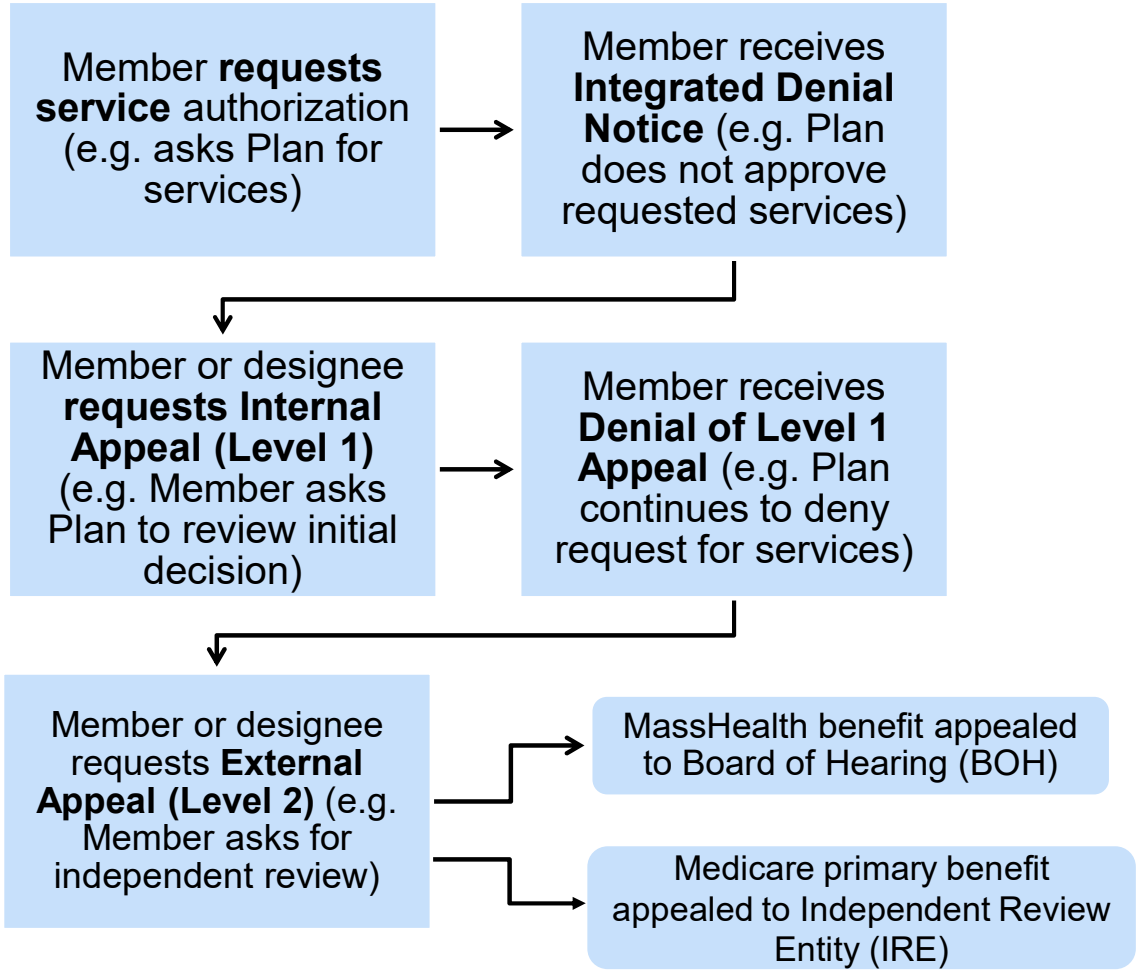
One Care:
Implementation Council Meeting

Executive Office of Health and Human Services
MassHealth Demonstration to
Integrate Care for Dual Eligibles
December 12, 2023, 10:00AM – 12:00PM
Virtual Meeting via Zoom

One Care Appeals Process Flow Chart



Enrollee Appeals (Section 2.11.2)

Section 2.11.2 of the One Care Three-way Contract outlines Member Appeals processes for both Internal and External Appeals and their associated timeframes

Internal Appeals (Level 1 appeals)	External Appeals (Level 2 appeals)
❑ Internal Appeals must be submitted to the One Care Plan within sixty (60) calendar days of the receipt of the denial notice ❑ Internal Appeals can be submitted in writing, via fax, or by calling the One Care Plan directly ❑ Verbal appeals requests must be documented in writing by the One Care Plan ❑ A Member's Provider or authorized representative can file an internal appeal on behalf of the Member ❑ The One Care Plan must acknowledge receipt of each appeal ❑ The One Care Plan must provide the Member and/or the authorized representative access to the Member's medical records during the time of the appeal ❑ The One Care Plan must ensure that denials are reviewed by individuals who have the appropriate clinical expertise and were not involved in making the initial decision to deny the service.	❑ The One Care Plan will automatically forward Medicare primary services to the CMS IRE if am internal appeal is upheld ❑ If the CMS IRE overturns the One Care Plans decision to deny a service, the plan must authorize or the provide the service within seventy-two (72) hours of the decision ❑ MassHealth only services are **ONLY** reviewed by the BOH at the request of the Member or their authorized representative ❑ If the BOH overturns the One Care Plans decision to deny a service, the plan must authorize or the provide the service within seventy-two (72) hours of the decision ❑ Appeals for services where Medicare and MassHealth overlap, the One Care Plan will automatically forward the appeal to the IRE. The Member can simultaneously request/file an appeal with the BOH. If an appeal is filed both the IRE and BOH, and either overturns the appeal, the One Care Plan must provide the service requested by the Member.

