# County Medical Services Program Guide (CMSPG) Letter #05

October 10, 2011

**Subject** **ARTICLE A - LOW INCOME HEALTH PROGRAM (LIHP) GRIEVANCE AND APPEALS PROCESS**

**Effective Date** July 1, 2011

**Reference** Centers For Medicare & Medicaid Services Special Terms and Conditions 11-W-00193/9; State Material 06/30/11

**Purpose** To provide staff with the Low Income Health Program (LIHP) Grievance and Appeal process.

**Background** The Coverage Initiative program was San Diego's Medicaid-waiver program thru 06/30/11. CI had two types of Administrative Reviews: Eligibility and Medical. All CI Administrative Reviews were resolved at the local level, and the results of the Administrative Reviews were final.

Upon 07/01/11 implementation of LIHP, the new Medicaid-waiver program, CI expired and new regulations went into effect for LIHP. The California Department of Health Care Services (DHCS) has outlined the LIHP Grievance and Appeals process which each LIHP must adhere to.

**Changes** The CI Administrative Review process terminated with the implementation of LIHP. New State mandated LIHP requirements related to process, written communication, and timeframes replace the CI process.

<u>HHSA: LIHP-19 Your Grievance and Appeal Rights</u>
All LIHP applicants must be given form "Your Grievance and Appeal Rights" (LIHP-19) (Attachments A & B) to inform applicants of their right to file a County-level grievance or appeal and the procedures for exercising this right. Information is also included regarding the right to appeal an action to a State Fair Hearing upon exhaustion of the internal process.

For those individuals whose LIHP eligibility is determined by the State,

the State assumes the responsibility for the resolution process. For those individuals whose LIHP eligibility is determined by the County, the County assumes the responsibility for the resolution process.

Exhaustion of the County-level appeal process will be required of an applicant or enrollee prior to filing a request for a State Fair Hearing to appeal an action. Grievances are not appealable to a State Fair Hearing.

An "appeal" is defined as a request for review of an action. A "grievance" is an expression of dissatisfaction about a matter other than an action.

New LIHP Notices of Actions (NOA) have been created to inform applicants/enrollees of the County-level LIHP grievance and appeal process.

HHSA: LIHP-110R Appeal Resolution Informing Notice
This informing notice (Attachment C & D) informs the applicant/enrollee that a review regarding the denial or discontinuance of their application for LIHP was conducted and as a result of the review:

- the County has rescinded the denial or discontinuance; and
- a new NOA will be sent regarding the new eligibility determination.

LIHP grievances and appeals are available for eligibility determinations, physical health services, and mental health services. The process for grievance and appeals related to physical health and mental health services are outlined in the Enrollee and Provider Handbooks. The grievance and appeal processes related to eligibility issues are contained in the attached program material.

**Required Actions**

Workers are to familiarize themselves with the new process in order to accurately inform applicants/enrollees of the change.

**Forms Impact**

The table below shows the new forms affected by this letter.

| Forms | Title | Change | Attachments |
|---|---|---|---|
| LIHP-19 (Eng/Span) | Your Grievance and Appeal Rights | New | A & B |
| LIHP-110R (Eng/Span) | Appeal Resolution Informing Notice | New | C & D |

**Appeals Impact**

As stated in this letter.

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**Quality Assurance**

Effective with the November 2011 review month, Health Care Policy Administration (HCPA) will cite with the appropriate error any LIHP case that does not comply with requirements outlined in this letter.

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**CMS IT System**

The new form and notice will be uploaded into the CMS IT system.

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**Summary of Changes**

The table below shows the changes made to Article A of the CMSPG.

| Article | Changes |
|---|---|
| A.08.01 | Reflects the new grievance and appeal process. |

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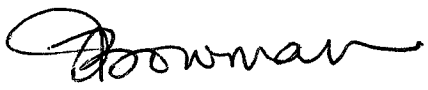
**Manager Approval**



Janya Bowman, Assistant Deputy Director
Health Care Policy Administration
Strategic Planning and Operational Support

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# LOW INCOME HEALTH PROGRAM

# YOUR GRIEVANCE AND APPEAL RIGHTS

If you are dissatisfied with the Low Income Health Program (LIHP), you have the right to ask for a grievance or appeal review. The timeframes and procedures for making these requests are listed below.

