services. ***For grievances related to mental health or behavioral health services***, call or submit grievance in writing to:<br><br>Quality Department – Ombudsman<br>Beacon Health Strategies, LLC<br>500 Unicorn Park Drive, Suite 401<br>Woburn, MA 01801<br><br>Fax: 781-994-7636<br>Phone: 855-834-5655 | New Hampshire Healthy Families contracts with Cenpatico to manage behavioral health and specialty therapy services. ***For grievances related to mental health or behavioral health services and specialty therapy services***, call or submit grievance in writing to:<br><br>Cenpatico<br>Grievance Department<br>12515-8 Research Boulevard, Suite 400<br>Austin, Texas 78759<br><br>Fax: 866-714-7991<br><br>Phone: 888-282-7767 |

**When will I receive a response to my grievance?**

MCOs are required to resolve a grievance and provide notice to members as "expeditiously as the member's health condition requires," but not later than 45 calendar days from the date the MCO received the grievance. Each MCO has its own process for receiving and resolving member grievances. The chart below contains information about each MCO's grievance process.

| MCO GRIEVANCE PROCEDURES | |
|---|---|
| **Well Sense** | **New Hampshire Healthy Families** |
| According to the Well Sense member handbook, the company will respond within 30 calendar days of receipt of the grievance. | According to the NH Healthy Families member handbook, the company will respond within 45 calendar days of receipt of the grievance. |

**Will the response to my grievance be in writing or over the phone?**

MCOs are required to respond in writing to grievances involving clinical issues. If your grievance does not involve a clinical issue, the MCO may respond to your grievance over the phone. An example of a non-clinical grievance is a complaint that an MCO employee was rude to you over the phone.

**Can I appeal my grievance to the State?**

You do not have the right to appeal the MCO's response to your grievance. However, you have the right to voice any concerns to New Hampshire Medicaid at any time. You may contact New Hampshire Medicaid Client Services by phone at 1-800-852-3345, extension 4344 or 603-271-4344.

**Ombudsman's Office**

In addition to filing a grievance or appeal, you can contact the Department of Health and Human Services Ombudsman's Office at 603-271-6941, 603-271-5573, or 1-800-852-3345 ext. 6941 to discuss your issues. While the Office of the Ombudsman cannot overturn the decision of an MCO, it may be able to provide information on how to file an appeal or grievance or intervene on your behalf to resolve any conflict. It is important, however, that you file your appeal and/or grievance first, then contact the Office of the Ombudsman so you do not miss any deadlines and lose your right to appeal.

## USEFUL INFORMATION

**Well Sense Health Plan**:

http://wellsense.org/

Well Sense Member Handbook

Beacon Health Strategies: http://beaconhealthstrategies.com/

**NH Healthy Families**:

http://www.nhhealthyfamilies.com/

NH Healthy Families Member Handbook

The Developmental Services Coordinator is Amy Bandreth, 603-263-7151 or abandreth@centene.com

**Cenpatico**: http://www.cenpatico.com/

**New Hampshire Department of Health and Human Services (DHHS)** – Medicaid Care Management Information: http://www.dhhs.nh.gov/ombp/caremgt/

**Contacts at New Hampshire Department of Health and Human Services:**

- ✓ Medicaid Client Services: 1-800-852-3345, extension 4344 or 603-271-4344
- ✓ Medicaid Service Center at 888-901-4999
- ✓ Lisabritt Solsky, DHHS Deputy Medicaid Director: 603-271-9408
- ✓ Donna Mombourquette, DHHS Account Manager for **Well Sense**: 603-271-9429
- ✓ Laura Vincent Ford, DHHS Account Manager for NH Healthy Families: 603-271-9536
- ✓ Office of the Ombudsman: 603-271-6941, 603-271-5573, or 1-800-852-3345 ext. 6941

Call the **Disability Rights Center - NH** at 1-800-834-1721 for more information about the grievance and appeal processes or for advice and/or representation in a fair hearing.

**IMPORTANT THINGS TO REMEMBER WHEN FILING GRIEVANCES AND APPEALS:**

- ✓ **Timeframes are important.** If you do not follow the prescribed timeframes, you may lose your right to file a grievance or appeal. You could also lose your rights to continued services pending your appeal.
- ✓ **MCO grievances and appeals can be made by phone or in writing.** If you file by phone, you should make a note of the day the appeal was filed and the name of the plan representative who took the appeal. If you file in writing, try to send it some way that there's proof that it was delivered (i.e., certified mail or delivery confirmation) and keep a copy for your records. The plan should send a written confirmation the complaint/appeal was received.
- ✓ **You have the right to receive continued benefits pending your appeal.** Continued benefits are not automatic. You must make a specific request for continued benefits pending your appeal at <u>each</u> step of the appeal process and do so within the prescribed timeframe.
- ✓ **Call Disability Rights Center - NH** at 1-800-834-1721 for more information about the grievance and appeal processes or for advice and/or representation in a fair hearing.
- ✓ **Call the State.** You have the right to voice any concerns to New Hampshire Medicaid at any time. You may contact New Hampshire Medicaid Client Services by phone at 1-800-852-3345, extension 4344 or 603-271-4344, or the Medicaid Service Center at 888-901-4999.

**STANDARD APPEAL PROCESS**
**MEDICAID MANAGED CARE**

MCO must issue written notice of action at least 10 days in advance of action

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**Level I: Appeal to MCO**

Member must request appeal of MCO's action within 30 calendar days from the date of the written notice of action. Member has right to appeal even if no notice is sent.

*Benefits continue while appeal is pending if: 1) member specifically requests continuation of benefits and 2) member appeals within 10 calendar days from the date member ***receives*** the notice of action

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MCO must issue written decision within 30 calendar days after receipt of the appeal request, unless MCO requests extension of up to 14 calendar days

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If MCO decision is favorable to member, decision is implemented

If MCO decision is not favorable, member may request a fair hearing with the State within 30 calendar days of the date of the MCO's written decision. Member has right to appeal even if no notice sent.

*Benefits continue while appeal is pending if: 1) member specifically requests continuation of benefits and 2) member appeals to State within 10 calendar days from the date the individual ***receives*** the MCO's written decision

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**Level 2: State Fair Hearing**

The State must issue a hearing decision within 90 days of the date individual first requested the MCO appeal (not including number of days individual subsequently took to request fair hearing)

**GRIEVANCE PROCESS**
**MEDICAID MANAGED CARE**

Member may file a grievance for any matter other than an "*action*"

Examples: concerns regarding quality of care or services provided; concerns with the way you were treated by providers or MCO employees; failure to respect individual's rights

MCO must complete the disposition of a grievance and provide notice to member as "expeditiously as the member's health condition requires," but not later than 45 calendar days from the date the MCO received the grievance

Written decisions on clinical issues must be in writing.
Written decisions on issues not involving clinical issues may be orally or in writing.

*Each MCO has its own process for receiving and resolving member grievances*

Members do NOT have the right to appeal if they are dissatisfied with the resolution of a grievance but may voice any concerns to New Hampshire Medicaid Client Services at any time.

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