Internal Appeal Timeframes and Processes

The One Care Three-way contract outlines processes for Standard Internal Appeal and Expediated Internal Appeal timeframes and processes.

Standard Internal Appeal	Expedited Internal Appeal
❑ The One Care Plan must make a standard internal appeal decision within thirty (30) days ❑ The One Care plan may extend this timeframe for up to fourteen (14) days if an extension is requested by the Member or if the One Care Plan justifies the need for additional information and is able to demonstrate how the extension will benefit the Member ❑ The One Care plan must inform the Member that they have the right to file a Grievance when an extension is requested ❑ If the One Care plan overturns their initial decision (decides fully in favor of the Member) they must provide or authorize the service within thirty (30) days of the receipt of the appeal	❑ The Member or their authorized representative has right to request an expedited appeal ❑ The Member or their authorized representative must request the seventy-two (72) hour expedited review at the time that the Appeal request is made ❑ If the One Care Plan determines that the Members situation is time-sensitive they must make expedited internal appeal decision within seventy-two (72) hours ❑ If the One Care Plan determines that the Members situation is not time-sensitive they must verbally notify the Member and provide notice within two (2) days that the Appeal will be decided using the standard internal appeal timeframe ❑ If the One Care Plan overturns their decision they must provide or authorize the service within the timeframe used to review the appeal (e.g. within 72 hours for an expedited appeal or 30 days for a standard appeal)

Integrated Denial Notice

In Section 2.11.2 the One Care Three-way contract also outlines that members will be notified of all applicable Demonstration, Medicare, and MassHealth Appeal rights through a single notice for each of the internal and external appeal processes.

The written notice must explain:

- ❑ The action that the One Care Plan has taken;
  - ➢ Denied the request
  - ➢ Modified or changed the request (i.e. approved PCA hours, but give fewer hours that initially requested)
- ❑ The reasons for the action, including the right of the Member to be provided reasonable access to and copies of all documents, records, and any other information used to evaluate the request for services, including but not limited to, the One Care Plans medical necessity criteria and processes, and the citations of regulations supporting their action. This information must be shared with the Member free of charge upon their request;
- ❑ Notify the Member of their right to Appeal the decision;
- ❑ Clearly outline how to request a standard or expedited appeal; and
- ❑ Provide resources and supports for filling an appeal.

Appeal Denial Notices

The One Care Plan must notify the Member of its internal appeal decision in writing in accordance with **Section 2.11.2 Enrollee Appeals** of the One Care Three-way Contract. Model Notices for Internal (Level 1) Appeals must be used by One Care Plans and can be found on the CMS marketing information resources page

The written notice must include the following elements:

- ❑ Identify what was initially requested by the Member;
- ❑ The results of the decision, including a clear explanation of why the request is continuing to be denied; and
- ❑ The date of the decision.

For Appeals that uphold the denial the notice must also include:

- ❑ The right to request a BOH appeal for MassHealth only services and how to do so within one hundred and twenty (120) calendar days from the Adverse Benefit Determination Notice; or
- ❑ An explanation that Medicare only services are automatically forwarded to the IRE for an External (Level 2) Appeal
- ❑ If the internal Appeal was received within ten (10) calendar days of the Adverse Benefit Determination Notice or prior to the date of action, the right to continue to receive benefits and how to do so while the Appeal is pending.

The written notice must also be:

- ❑ Written in language that is easily understood by the member
- ❑ Provide resources for support including contact information for My Ombudsman, 1-800-Medicare, etc.

Appeal Notices – Board of Hearing Information

❑ How to make a Level 2 Appeal to the MassHealth Board of Hearings:

- ❑ You, or your authorized representative, including your health care provider acting on your behalf, must ask for a Level 2 Appeal within 120 calendar days of the date at the top of this notice.
  - ❑ Step 1: Complete the Fair Hearing Request Form that is attached to this notice. You can also get the form:
    - ❑ Online in English, Spanish, Portuguese, etc. at: www.mass.gov/service-details/masshealth-member-forms
    - ❑ By calling MassHealth Customer Service at 1-800-841-2900, TTY 711 (for people who are deaf, hard of hearing, or speech disabled).
  - ❑ Step 2: Make a copy of this notice.
  - ❑ Step 3: Send the completed Fair Hearing Request Form and the copy of this notice to the MassHealth Board of Hearings. You can:
    - ❑ Mail to: Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171, or
    - ❑ Fax to: 617-847-1204.