**Grievance**

A "grievance" is an expression of dissatisfaction about any matter other than an action (defined below).

- You have **60 calendar days** from the date of the incident giving rise to the grievance to file a County level grievance.

**Appeal**

An "appeal" is defined as a request for review of an action. An "action" is:

1. A denial, termination or reduction of eligibility for LIHP.
2. A denial or limited authorization of a requested LIHP service, including the type or level of service.
3. A reduction, suspension, or termination of a previously authorized service.
4. A failure to provide 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 County or the State to act within the timeframes for grievances and appeals as outlined here.

- You have **60 calendar days** from the date of the Notice of Action to file a County level appeal.

**Requesting a grievance or appeal review:**

You may request a grievance or appeal by writing or calling:

San Diego County Health And Human Services Agency
Appeals Section - GR/CMS Calendar Clerk
4990 Viewridge Avenue
San Diego, Ca 92123
Phone: (858) 514-6887

**Your appeal rights:**

- You and your representative will have the opportunity, before and during the appeals process:
  1. To examine the County's position statement related to the reason services are delayed, denied or withdrawn by the County or the State;
  2. To examine your case file, including medical records, and any other documents under consideration in the appeal; and
  3. To confront and cross-examine adverse witnesses.
- You and your representative 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 you.
- Hearings can be conducted by telephone or video conference in lieu of an in-person hearing.
  1. You may request a telephonic hearing at any stage of the appeals process, free of charge.
  2. Your record must be kept open for 15 calendar days to permit you and your representative to submit evidence and any other documents for consideration in the appeal after the hearing has concluded.
  3. You and your representative are able to obtain reimbursement of your costs in order to attend an in-person hearing, i.e. transportation.
  4. 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.
- The County 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 for all stages of the grievance and appeal processes, at no cost to you.

**Timeframe for resolution of grievances and appeals**

1. Standard disposition of grievances – Oral or written notice must be given within 60 calendar days of

receipt of the grievance.
2. Standard resolution of appeals – Written notice must be mailed within 45 calendar days of receipt of the appeal.
3. Expedited resolution of appeals – Written notice must be mailed 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 you request it, or the County can show that there is a need for additional information and how the delay is in your interest.
5. Written notice of the reason for the delay must be provided, unless requested by you.
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.

**State Fair Hearing**

- If the outcome of the County level appeal is not completely in your favor, you may request a State Fair Hearing.
- You have 90 days from the date of the Notice of Appeals Resolution to request a State Fair Hearing. You may request a State Fair Hearing by calling 1-800-952-5253. For hearing or speech impaired who use TDD, call 1-800-952-8349.
- The County level appeal must be completed before you can request a State Fair Hearing.
- Grievances are not appealable to a State Fair Hearing.

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

Your benefits must be continued if:

1. Your eligibility is terminated or reduced;
2. Your appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The original period covered by the original authorization has not expired;
5. You or your provider (on your behalf) timely files an appeal; and
6. You request extension of benefits.

"Timely filing" means filing on or before the later of either:

1. Ten (10) calendar days from the mailing of the Notice of Action
2. The intended effective date of the proposed action.
3. In the case of a State fair hearing, 10 calendar days from the date of the Notice of Appeals Resolution.

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

1. The enrollee withdraws the appeal;
2. Ten (10) calendar days pass after the mailing of a Notice of Appeals Resolution to you, unless you request a State Fair Hearing with continuation of benefits within 10 calendar days of the issuance of the Notice of Appeals Resolution;
3. A State Fair Hearing decision adverse to you is issued,
4. As ordered by the Administrative Law Judge at the State Fair Hearing, in limited permissible circumstances, such as 431.230(a)(1); or
5. The time period or service limits of a previously authorized service has been met.

