KanCare Ombudsman Office
Phone: Toll Free: 1-855-643-8180
Relay: 711
Email: KanCare.Ombudsman@ks.gov
Website: www.KanCareOmbudsman@ks.gov

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 Aetna, Sunflower or UnitedHealthcare.

What is an appeal?

- An appeal is a request for a review by an MCO of an ***Adverse Benefit Determination***. An Adverse Benefit Determination is when a managed care organization (MCO) 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 Aetna, Sunflower or United.)
- 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.

What is an expedited (fast) appeal and how does it work?

A member/representative may submit a request for an expedited appeal resolution (electronically, orally or in writing) if the member or his/her provider believe that resolution within 30 calendars days could seriously jeopardize the Member's physical or mental health. The MCO will determine if an expedited appeal request qualifies for expedited resolution.

- For expedited appeal requests that qualify, the MCO must resolve the expedited appeal and provide notice within 72 hours of receipt.
- For expedited appeal requests that do not qualify, the MCO will transfer the appeal request to the usual 30 calendar day resolution timeframe.

The KanCare Ombudsman recommends: 72 hours after submitting an expedited appeal to your MCO, contact the MCO to confirm whether it qualifies as a standard or expedited appeal.

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When do I file for an appeal?

- The member must complete the MCO's appeal process ***before*** making a request for a fair hearing.
- **Submission deadline for member appeals is *60 calendar days*** (changed from 30 days), plus an additional 3 calendar days from the date of the notice if mailed.
- ***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.)

How do I file an appeal?

- You can use the MCO Appeal worksheet below to help you pull the information together.
- Call or write to the MCO about it or send a copy of the MCO worksheet below; or
- Ask a representative of your choice to call or write a letter or send a copy of the MCO worksheet to the MCO. If you ask a provider or other person to call or write to the MCO, you will need to include written approval for them to represent you. You may choose from one of the following:
    - The written approval is usually a form found in your managed care provider's manual on your MCO's website.
    - Authorized Representative Designation Form: for Grievances, Appeals and Hearings

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:

- the change that has been determined by the managed care organization
- why this should not be done and the problems it will cause
- 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.

Where do I file an MCO Appeal?

To submit an MCO appeal, contact your managed care organization (MCO):

Aetna

Mail to:

Aetna Grievance and Appeal Dept.

9401 Indian Creek Parkway

Suite 1300

Overland Park, KS 66210

Toll Free: 1-855-221-5656

Relay: 711

Fax: 1-833-857-7050

Sunflower

Mail to:

Sunflower Health Plan

Quality Department

8325 Lenexa, KS 66214

Toll Free: 1-877-644-4623

Relay: 711

Fax: 1-888-453-4755

United

Mail to:

United Grievance and Appeals

PO Box 31364

Salt Lake City, UT 84131-0364

Toll Free: 1-877-542-9238

Relay: 711

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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 mail/send date on the notice of adverse determination or on/before the notice's *effective date*, whichever is later.
- If a member/representative requests an appeal and continuation of services on time, the MCO must continue service for 10 calendar days following the mailing/sending date of the notice of appeal resolution to allow the member/representative time to request a state fair hearing. Continued services will end 10 calendar days following the mailing/sending date of the notice of appeal resolution unless a member/representative requests a state fair hearing.
- If a member/representative submits a request for a state fair hearing and continuation of services within 10 calendar days of the mailing/sending date of the notice of appeal resolution, the MCO must continue the services through the date of the decision in the state fair hearing.
- You may have to pay for this care if the appeal decision is not in your favor.
    - If services are requested in the 10-day timeframe, the member must continue to receive current services until the conclusion of the appeal.
    - Providers may not request continuation of benefits for members even if they are the member's authorized representative. Members must request continuation of benefits.
    - 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.

