HealthPAC
Health Program of Alameda County

Alameda County Health Care Services Agency
POLICY AND PROCEDURE

Policy Name	Hearings and Appeals
Department Owner	HealthPAC Administrator
Lines of Business	LIHP – MCE / HCCI
Effective Date	6/30/2011

HEARINGS AND APPEAL PROCESS

I. Definitions

A. An "action" is:

1. A denial, termination or reduction of eligibility for Medicaid Coverage Expansion (MCE) or Health Care Coverage Initiative (HCCI).

2. A denial or limited authorization of a requested HealthPAC service, including the type or level of service,

3. A reduction, suspension, or termination of a previously authorized service.

4. A failure to provide HealthPAC services in a timely manner pursuant to the Special Terms and Conditions of the California Bridge to Reform Demonstration for the LIHP.

5. A failure of the HealthPAC to act within the timeframes for grievances and appeals as outlined herein.

B. A "grievance" is an expression of dissatisfaction about any matter other than an action, as "action" is defined above.

C. An "appeal" is defined as a request for review of an action, as defined in A., above.

II. Processes

A. **A process** for internal resolution of HealthPAC applicants and enrollees grievances and appeals of actions; and

B. A process for HealthPAC applicants and enrollees appeal of actions to a State fair hearing.

III. Internal grievance and appeal process and coordination with the State fair hearing process.

A. For those individuals whose HealthPAC eligibility is determined by the State, the State assumes the responsibility and accountability for the resolution process. For those individuals whose HealthPAC eligibility is determined by the county, the State delegates to the county responsibility for the resolution process.

B. Exhaustion of the internal appeal process will be required of a HealthPAC applicant or enrollee prior to filing a request for a State fair hearing to appeal an action. (42 C.F.R. 438.402.)

C. Grievances will not be appealable to a State fair hearing.

IV. Matters outside the scope of the grievance and appeal process, including the right to a State fair hearing.

A. The sole issue is one of Federal or State law or policy, LIHP protocols approved under the Demonstration Standards, Terms and Conditions (STC). (42 C.F.R. 431.230(1).)

B. The establishment of and any adjustments to the upper income limit made by the LIHP, in accord with STC 58(b).

C. The establishment by a LIHP of enrollment caps of HCCI, and if as the result of such cap the HCCI is completely closed, establishment of enrollment caps for MCE. (STC 58(c).)

D. The establishment by a LIHP of wait lists as a result of enrollment caps created in accord with STC 58(c). (STC 58(d).)

E. The requirement that a LIHP make a timely eligibility determination is waived with respect to individuals' eligibility for a capped program while those individuals are placed on a county wait list for that program. The County's determination to place individuals on a wait list, rather than enrolling them in the capped program directly, is not subject to appeal. Nothing in this provision shall preclude those individuals from appealing the County's determination of eligibility for other programs.

V. Grievance and Appeals Process

A. Notice of Grievance and Appeal Rights

1. HealthPAC applicants will be informed of their right to file an internal grievance or appeal and the procedures for exercising this right, as well as the right to appeal an action as identified herein to a State fair hearing upon exhaustion of the internal process. Such information shall be made available in languages in addition to English as outlined in 42 CFR 438.10(c).

2. Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all HealthPAC enrollees at the same time that a Notice of Action is issued (as generally required in B.,(below), and in B.2 and B.3., specifically.

3. Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all providers within the HealthPAC network at the time they enter into a contract, or when the HealthPAC begins, whichever is earlier.

B. Notice of Action

1. Format - the notice of action will be in writing, and available in languages in addition to English as outlined in 42 C.F.R 438.10(c).

2. Notice to Applicants – notice will be provided upon completion of an eligibility determination.

3. Timing of Notice for LIHP enrollees – a notice of action will be mailed to HealthPAC enrollees at least 10 calendar days before the date of the action. Exceptions to such notice will follow 42 C.F.R. 431.213.

   a. Notices regarding standard authorization of service that deny or limit services will be provided as expeditiously as the HealthPAC enrollee's health condition requires and within 14 calendar days following receipt of the request for service. (42 C.F.R. 438.210(d)(1).) The timeframe may be extended for up to 14 additional calendar days if the HealthPaC enrollee or provider requests the extension, and the HealthPaC justifies (to the State agency upon request) a need for additional information and how the extension is in the HealthPAC enrollee's interest. Failure to timely reach authorization decisions constitute a denial and an adverse action, and notice must be provided on the date the timeframe expires. (42 C.F.R. 438.404(c)(5).)

   b. When the HealthPAC determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that following the standard timeframe in (a), above, could seriously jeopardize the HealthPAC enrollee's life or health or ability to attain, maintain, or regain maximum function, the HealthPAC must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the HealthPAC enrollee's health condition requires and no later than 3 working days. The 3 working days time period may be extended by up to 14 calendar days if the HealthPAC enrollee requests an extension or if the HealthPAC justifies (to the State agency upon request) a need for additional information and how the extension is in the HealthPAC enrollee's interest.

   c. The requirement for advance notice may be shortened to 5 calendar days in case of probable fraud by HealthPAC enrollees where the agency has facts indicating probable fraud and those facts have been verified, if possible, through secondary sources. (42 CFR 431.214.)