If the final resolution of the County level appeal or the State Fair Hearing is adverse to you, the County may recover the cost of the services furnished to you while the appeal was pending.

If services were not furnished pending the County level appeal or the State Fair Hearing, and the resolution of the appeal is favorable to you, the County must provide the disputed services promptly, and as expeditiously

as your health condition requires.

If you received disputed services while the County level appeal or the State Fair Hearing was pending, and the resolution reverses a denial of services, the County must cover such services.

If you would like more information about your hearing rights, the Consumer Center for Health Education and Advocacy may be able to offer you free advice. For more information, call 1-877-734-3258.

# LOW INCOME HEALTH PROGRAM
# SUS DERECHOS DE QUEJAS Y APELACIONES

Si no está satisfecho con el programa Low Income Health Program (LIHP, por sus siglas en inglés), usted tiene el derecho de pedir una revisión de queja o de apelación. Los plazos límites de tiempo y procedimientos para hacer estas peticiones están anotados abajo.

**Queja**

Una "queja" es una expresión de insatisfacción sobre cualquier asunto excepto una acción (definida abajo).

- Usted tiene **60 días consecutivos** de la fecha del incidente que ocasionó la queja para presentar una queja a nivel del Condado.

**Apelación**

Una "apelación" se define como una petición de revisión de una acción. Una "acción" es:

1. Una negación, terminación o reducción de elegibilidad para LIHP.
2. Una autorización limitada o negación de un servicio solicitado, incluyendo el tipo o nivel de servicio.
3. Una reducción, suspensión o terminación de un servicio previamente autorizado.
4. Falta de proveer servicios de manera oportuna de acuerdo con los Términos Especiales y Condiciones de California Bridge Reform Demontration del programa LIHP.
5. Falta del Condado o del Estado de actuar dentro de los límites de tiempo para quejas y apelaciones como se describen aquí.

- Usted tiene **60 días consecutivos** de la fecha del Aviso de Acción para solicitar una apelación a nivel del Condado.

**Cómo pedir una revisión de apelación o de queja:**

Usted puede solicitar una revisión de apelación o queja llamando o escribiendo al:

San Diego County Health And Human Services Agency
Appeals Section - GR/CMS Calendar Clerk
4990 Viewridge Avenue
San Diego, CA 92123
Teléfono: (858) 514-6887

**Sus derechos de Apelación:**

- Usted y su representante tendrán la oportunidad, antes y durante el proceso de apelación a:
  1. Examinar la declaración de posición del Condado relacionada a la razón por la cual los servicios fueron retrasados, negados o retirados por el Condado o el Estado;
  2. Examinar su expediente de caso, incluyendo su historial médico, y cualquier otro documento considerado en la apelación; y
  3. Enfrentar e interrogar testigos adversos.
- Usted y su representante tendrán oportunidad razonable para presentar evidencia y alegaciones legales o de hechos, y de interrogar testigos, en persona, por escrito, o por teléfono, si así lo solicita usted.
- Las Audiencias se pueden conducir por teléfono o conferencia de video en lugar de en persona.
  1. Usted puede solicitar una audiencia telefónica en cualquier etapa del proceso de apelación, sin costo.
  2. Su archivo se mantendrá abierto por un periodo de 15 días consecutivos para permitirle a usted y a su representante entregar evidencia y cualquier otro documento para consideración en la apelación después de que ha concluido la audiencia.
  3. Usted y su representante podrán obtener reembolso de sus gastos para atender la audiencia en persona, por ejemplo transportación.
  4. En cualquier momento antes o durante una audiencia por teléfono o conferencia de video, a petición de cualquiera de los participantes o persona haciendo la decisión, se podrá ordenar una audiencia en persona.
- El Condado proveerá cualquier asistencia razonable para completar formularios y otros pasos del proceso. Esto incluye, pero no se limita a, proveer servicios de intérprete y números de teléfono sin

costo con capacidad de intérpretes TTY-TTD adecuados en todas las etapas del proceso de apelación o de queja, sin costo a usted.

