NM Medicaid Fair Hearings: How to Advocate for Yourself & Others

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Fair Hearings Guide: How to Advocate for Yourself (or Others) in a Medicaid Fair Hearing

What Is This Guide About?

You or someone you know may receive Medicaid services through the New Mexico Turquoise Care Program. At this time, Turquoise Care is delivered by four Managed Care Organizations (MCOs): Presbyterian, BlueCross BlueShield of NM (BCBS), United Health Care, and Molina Health Care. As a Turquoise Care participant, your Medicaid services are managed by one of these MCOs.

This tip sheet will help you to appeal a denial, reduction, or termination of Medicaid services. Below, we will cover how to:

1) Submit an "internal appeal" to your MCO, which is the first step in the appeals process.
2) Request and prepare for a Fair Hearing, which is the second step in the appeals process.

But first, let's look at *how* Medicaid delivers services and identify the program in which you are enrolled.

How does Medicaid serve individuals with disabilities?

Under Medicaid in New Mexico, long-term services for most individuals with disabilities are provided through the Community Benefit program. Some people with very significant disabilities receive their services through a Medicaid Waiver program, such as the Mi Via, Medically Fragile, or Developmental Disabilities Waivers. (If you receive services through a waiver, please see DRNM's separate Tip Sheet called "Advocating for Waiver Services".)

If you receive services through the Community Benefit of Turquoise Care, those services are administered through one of these programs:

1) The **Self-Directed Community Benefit (SDCB) program**, in which the participant makes his or her own budget requests, coordinates services, and manages his or her own care, or
2) The **Agency Based Community Benefit (ABCB)**, in which a provider agency may make budget requests, coordinate services, and manage the participant's care.

The information in this guide can be used for services that you receive from Turquoise Care, including those services that you receive through the Community Benefit program. If you have been denied a *non*-Community Benefit service, such as a medication, skip on down to page 3: "The First Step of Appeals: Asking Your MCO to Reconsider."

In addition to using this guide, it may be helpful to review your participant rights found in your member handbook from Presbyterian, BlueCross BlueShield, Molina, or United.

How it All Begins: the Comprehensive Needs Assessment

Once a year, every Turquoise Care participant undergoes a Comprehensive

Needs Assessment (CNA). The CNA is a list of approximately 200 questions about your health and safety needs. Usually, your Care Coordinator from your MCO (Presbyterian, BlueCross BlueShield, Molina, or United) comes to your home and asks you these questions. The questions should cover issues such as your medical health, mental health, and your ability to care for yourself (i.e., your level of independence when it comes to hygiene, dressing, cooking, laundry, cleaning, etc.). The CNA should ask about your personal care service needs, and also include a Community Benefit Service Questionnaire (CBSQ) to ask about your needs for other services as well.

The CNA is then used by your MCO to determine what services you will receive during the next year, as well as the amount of services you will need.

Often, following completion of the CNA, you will receive a letter from your MCO indicating that one or more of your services have been denied, reduced or cut altogether. For instance, you may currently receive 24 hours per week of Personal Care Service hours, but the letter indicates that in the coming year you will only receive 14 hours per week. The letter should tell you *why* the MCO made this decision to deny, reduce, or terminate your services. In the letter, your MCO should also quote a New Mexico Medicaid regulation to back up its position.

Sometimes the language in these letters is very confusing. If you read the letter and cannot figure out *why* your service was denied or cut, or there is no legal citation to support the decision, make a note of this. This information will be important to tell the Hearing Officer if you participate in a Fair Hearing.

The good news is that you have the right to appeal the MCO's decision. ***Your job now is to show how the CNA did not capture all of your individual needs.*** You, your medical providers, and your caregivers know your needs best. You and your people can show how *your* individual needs must be met by the Medicaid program in which you are enrolled.

First Step of Appeals: Appealing to Your MCO

The first step in advocating for your denied or reduced services is to appeal directly to your MCO. There should be information about how to do this in the letter that you received. **You typically have 60 calendar days from the date on the MCO's letter to appeal their decision.** You should clearly state that you want to **appeal** the decision, and not just complain or submit a **grievance**.

You can call, email, fax, or write a letter to the MCO explaining why you need the services that were denied, reduced, or terminated. If you request the appeal over the phone, you have to follow that up in writing within 13 days. The contact information, such as the MCO's phone number, email address, fax number, and post office address, should be listed at the end of the MCO's letter. DRNM suggests that you save a written copy of your appeal, such as the e-mail or fax you sent.