4. Content of Notice - the intended action; the reasons for the action (including statutory and regulatory references, if applicable); the

effective date of the action; the program requirements that support the action; the HealthPAC enrollee's right to file an appeal; the procedures for exercising these rights; the circumstances under which expedited resolution is available and how to request it, and the circumstances under which benefits are continued and how to request it. (42 CFR 438.404.)

C. The Internal Grievance and Appeal Requirements

1. For both grievances and appeals

   a. The HealthPAC will provide any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability (42 C.F.R. 438.406.) for all stages of the grievance and appeal processes, at no cost to applicants or HealthPAC enrollees.

   b. HealthPAC applicants and enrollees must file an internal grievance within 60 calendar days of the incident giving rise to the grievance, and must file an appeal of action within 60 calendar days of the date of the notice of action.

   c. The HealthPAC will acknowledge receipt in writing of each grievance and appeal.

   d. The decision maker must not be involved in any previous level of review or decision making.

   e. The decision maker in the following cases must be a health care professional with the appropriate clinical expertise in treating the HealthPAC enrollee's condition or disease:

      i. An appeal of a denial based on lack of medical necessity.

      ii. A grievance regarding denial of expedited resolution of an appeal.

      iii. Grievance or appeal that involves clinical issues.

2. Requirements for appeals of actions

   a. Oral inquiries seeking to appeal an action will be treated as an appeal and confirmed in writing by the HealthPAC unless the applicant, HealthPAC enrollee or provider requests expedited resolution. The request for expedited resolution may be made orally or in writing.

   b. Applicants, HealthPAC enrollees and their representatives will have the opportunity, before and during the appeals process:

i. To examine the HealthPAC's position statement related to the reason services are delayed, denied or withdrawn by the HealthPAC, the HealthPAC enrollee's case file, including medical records, and any other documents under consideration in the appeal, and

ii. To confront and cross-examine adverse witnesses.

c. HealthPAC applicants and enrollees and their representatives will be provided a reasonable opportunity to present evidence and allegations of fact or law, and cross examine witnesses, in person, in writing, or by telephone if requested by the individual.

d. In regard to the option for HealthPAC applicants and enrollees and their representatives to present evidence via the telephone, hearings can be conducted by telephone or video conference in lieu of an in-person hearing. Such hearings conducted in this manner must meet the following criteria:

i. Telephonic hearings may be requested by the individual, at any stage of the appeals process, free of charge,

ii. The individual must receive a written notice that a hearing can be conducted by telephone or video conference in lieu of an in-person hearing. Such notice must contain information about the process for an individual to review the records, submit evidence, and receive reimbursement for costs in accordance with (3) through (7) of this section C.2.d.

iii. HealthPAC applicants and enrollees and their representatives must have the opportunity, before, and during the appeals process, to examine the HealthPAC's position statement, the HealthPAC enrollee's case file, including medical records, and any other documents under consideration in the appeal.

iv. HealthPAC applicants and enrollees and their representatives must be able to submit evidence and any other documents for consideration during the appeal.

v. The record must be kept open for 15 calendar days to permit HealthPAC applicants and enrollees and their representatives to submit evidence and any other documents for consideration in the appeal after the hearing has concluded.

vi. HeathPAC applicants and enrollees and their representatives must be able to obtain reimbursement of HealthPAC enrollee's costs in order to attend an in-person hearing, i.e. transportation.

vii. Change in Process

a. At any point prior to or during a telephone or video conference hearing, at the request of either party or the decision maker, an in-person hearing can be ordered.

b. If an individual has an in person hearing scheduled, he or she may request a telephonic hearing 24 hours prior to the hearing date.

D. Timeframe for resolution of appeals and grievances

1. Standard disposition of grievances – Oral or written notice must be mailed within 60 calendar days of receipt of the grievance.

2. Standard resolution of appeals – HealthPAC must mail written notice within 45 calendar days of receipt of the appeal.

3. Expedited resolution of appeals – HealthPAC must mail written notice within 3 working days of receipt of the appeal. In addition, reasonable efforts to provide oral notice will be made.

4. Timeframes on the above may be extended by up to 14 calendar days if either the HealthPAC enrollee requests it, or the HealthPAC can show (to the satisfaction of the State DHCS upon its request) that there is a need for additional information and how the delay is in the HealthPAC enrollee's interest.

5. Written notice of the reason for the delay under (4.), above, must be provided, unless requested by the HealthPAC enrollee.