**Límites de tiempo para resoluciones de quejas y apelaciones**

1. Disposición estándar de quejas – Se debe presentar aviso oral o por escrito dentro de 60 días consecutivos de la fecha en que se recibió la queja.
2. Resolución estándar de apelaciones – Se debe enviar aviso escrito por correo dentro de 45 días consecutivos de la fecha en que se recibió la apelación.
3. Resolución acelerada de apelaciones – Se debe enviar aviso escrito por correo dentro de 3 días áviles de la fecha en que se recibió la apelación. También, serán hechos esfuerzos razonables para proporcionar aviso verbalmente.
4. Los límites de tiempo mencionados arriba se pueden extender por hasta 14 días consecutivos ya sea si usted lo solicita, o el Condado puede demostrar que se necesita información adicional y cómo el retraso es para su beneficio.
5. Se debe presentar un aviso por escrito de la razón del retraso, al menos que usted haya pedido el retraso.
6. Si la resolución acelerada de una apelación es negada, la apelación se debe tratar bajo los límites de la resolución estándar. También, serán hechos esfuerzos razonables para informarle verbalmente de la negación, y dar seguimiento para proporcionar un aviso por escrito dentro de 2 días consecutivos.

**Audiencia Imparcial con el Estado**

- Si el resultado de su apelación a nivel del Condado no es completamente en su favor, puede solicitar una Audiencia Imparcial con el Estado.
- Tiene 90 días de la fecha del Aviso de Resolución de Apelaciones para solicitar una Audiencia Imparcial con el Estado. Puede pedir una Audiencia Imparcial con el Estado llamando al 1-800-952-5253. Para personas con dificultades del habla o del oído que utilizan TDD, llame al 1-800-952-8349.
- La apelación a nivel del Condado debe ser completada antes de poder solicitar una Audiencia Imparcial con el Estado. La apelación a nivel del Condado no será requerida cuando el proceso de apelación a nivel del Condado es inadecuado, fútil, o podría causar daños irreparables.
- Las quejas no son apelables a una Audiencia Imparcial con el Estado.

**Continuación de beneficios durante una apelación de acción o Audiencia Imparcial con el Estado**

Sus beneficios deben continuarse si:

1. Su elegibilidad es terminada o reducida;
2. Su apelación implica la terminación, suspensión, o reducción de un plan de tratamiento previamente autorizado;
3. Los servicios fueron ordenados por un proveedor autorizado;
4. El periodo original cubierto por la autorización original no ha vencido;
5. Usted o su proveedor (de parte de usted) solicita una apelación de manera oportuna; y
6. Usted solicita una extensión de sus beneficios.

"De manera oportuna" quiere decir solicitar la apelación antes o dentro de:

1. Diez (10) días de la fecha en que se envió el aviso de acción
2. La fecha prevista en que entra en vigor la acción propuesta.
3. En el caso de una Audiencia Imparcial con el Estado, 10 días consecutivos de la fecha del Aviso de Resolución de Apelaciones.

Los beneficios continuados bajo esta sección se continuarán hasta que:

1. El miembro retire la apelación;
2. Pasen diez (10) días consecutivos de la fecha en que se envió el Aviso de Resolución de Apelaciones, al menos que usted solicite una Audiencia Imparcial con el Estado con continuación de beneficios dentro de 10 días consecutivos de la fecha de expedición del Aviso de Resolución de Apelaciones;
3. Se expida una decisión en su contra en una Audiencia Imparcial con el Estado,
4. Así lo ordene el Juez de Derecho Administrativo en la Audiencia Imparcial con el Estado, bajo circunstancias permitidas limitadas, tal como 431.230(a)(1); o

5. Se haya cumplido el periodo de tiempo o los límites de un servicio previamente autorizado.

Si la resolución final de la apelación a nivel del Condado o de la Audiencia Imparcial con el Estado es en su contra, el condado puede recuperar el costo de servicios proporcionados a usted mientras la apelación estaba pendiente.