If you appeal to your MCO, and do so within 10 days of the date on the denial or reduction letter, you may ask for "continuation of benefit" for services that are currently in place but are being reduced or stopped. The continuation of benefit should keep the services in place at least until the end of your appeal. If you do not win your appeal, however, the MCO can try to get you to repay the cost of the services during the appeal. If you want the **continuation of benefit**, you must say so clearly in your appeal to the MCO.

You should include important documentation with your appeal, such as letters of

support from your doctors, therapists, caregivers, or others who know your needs. You may want to contact your doctor's office to get medical records to submit with your appeal. You can include records that show your various diagnoses and their impact on you.You may want to include a letter from another clinician, such as a speech or physical therapist, who works with you and knows your limitations. You could also include a letter from a caregiver who is familiar with your home and your needs. *It's up to you to paint a picture of what your daily life is like, and how the Community Benefit services allow you to live in your community.*

Within 30 days of submitting your appeal to your MCO, you should receive another letter from the MCO. This letter will either grant you the services you requested, or uphold the denial. Sometimes there is a mixture of the two, meaning that some services are still denied while other services have been approved. If the letter indicates that the services you want are still denied, you can then request a Fair Hearing.

Step Two: How to Request a Fair Hearing

Important Deadlines:* If *you want to request a Fair Hearing, you will need to make this request within 90 calendar days from the date of the appeal denial letter that you received from your MCO.

If you got "continuation of benefit" during the MCO appeal and want to keep receiving the denied or reduced service(s) until the matter is resolved, you need to request the Fair Hearing within 10 calendar days of the date on the MCO's appeal denial letter. As with the MCO for that appeal, you need to let the Office of Fair Hearings know explicitly that you are requesting the continuation of benefit.

You can request a Fair Hearing by contacting the New Mexico Office of Fair Hearings. You may email the office at HCA-FairHearings@hca.nm.gov or call (505) 4476-6213 or 1-800-283-4465.

Info about the NM Office of Fair Hearings:

Tell them that you want to request a Fair Hearing and if you also want a "continuation of benefit." When you speak with a Fair Hearings representative, tell them that you are requesting a Fair Hearing and why you are requesting it (i.e., tell them which service(s) have been denied or reduced, and who your MCO is – Presbyterian, BlueCross BlueShield, Molina, or United). Remember, if you want to keep the denied/reduced service(s) at the same frequency until the matter is resolved, tell the Fair Hearings representative that you are requesting the "continuation of benefit."

Again, to request continuation of benefit, this phone call needs to be made within 10 days of the date on the last denial letter you received from your MCO.

After requesting your Fair Hearing by phone, you should receive a letter from the NM Office of Fair Hearings called "Notice of Request for Fair Hearing." It should note that you made your request over the phone, and if you requested to continue your benefit(s). This letter will include your Fair Hearing case number, which is located in the top right corner. You will need to use this case number in your communications with the Fair Hearings Bureau and your MCO.

Within several weeks, you should receive a second letter in the mail from the Office of Fair Hearings. This letter should be labeled "Notice of Scheduled Fair Hearing." This letter should list the date and time of your Fair Hearing. It will explain that Fair Hearings take place over the phone, and it will list a phone number and passcode for you to enter at the time of your Fair Hearing. It will also list the name of your Hearing Officer, who is also referred to as a judge. This is a very important letter that gives you information to access your hearing, so it is important to keep it in a safe place.

Preparing for the Fair Hearing

1. The first step in Fair Hearing preparation is to request your medical records. You can request your entire file from your MCO by calling the number on the back of your Turquoise Care card. You may need to submit a signed form to the MCO giving your permission to release your records. You can use anything in your record as evidence.

2. Gather additional medical records from: your doctors, your therapists, and any other providers, such as your caregivers. You can also ask those people to write letters of support on your behalf. Their letters will need to explain why the service you have requested is medically necessary for your health and safety. The letters will need to explain your physical or mental limitations, and how the service(s) that were cut or denied allow you to remain living in your community.

