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THE MEDICAID APPEALS PROCESS

By Ryan Long

Federal and state laws allow Medicaid applicants and clients who have their benefits denied, terminated, or reduced to appeal the decision. This *issue brief* provides an overview of the Medicaid appeals process in Colorado.

Background

The Colorado Department of Health Care Policy and Financing (HCPF) oversees and operates Colorado's Medicaid program, with the administration of public benefits occurring at the county level. Eligibility is determined through the Colorado Benefits Management System (CBMS), which is a database system that processes applications for public benefits.

Filing an Appeal

As of September 1, 2016, Medicaid clients have 60 days after the notice of an intended action to file an appeal. An intended action is the suspension, termination, or modification of a client's medical assistance benefits. Under current law, HCPF is required to mail a written notice to Medicaid clients at least ten days before an intended action. Notices include an explanation of the intended action, the reasons for taking the action, and an explanation of the process going forward.

Status of benefits. If a Medicaid recipient files an appeal before the intended action goes into effect, medical assistance benefits automatically continue until the end of the appeals process. Medicaid recipients can choose to stop benefits during the appeals process by making a written request. If a recipient chooses to continue benefits, HCPF can seek to recover the cost of any services provided during the appeals process if the client is determined ineligible.

Requesting a hearing. An applicant or client may request a hearing if he or she believes the action was incorrect, the application for services was improperly denied, or the application was not addressed in the required time frame. A request for a hearing must be in writing and contain:

- the recipient/applicant's name, address, and state identification number (if applicable);
- the action or decision being appealed; and
- the reason for the appeal.

A Medicaid applicant or recipient and his or her authorized representative are entitled to examine the complete case file and all documents used for the hearing. If an applicant or recipient makes an oral request for a hearing, a written request can be prepared for the client's signature. HCPF will also arrange to have a qualified interpreter if the applicant or recipient is not fluent in English or has a language difficulty.

Hearings Process

An administrative law judge at the Office of Administrative Courts (OAC), which is an independent agency within the executive branch, conducts Medicaid hearings.

Fair hearings. The OAC must give at least 10 days' notice of the hearing date for the appeal, and all hearings must occur within 45 days of the hearing request. Hearings related to a disability determination, level of care determination, or target group eligibility must occur within 20 days of the hearing request. Unless otherwise requested, hearings are private and can be conducted either face-to-face or over the phone.

Denial of a hearing occurs when an applicant or recipient withdraws his or her request in writing or fails to appear at the scheduled hearing without good cause. If an administrative law judge finds that there was good cause for missing the hearing, he or she can reschedule the hearing for another date.

Initial decisions. Administrative law judges will issue an initial decision to the Office of Appeals in HCPF soon after the hearing. Initial decisions rely solely on evidence introduced in the hearings, and:

- summarize the facts;
- identify the regulations and evidence supporting the decision; and
- explain that failing to file exemptions waives the right to seek judicial review of a final agency decision.

Hearings concerning disability determinations only consider whether the recipient meets the Medicaid definition of disability or blindness.

Anyone who seeks to reverse, modify, or remand an initial decision must file exceptions with the Office of Appeals within 18 days (including 3 days for mailing) of the date the initial decision was mailed. Exceptions must be in writing and state the specific grounds for requesting a reversal, modification, or remand of the initial decision.

Final agency decisions. After the initial decision is filed with the HCPF Office of Appeals, HCPF issues a final agency decision based on the record of:

- the written transcript of testimony and exhibits;
- all papers and requests filed in the proceeding;
- the initial decision of the administrative law judge; and
- any exceptions and requests filed in response to the initial decisions.

Unless an extension has been granted, the Office of Appeals will issue the final agency decision within 90 days of the date the request for a hearing was received. If the final decision is favorable for the appealing client, corrective action occurs within three working days of the final decision, retroactive to the date of the incorrect action.

An applicant or recipient can file a written motion for reconsideration with the Office of Appeals within 15 days of the final decision. Applicants can file a motion if they can provide a good reason for not filing exemptions within the required time frame, or by showing that the final decision was based on a clear error of fact or law.

Dispute Resolution Process

Medicaid applicants and recipients can also request to enter the dispute resolution process with their county department of human services, either before or after an appeal. Every county department or service delivery agency is required to offer dispute resolution to clients as an alternative to the formal appeal process. If a dispute is resolved through the dispute resolution process, any pending appeals are withdrawn and dismissed.