Si no se le proporcionaron servicios mientras quedaba pendiente la apelación a nivel del Condado o la Audiencia Imparcial con el Estado, y la resolución de la apelación es en su favor, el Condado debe proveer los servicios en cuestión de inmediato, y tan rápidamente como su salud lo requiera.

Si usted recibió los servicios en cuestión mientras la apelación a nivel del Condado o la Audiencia Imparcial con el Estado estaba pendiente, y la resolución revoca una negación de servicios, el Condado deberá cubrir dichos servicios.

Si necesita más información sobre sus derechos de audiencia, El Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos puede ofrecerle consejo gratuito. Para más información llame al 1-877-734-3258.

# LOW INCOME HEALTH PROGRAM
# APPEAL RESOLUTION INFORMING NOTICE

Date: _____ Member ID #: _____

Representative: _____

To _____ Phone: _____

_____ Location: _____

_____ Address: _____

_____

_____

A pre-hearing review regarding the Notice of Action dated ____ for your Low Income Health Program (LIHP) application dated ____ has been conducted. After reviewing the case record, the County has rescinded this Notice of Action. Your LIHP application will be re-evaluated and a new Notice of Action will be sent to you regarding the new eligibility determination.

If you have any questions regarding this notice, please call the Representative listed above.

The Consumer Center for Health Education and Advocacy may be able to offer you free advice on how to handle your appeal. For more information, call 1-877-734-3258.

Thank you.



LIHP Regulations:

# LOW INCOME HEALTH PROGRAM
# RESOLUCION DE AUDIENCIA CARTA INFORMATIVA

Fecha: _____ No. de Miembro: _____

Representante: _____

Para: _____ Teléfono: _____

_____ Ubicación: _____

_____ Domicilio: _____

_____

_____

Se ha llevado a cabo una revisión antes de la audiencia con respecto al Aviso de Acción con fecha del _____ para el programa Low Income Health Program (LIHP, por sus siglas en inglés) con fecha del _____. Después de haber revisado su caso, el Condado ha revocado este Aviso de Acción. Su solicitud para LIHP será reexaminada y un nuevo Aviso de Acción sobre la nueva determinación de elegibilidad será enviado.

Si tiene alguna pregunta sobre esta carta, por favor llame al Representante anotado arriba.

El Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos puede darle información gratuita de cómo llevar acabo su apelación. Para más información, llame al 1-877-734-3258.

Gracias.



LIHP Regulations:

# Article A Section 08.01 Grievance and Appeals

**Table of Contents**



# A.08.01 Grievance and Appeals

**A.08.01A General**

All LIHP applicants must be given form “Your Grievance and Appeal Rights” (LIHP-19) to inform applicants of their right to file a County-level grievance or appeal and the procedures for exercising this right. Information is also included regarding the right to appeal an action to a State Fair Hearing upon exhaustion of the internal process.

Notice of grievance, appeal and fair hearing procedures and timeframes will be provided to all enrollees at the same time that a Notice of Action is issued (as required in 08.01.01E below).

CMSPG LTR 05 (10/11)

**A.08.01B Appeal**

An "appeal" is defined as a request for review of an action. 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 LIHP service, including the type or level of service.
3. A reduction, suspension, or termination of a previously authorized service.
4. A failure to provide 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 County or the State to act within the timeframes for grievances and appeals as outlined herein.

In LIHP there are two types or levels of appeal: a County-level appeal and a State Fair Hearing. An appeal does not change policy or regulation; it can only ensure that policy or regulation has been followed or applied correctly.

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**A.08.01C Grievance**

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

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**A.08.01D Matters Outside the Scope of the Grievance and Appeal Process**

Matters outside the scope of the grievance and appeal process, including the right to a State Fair Hearing are as follows:

1. The sole issue is one of Federal or State law or policy, LIHP protocols approved by DHCS.
2. The establishment of and any adjustments to the upper income limit made by the County.
3. The establishment by the County of enrollment caps for LIHP.