Components of a strong letter of medical necessity:

a. Client's name, date of birth, Medicaid ID# (if available).
b. How the doctor knows the client ("I have been treating her for XX years for…").
c. List of diagnoses.
d. Items or services that got denied.
e. Quote from denial letter about why they were denied. Be sure to mention the clinical guidelines or regulations used to make the determination (they should be listed in the denial letter).
f. In-depth narrative explanation of how the requested item/services are medically necessary according to the specific criteria used to make the denial.

g. Wrap it up with “Please reach out to me with any further questions or if more documentation is needed.”
h. MUST be signed by provider (NMAC requires this).
i. Should be printed on provider letterhead, or have logo appear somewhere.

Important Deadline: You will need to submit all written evidence that you intend to discuss during the hearing at least 3 business days before the Fair Hearing date. This includes medical records, letters of support, and any other written evidence. You will need to submit these documents to both the Office of Fair Hearings *and* your MCO. You can send them to the Office of Fair Hearings at:

Email: HSD_FairHearings@state.nm.us
Fax: (505) 476-6215

You may send these same documents to your MCO using the contact information listed on your last denial letter from the MCO.

3. Ask your care providers if they would be willing to participate in the Fair Hearing as witnesses. You can give them the phone number and passcode to participate during the Fair Hearing from any location. They may like to provide a verbal statement to the judge during the hearing. If they are willing to participate, they will also need to be available to answer questions either from the judge or from the MCO’s representative.

4. In the weeks prior to your Fair Hearing date, you should receive in the mail a packet called the “Summary of Evidence” (SOE) from your MCO. The SOE should contain a copy of your most recent Comprehensive Needs Assessment (CNA), which was the evaluation containing 200+ questions that your Care Coordinator asked you. Read through the CNA. Were the answers that your Care Coordinator recorded accurate? Do you remember being asked all of the questions? What does the CNA fail to highlight about your current condition and need for services? What special circumstances do you have that were not included in the CNA? These are all essential points to make to the Hearing Officer during your Fair Hearing.

Also in the SOE, you may find internal communications between staff members at your MCO. You may see that staff discussed your case or made notes about your condition. Check on the accuracy of these notes. For instance, an MCO staff member may have written that you are able to walk, unassisted, at least 20 feet. If you are unable to do this, consider asking your doctor, provider, or caregiver to write a letter or to verbally testify to your inability to do what the CNA says you are capable of doing. Your condition may have declined since the CNA was conducted, or the answers on the CNA simply may be inaccurate. *It’s up to you to describe your limitations and to provide evidence of those limitations through medical records, letters of support from providers, or the testimony of witnesses who know your condition.*

5. You may find it helpful to write down all of your thoughts in advance. Some people like to prepare a statement to read to the judge. You will need to be able to talk honestly about your disability and your needs, or to have others testify on your behalf about these issues.

6. Some people like to have someone talk for them. You can ask anyone you know to serve as an **"Authorized Representative"** who tells your story to the judge and presents evidence on your behalf. An Authorized Representative can also ask questions of the MCO's representative, and may answer questions from the Hearing Officer. If you have someone that you would like to serve as your Authorized Representative, you must let the Office of Fair Hearings know this in writing before the hearing. You can send a letter designating who your Authorized Representative is by using the Office of Fair Hearings form found here:

7. If you require extra time to prepare for your Fair Hearing, you are entitled by Medicaid law to request one "continuation" of your Fair Hearing. This means that you may contact the Office of Fair Hearings to request that your hearing date is rescheduled for a later date. Your MCO may make the same request for a continuation.

The Day of Your Fair Hearing: What to Expect

There are some legal words that would be helpful to know before the Fair Hearing begins. These legal terms include:

Claimant – You, or the Turquoise Care participant, are the claimant. You are bringing a claim against your MCO and the NM Human Services Department for an adverse action that impacts your health and safety.

Respondent – Your MCO and the NM Health Care Authority are the respondents because they are the ones responding to your claim. This is why there are usually representatives from both your MCO and the Human Services Department present at the Fair Hearing.

Hearing Officer – The Hearing Officer is the administrative law judge who is in charge of your fair hearing. They manage the hearing process, examine the evidence, and issue a recommended decision in your case (which, as discussed below, may or may not be accepted by the Medical Assistance Division as the final ruling in your case). It is appropriate to refer to the Hearing Officer as "Your Honor" throughout the hearing process.

The Department – Throughout the Fair Hearing, you will hear your MCO and the

NM Health Care Authority referred to interchangeably as “the Department.” This is because your MCO is a contracted agency working on behalf of the NM Health Care Authority.