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

Home and Community Based Services (HCBS):

- The MCO must continue previously authorized services for 63 calendar days following the date of the notice of adverse benefit determination, to allow time for the member to request an appeal.
- No request for continued services from the member/representative is required.
- 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.
- Continued services will be automatically continued for 123 calendar days following the date of the notice of appeal resolution to allow the member/representative time to request a state fair hearing.
- If a member/representative submits a request for a state fair hearing within 123 calendar days of the date of the notice of appeal resolution, the MCO must continue the services until the date of the decision in the state fair hearing.
- If a member/representative fails to submit a request for a state fair hearing within 123 calendar days, continued services will end.
- You will ***not*** have to pay for this care even if the appeal decision in not in your favor, unless fraud is present. (Share of Cost such as Client Obligation, Patient Liability or Participant Obligation would still be necessary to maintain services).

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What is the timeline?

- The appeal must be filed within ***60 calendar* days** from the date of the letter *(plus an additional 3 calendar days if the notice was mailed)*.
- *The MCO must acknowledge receipt of the standard appeal in writing within 5 calendar days of receipt*.
- *All* MCO appeals must be resolved within 30 calendar days of when the appeal was received.
- *If the appeal is denied, you have 123 days, from the date on the MCO appeal denial notice, to file for a fair hearing*.

Additional information for the Appeal process

- You should not be treated differently by your MCO or MCO Care Coordinator if you file an appeal.
- 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).
- 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 (Aetna, Sunflower or United) will assign a new person/team to review your case information and any new documentation you send, to determine if they agree with you or with the original decision.
- Exception to Appeal Requirement: Failure by MCO to resolve appeal and issue notice within 30 calendar days, then the member has the right to file a fair hearing.
- Prior Authorizations: If the MCO fails to issue service authorization decisions within 14 calendar days for standard and 72 hours for 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.)

Foster Care Children

- Child Welfare Contractors, not foster parents, submit appeals to the MCOs.

MCO Member Disenrollment or Changing an MCO

Normal enrollment timeframes without requiring a request for change are:

- No cause required during the first 90 days of initial enrollment (open enrollment period for new enrollees.)
- No Cause required during 60 days of re-enrollment for member (open enrollment period).
- Cause required for requests to change an MCO outside of member's open enrollment period.) See Selecting/Changing MCO Fact Sheet for more information.

The Medicaid program, not the MCOs, processes all requests for disenrollment (changing MCO) submitted by members. Denials of disenrollment requests may not be appealed to the MCO, but requests for state fair hearings may be submitted.

Legal Services

The Disability Rights Center of Kansas

The Disability Rights Center of Kansas (DRC) is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC is the Official Protection and Advocacy System for Kansas and is a part of the national network of federally mandated and funded protection and advocacy systems.

Contact Information

214 SW 6th St., Suite 100

Topeka, KS 66603

Voice: (785) 273-9661

Toll Free Voice: (877) 776-1541

Kansas Legal Services

Kansas Legal Services is a statewide non-profit organization dedicated to helping low-income Kansans meet their basic needs through the provision of essential legal, mediation and employment training services. Kansas Legal Services can assist individuals with cases involving health issues, housing, employment, juvenile issues (delinquent, termination of parental rights), income maintenance, Indian laws, family issues, individual rights and consumer issues.

Legal Assistance Toll Free Central Intake Line

Phone: (800) 723-6953

Main Office: (785) 233-2068 (voice)

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Appeal Worksheet

- **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.

This information is provided in cooperation with the Kansas Department of Health and Environment, Health Care Finance.

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MCO (Managed Care Organization) Appeal 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: _____

4. Medicaid ID# or Case #: _____

5. *Date* on Adverse Benefit Determination Letter from MCO/State Agency:

   _____

6. 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.

7. Date member requested appeal (by phone or in writing): _____

8. **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): _____.

- Please keep in mind that the member may have to pay for *Non-HCBS related services* if they lose the appeal.

9. Date member sent copy of the appeal letter (or this worksheet) and any additional documentation from KanCare member that supports member's case: _____
10. **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)?
   _____
   _____