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**A.08.01E Notice of Action (NOA)**

1. Format - the NOA will be in writing and available in threshold languages.
2. Notice to Applicants – notice will be provided upon completion of an eligibility determination.
3. Timing of Notice for Enrollees – a NOA will be mailed to enrollees at least 10 calendar days before the date of the action.

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

4. Content of Notice
   a. the intended action;
   b. the reasons for the action (including statutory and regulatory references, if applicable);
   c. the effective date of the action;
   d. the program requirements that support the action;
   e. the enrollee's right to file an appeal;
   f. the procedures for exercising these appeal rights;
   g. 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.

CMSPG LTR 05 (10/11)

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**A.08.01F Scope of Services and Payment Issues**

LIHP beneficiaries have the right to make a complaint or file an appeal with the Administrative Services Organization (ASO) when they do not agree with the County's actions concerning access to medical or mental health services, quality of care, scope of services, or payment of claims. These procedures are in the ASO Complaint and Appeal Policy and Procedures Manual.

**Note:** An appeal related to scope of services, access to medical or mental health services, quality of care, or payment of claims are handled through the ASO and are not within the jurisdiction of the County HHSA Appeals office.

CMSPG LTR 05 (10/11)

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**A.08.01G Grievance and Appeals Process**

1. For those individuals whose LIHP eligibility is determined by the State, the State assumes the responsibility and accountability for the resolution process.
2. For those individuals whose LIHP eligibility is determined by the County, the State delegates to the County responsibility for the resolution process.
3. Exhaustion of the County- level appeal process will be required of an applicant or enrollee prior to filing a request for a State Fair Hearing to appeal an action.
4. If dissatisfied with the County- level appeal decision, the applicant may file for a State Fair Hearing.
5. Grievances are not appealable to a State Fair Hearing.

**A.08.01H Authorized Representatives (AR)**

1. **General:** Applicants/enrollees may designate an Authorized Representative (AR) for appeal purposes. Such designation must be made in writing and the designation must be signed and dated by the applicant or enrollee on or after the date of the action or inaction with which the applicant is dissatisfied.

2. **AR Assisting:** If the applicant/enrollee wants to designate an AR to accompany and assist with all aspects of the appeal process, the applicant or enrollee and AR must sign and date the Appointment of Representative form MC 306/MC 306(SP) or any other written statement which contains the same information as the MC306 on or after the date of action or inaction with which the applicant/enrollee is dissatisfied.

3. **AR Acting on Behalf:** If the applicant/enrollee is or is not present at the hearing and wants to designate an AR (person or organization) to act on their behalf with all aspects of the appeal process, they must sign and date the Authorized Representative form DPA19/DPA19 (SP) or any other written statement containing the same information as the DPA19 on or after the date of the action or inaction with which the applicant/enrollee is dissatisfied. If a DPA19/DPA19 (SP) is secured, an MC306 is not needed for the same AR. A DPA19/DPA19 (SP) or any other written statement designating an AR to act on the behalf of an applicant/enrollee will only be recognized during the appeals process and thru the end of the compliance with that appealed action.



**A.08.01I Interpreters**

1. **General:** If it is determined the applicant/enrollee cannot effectively communicate in English because it is not his/her native language, and his/her native language is not a threshold language, the County will provide an interpreter.

2. **Interpreters provided:** In order to assist the applicant during the grievance/appeal process, the County will provide or secure:
   - either a bilingual interpreter who has passed the technical portion of the County's bilingual proficiency evaluation; or
   - an interpreter who is certified by the state, federal government or by the California Department of Social Services (CDSS).

   County bilingual employees will not serve as an interpreter who

are:

- the applicant's/beneficiaries relatives, friends, or an authorized representative;
- County staff who participated in making the decision complained of; or
- County staff who are conducting the review.