Representatives – Representatives are employees of either your MCO or the NM Health Care Authority, or your own Authorized Representative whom you have invited to speak on your behalf. Sometimes the MCO will send a legal representative (an attorney) to speak on behalf of the MCO. Other times, representatives from your MCO may include a Medical Director (doctor), a secondary reviewer (who has reviewed your CNA), or other staff, such as nurses, or your Care Coordinator’s supervisor.

Medical Assistance Division – The NM Medical Assistance Division is the state entity that administers Medicaid, along with the NM Health Care Authority. After your Hearing Officer has issued a decision in the case, your case is passed up to the Medical Assistance Division Director. He or she will either agree or disagree with the Hearing Officer’s recommendation, and this is the final decision in your case at the administrative hearing level. You will receive a letter from the Medical Assistance Division Director letting you know the final outcome of your case.

Frequently Used Medicaid Regulations

8.200.400 NMAC General eligibility categories and recipient requirements

8.200.410 NMAC Residency and application requirements

8.200.430 NMAC Who determines eligibility, referrals, timeliness

8.200.500 NMAC Income and resource limits by category

8.200.600 NMAC Benefit descriptions

8.100.970 NMAC Administrative Fair Hearing Rules

8.302.1.7 NMAC Medical Necessity of Medicaid goods and services.

How the Fair Hearing is Structured

On the day of your hearing, call the phone number listed on your “Notice of Scheduled Fair Hearing.” When prompted, enter the passcode listed on the letter. The Hearing Officer will ask you and everyone else on the phone line to identify themselves. ***Important: If you call 15 minutes past the time listed on your letter, you may***

relinquish your right to a Fair Hearing.

Fair Hearings usually follow this order:

1. Opening

   A. The Hearing Officer explains the procedures for the hearing and turns on the audio recorder.
   B. Everyone identifies themselves.
   C. The Hearing Officer explains the "order of testimony."
   D. An oath is administered to each witness. You will be asked to raise your right hand (if you are able) and pledge to tell the truth during the hearing.
   E. The Hearing Officer will identify the issue(s), meaning that he or she will clarify which benefits you have been denied and are seeking to receive or restore.
   F. All pleadings, papers, and requests are identified, presented, and entered into the record by the Hearing Officer. You will be asked if you agree that the records submitted by the Department (the Summary of Evidence you received in the mail) may be entered into the record. The Department will then be asked if it agrees that the evidence you submitted may be entered into the record.

2. Order of Testimony

   A. Your MCO has the "burden of proof" to show that reducing, terminating, or denying your services was the legally correct course of action. The MCO gets to go first to present their evidence that supports their adverse action against you. This typically involves someone from the MCO reading parts of your CNA. There may be others, such as a doctor, present from the MCO to support the MCO's arguments.

      After the MCO makes its case, you or your Authorized Representative may ask questions from anyone on the MCO's team or from the Human Services Department. Don't be shy! You and your team know your needs best.

   B. You or your Authorized Representative are then asked to make your case. You can read a statement, read from notes, refer to the exhibits you submitted or the problems you found in the CNA. Be sure to explain how the Community Benefit that you have been denied is medically necessary.

      Explain how it allows you to continue living in your community, as opposed to living in a residential facility.

      After you make your case, individuals from the MCO, Human Services Department, or the Hearing Officer may ask you questions for clarification.

      You may request to make a closing statement if you like.

   C. As the hearing comes to a close, the Hearing Officer will tell you a date by

which he or she will render a recommendation in the case. There is typically little choice for you but to accept the Hearing Officer's proposed deadline. The Hearing Officer's decision then goes on to the Medical Assistance Division Director, who has the final say in the matter and makes the final decision.

After discussion of the decision deadline, the Hearing Officer typically turns off the audio recorder and you may hang up the phone.

After the Hearing

After the deadline established at the hearing, you will at some point receive a letter explaining the Hearing Officer and Medical Assistance Division Director's decision in your case. If you are not satisfied with the decision, you may choose to file an appeal in district court within 30 days of the date on that letter. You will most likely require an attorney for assistance at that point.

DRNM Is Here for You

DRNM provides technical assistance, advocacy support, and legal representation in Medicaid Fair Hearings. Please contact us so that we may evaluate your case and determine how we can help you.

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