6. If a request for expedited resolution of an appeal is denied, the appeal must be treated under the standard resolution timeframe. In addition, reasonable efforts to give prompt oral notice of the denial must be made, and follow up with written notice within 2 calendar days must be provided.

E. Content of Notice of Appeals resolution

1. Written notice of the resolution must include:

a. The results of the resolution process and the date it was completed.

b. Be available in languages in addition to English as outlined in 42 C.F.R 438.10(c)

c. For appeals not resolved wholly in favor of the HealthPAC enrollee:

i. The right to request a State fair hearing and how to do so and the date by which the request of a State fair hearing must be made to be considered timely;

ii. If applicable, the right to request to receive benefits while the hearing is pending, and how to make the request; and

iii. That the HealthPAC enrollees may be held liable for the cost of those benefits if the hearing decision upholds the HealthPACs action.

F. State Fair Hearing

1. A State fair hearing may be requested within 90 calendar days of the date of the Notice of Resolution of the internal appeal of an action.

2. The State will take final administrative action in accord with 42 CFR 431.244(f)(1), or 431.244(f)(2), if applicable.

3. The HealthPAC will be a party to the State fair hearing.

G. Continuation of benefits during an appeal of action or a State fair hearing

1. The HealthPAC enrollee's benefits must be continued if:

a. A HealthPAC enrollee's eligibility is terminated or reduced;

b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c. The services were ordered by an authorized provider;

d. The original period covered by the original authorization has not expired;

e. The HealthPAC enrollees or provider (on behalf of the HealthPAC enrollees) timely files an appeal; and

f. The HealthPAC enrollee requests extension of benefits.

2. "Timely filing" as used in this section means filing on or before the later of either:

a. Ten (10) calendar days from the mailing of the notice of action

b. The intended effective date of the proposed action.

c. In the case of a State fair hearing, 10 calendar days from the date of the internal appeal decision.

3. Benefits that are continued under this section shall be continued until:

a. The HealthPAC enrollees withdraw the appeal;

b. Ten (10) calendar days pass after the mailing of a notice resolving the internal appeal adverse to the HealthPAC

enrollees, unless the HealthPAC enrollees requests a State fair hearing with continuation of benefits within 10 calendar days of the issuance of the internal appeal decision;

c. A State fair hearing decision adverse to the HealthPAC enrollees is issued,

d. As ordered by the Administrative Law Judge at the State fair hearing, in limited permissible circumstances, such as 431.230(a)(1); or

e. The time period or service limits of a previously authorized service has been met.

4. If the final resolution of the internal appeal or the state fair hearing is adverse to the HealthPAC enrollees, the HealthPAC may recover the cost of the services furnished to the HealthPAC enrollees while the appeal is pending, to the extent they were furnished solely because of the requirements of this section of the procedures.

5. If services were not furnished pending the internal appeal or the State fair hearing, and the resolution of the appeal reverses an action to deny, limit, or delay services, the HealthPAC must provide the disputed services promptly, and as expeditiously as the HealthPAC enrollee's health condition requires.

6. If the HealthPAC enrollee received disputed services while the internal appeal or the State fair hearing was pending, and the resolution reverses a denial of services, the HealthPAC must cover such services.

VI. LIHP Monitoring Reporting

CMS expects LIHP's to maintain a health information system that collects, analyzes and integrates the data necessary to implement the grievance and appeals process. To demonstrate the efficacy of the State's grievance and appeals process, the State Medicaid agency will provide to CMS the following data by LIHP program on a quarterly basis:

A. Time Period(s) Covered

B. Average Number of LIHP enrollees in the time period

C. Total number of appeal and the total number of grievance cases received by the LIHP and the State in the period;

D. Rate of Appeals and the rate of grievances per 1000 LIHP

E. Number and percent of cases resolved internally and through the fair hearing process, and outcomes of cases in the period inclusive of;

1. Number and percent decided in fully favor of the LIHP enrollee

2. Number and percent decided partially in favor of the LIHP enrollee

3. Number and percent not decided in favor of the LIHP enrollee

4. Number and percent withdrawn by the LIHP enrollee;

5. Number and percent of cases resolved through the fair hearing process, using telephonic procedures

    a. Number and percent decided in fully favor of the LIHP enrollee using telephonic procedures

    b. Number and percent decided partially in favor of the LIHP enrollee using telephonic procedures

    c. Number and percent not decided in favor of the LIHP enrollee using telephonic procedures

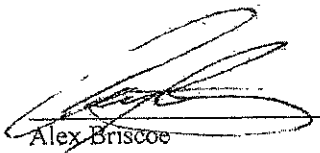
    d. Number and percent withdrawn by the LIHP enrollee using telephonic procedures;

F. Issues involved in all cases.

G. Time it takes to resolve the cases (upper and lower limits, median/mean)

    1. Number and percent of these cases involving expedited processing; and

H. Quality Improvement activities related to issues identified through the County's LIHP.

Signature  Date: 6/30/11

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