CMSPG LTR 05 (10/11)

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**A.08.01J County Level Grievance/ Appeal Requirements**

1. For both grievances and County- level appeals:
   a. The County 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 for all stages of the grievance and appeal processes, at no cost to applicants or enrollees.
   b. Applicants/enrollees must file a County-level grievance within 60 calendar days of the incident giving rise to the grievance.
   c. Applicants/enrollees must file a County-level appeal of action within 60 calendar days of the date of the Notice of Action (NOA).
   d. The County will acknowledge receipt in writing of each grievance and appeal.
   e. The decision maker must not be involved in any previous level of review or decision making.
2. Requirements for filing appeal requests of actions:
   a. Oral inquiries seeking to appeal an action will be treated as an appeal request and confirmed in writing by the County unless the applicant, enrollee or provider requests expedited resolution. The request for expedited resolution may be made orally or in writing.
   b. Applicants, enrollees and their representatives will have the opportunity, before and during the appeals process to:
      i. Examine the LIHP's position statement related to the reason services are delayed, denied or withdrawn by the LIHP or the State with advance notice to the County;
      ii. Examine the enrollee's case file, including medical records, and any other documents under consideration in the appeal with advance notice to the county; and
      iii. Confront and cross-examine adverse witnesses.
   c. Applicants, 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, keeping within the timeframes for resolution.
   d. In regard to the option for applicants, 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 (iii) through (vii) of this section.

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

iv. Applicants, enrollees and their representatives must be able to submit evidence and any other documents for consideration during the appeal within the required timeframes.

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

vi. Applicants, enrollees and their representatives must be able to obtain reimbursement of costs in order to attend an in-person hearing, i.e. transportation.

vii. Change in Process

- At any point prior to or during a telephone or video conference hearing, at the request of either party, applicant/enrollee, representative or decision maker, an in-person hearing can be ordered.
- If an individual has an in-person hearing scheduled, he or she may request a telephonic hearing 24 hours prior to the hearing date.



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**A.08.01K County Level Grievance/**

1. All applicants/enrollees are directed to call the County HHSA Appeals office to request a grievance review or County-level appeal.

**Appeal Process**

2. The County HHSA Appeals office shall send written acknowledgement of the grievance/appeal request as required by 08.01.01J above.
3. A face-to-face review is not scheduled unless requested by the applicant/enrollee or their AR.
4. The County HHSA Appeals office notifies the appropriate HHSA office within 1 workday of the grievance/appeal request and provides the applicant's/enrollee's identifying information (name, member ID number, address, telephone number, application date and scheduled hearing date).
5. For Appeals: The appropriate HHSA eligibility staff reviews the case within 3 work days of the HHSA Appeals office notification to determine whether the worker properly followed program policies.
   a. If yes:
      i. The appropriate HHSA office completes the electronic Pre-Hearing Supervisor Review Checklist & LIHP Summary, including recommended finding and supporting program citations.
      ii. The appropriate HHSA office forwards the case and e-mails the Pre-Hearing Supervisor Review Checklist and LIHP Summary form to the HHSA Appeals section within 3 work days.
      iii. HHSA Appeals completes a final review.
         - If HHSA Appeals upholds the appropriate HHSA office's recommended finding, Appeals finalizes the Notice of Appeals Resolution and mails it to the claimant within the designated timeframe (Refer to 08.01.01O below).
         - If HHSA Appeals does not uphold the appropriate HHSA office's recommended finding, Appeals contacts the Manager for the appropriate HHSA office to discuss the resolution.
   b. If no, the appropriate HHSA office:
      i. Rescinds the action being appealed and re-evaluates eligibility;
      ii. Must send notice LIHP-110R to inform the claimant that their case is being re-evaluated; and
      iii. Sends a new NOA to reflect the updated eligibility determination.
6. For Grievances: Grievances received by HHSA Appeals will be forwarded by Appeals to the appropriate HHSA office. The appropriate HHSA eligibility staff investigates the incident giving rise to the grievance.
   a. The appropriate HHSA office writes the Disposition of Grievance and mails it to the claimant within the designated timeframe listed in 08.01.01N.

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**A.08.01L 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 County-level appeal of an action.
2. The State will take final administrative action.
3. The County will be a party to the State Fair Hearing.

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**A.08.01M Aid Paid Pending (APP)**

Aid Paid Pending (APP) is a continuation of benefits during a County-level appeal of action or a State Fair Hearing.

1. The enrollee's benefits must be continued if:
   a. An 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 original period covered by the original authorization has not expired;
   d. The enrollee or provider (on behalf of the enrollee) files an appeal timely; and
   e. The 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 NOA.
   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 County-level appeal decision is issued.
3. APP benefits that are continued under this section shall be discontinued/terminated when:
   a. The enrollee withdraws the appeal;
   b. Ten (10) calendar days pass after the mailing of a notice resolving the County-level appeal adverse to the enrollee, unless the enrollee requests a State Fair Hearing with continuation of benefits within 10 calendar days of the issuance of the County-level appeal decision;
   c. A State Fair Hearing decision adverse to the enrollee is issued;
   d. As ordered by the Administrative Law Judge at the State Fair Hearing, in limited permissible circumstances; or
   e. The time period or service limits of a previously authorized service has been met or expired.
4. If the final resolution of the County-level appeal or the State Fair Hearing is adverse to the enrollee, the County may recover from the provider the cost of the services furnished to the enrollee 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 County-level appeal or the State Fair Hearing, and the resolution of the appeal reverses an action to deny, limit, or delay services, the County must provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
6. If the enrollee received disputed services while the County-level appeal or the State Fair Hearing was pending, and the resolution reverses a denial of services, the County must cover such services.

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**A.08.01N Timeframe for Resolution of Grievances and Appeals**

1. Standard disposition of grievances – Oral notice must be given or written notice must be mailed within 60 calendar days of receipt of the grievance.
2. Standard resolution of request for appeals – County must mail written notice within 45 calendar days of receipt of the appeal request.
3. Expedited resolution of appeals – County must mail written notice within 3 working days of receipt of the appeal request. 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 enrollee requests it, or the County 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 enrollee's interest.
5. Written notice of the reason for the delay under (4.), above, must be provided, unless waived by the 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.

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**A.08.01O 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 threshold languages.
    c. For appeals not resolved wholly in favor of the applicant or 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 enrollee may be held liable for the cost of those benefits if the hearing decision upholds the LIHP action.

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**A.08.01P Monitoring Reporting**

The County shall maintain a health information system that collects, analyzes and integrates the data necessary to implement the grievance and appeals process. The data listed below shall be provided to DHCS as required by regulation.

1. Time period(s) covered.
2. Average number of LIHP enrollees in the time period.
3. Total number of appeals and the total number of grievance cases received by the County in the period.
4. Rate of appeals and the rate of grievances per 1000 enrollees.
5. Number and percent of cases resolved internally and through the fair hearing process, and outcomes of cases in the period inclusive of:
   a. Number and percent decided in full favor of the enrollee.
   b. Number and percent decided partially in favor of the enrollee.
   c. Number and percent not decided in favor of the enrollee.
   d. Number and percent withdrawn by the enrollee.
   e. Number and percent of cases resolved through the fair hearing process, using telephonic procedures.
      i) Number and percent decided in fully favor of the enrollee using telephonic procedures.
      ii) Number and percent decided partially in favor of the enrollee using telephonic procedures.
      iii) Number and percent not decided in favor of the enrollee using telephonic procedures.
      iv) Number and percent withdrawn by the enrollee using telephonic procedures.
6. Issues involved in all cases.
7. Time it takes to resolve the cases (upper and lower limits, median/mean).
   a. Number and percent of these cases involving expedited processing; and
8. Quality Improvement activities related to issues identified through the County's LIHP.

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