Challenging Eligibility and Service Decisions Under The Community HealthChoices ("CHC") HCBS Waiver

The Community HealthChoices Home and Community-Based Services Waiver ("Community HealthChoices HCBS Waiver") provides services to enable individuals who need a nursing facility level of care to remain in their own homes and communities. This Fact Sheet provides information about: (1) how you can challenge decisions if you apply for the Community HealthChoices HCBS Waiver but are determined to be ineligible for the program or you do not receive a timely eligibility decision; and (2) if you are determined to be eligible for the Community HealthChoices HCBS Waiver and enrolled in one of the Managed Care Organizations ("MCOs"), how you can challenge decisions about your services or treatment.

I. Challenging Eligibility Determinations

A. What Can Be Appealed

When you apply for the Community HealthChoices HCBS Waiver, you can file an appeal (called a "Fair Hearing") in either of the following situations:

- You Are Determined Not to Be Eligible – You may be ineligible for the Community HealthChoices HCBS Waiver for various reasons, including if: (1) you will not be 21 or older by the time services will begin; (2) your doctor did not timely submit a Physician's Certification; (3) you are determined not to be Nursing Facility Clinically Eligible ("NFCE"); and/or (4) you are determined not to meet the financial eligibility requirements for the program because your income and/or resources are too high. When this

happens, you will receive a written notice that should state the specific reason(s) for the decision. If you disagree with the decision, you can file an appeal of that decision. For more detailed information about eligibility, please see our publication titled “Eligibility for Community HealthChoices (“CHC”) and Other Programs that Provide Home and Community-Based Services for Adults as Alternatives to Nursing Facilities.”

- You Do Not Receive an Eligibility Decision with Reasonable Promptness – When you apply for Medical Assistance benefits, you are entitled to receive a decision about your eligibility “with reasonable promptness.”Generally, eligibility decisions should be made within 90 days after you apply for the Community HealthChoices HCBS Waiver. There are times when a decision could take longer, such as if you are living in a nursing facility and waiting for housing. If you believe that you should have received an eligibility decision, you should contact the Independent Enrollment Broker – Maximus (by phone at 877-550-4227 or online at https://www.paieb.com/) -- to determine if there is a reason for the delay and see whether it can be fixed. But if the problem is not quickly resolved, you can file an appeal to challenge the failure to make the eligibility determination with reasonable promptness.

B. Filing Appeals of Eligibility Denials and Delays

1. Appeals from Denials

When you receive a notice stating that your application for the Community HealthChoices HCBS Waiver has been denied, the notice should include detailed instructions about when and how to file an appeal if you want to challenge the decision.You should read the notice carefully and follow those instructions.

The written notice should include a form that applicants can complete to file appeals.

- You must state the reason for appeal – why you disagree with the denial. The answer does not need to be lengthy.
- You will need to state the type of hearing you want. You will generally have the choice between a telephone hearing or a face-to-face hearing.
- You can ask for an expedited hearing and decision if your life, health, or ability to attain, maintain, or regain maximum function will be harmed by delay. You will need to explain how you will be harmed and to provide a signed medical certification from your doctor to support it.
- You can ask for any necessary language interpreter services to be provided at the hearing or for disability-related accommodations. These services are provided free of charge.
- You can state whether you want to be represented at the hearing by another person (such as a relative, friend, advocate, or lawyer) and identify the representative.
- You MUST sign and date the form.
- You should include a copy of the denial notice when you submit the completed form.
- You should maintain a copy of the notice and envelope for your records.
- You should deliver the appeal in a way that allows you to track the delivery and confirm receipt.

Appeals of decisions denying eligibility for the Community HealthChoices HCBS Waiver must be postmarked or delivered no later than 30 days of the date on the notice.NOTE: The 30-day time period runs from the mail date on the notice – not the date you received the notice, which may be considerably later than the date on the notice. If you do not file an appeal within the 30-day period, your appeal may be dismissed. If the date on the notice is earlier than the postmark date on the envelope, you may be able to argue that the 30-day period should run from the date of the postmark but there is no guarantee that the argument will be accepted.

2. Appeals When Determination Is Delayed

If you do not receive a determination of your eligibility for the Community HealthChoices HCBS Waiver within 90 days (and thus have no written notice of decision), you can file an appeal. You have up to six months after the date that the decision should have been made to file the appeal. You can find a form to submit if you want to appeal a delayed decision at https://www.paieb.com/doc/Request_for_Fair_Hearing.pdf. You can also submit an appeal by writing a letter that includes the following information:

- Your name, address, and contact information.
- The date you applied for the Community HealthChoices HCBS Waiver and a statement that you are appealing because you have not received a written eligibility decision.
- A statement as to whether you want a telephone hearing or face-to-face hearing.
- If you need a speedy decision because delay will jeopardize your life, health, or ability to attain, maintain, or regain maximum functioning and, if so, you should ask for “expedited review” and submit a signed certification from your doctor to support that request.

- If you need a language interpreter or any disability-related accommodations, you should state what you need in the letter.
- You MUST sign and date the letter.
- You should send it to the following address in a way that allows you to track and confirm delivery:

PA Independent Enrollment Broker
6385 Flank Drive, Suite 400
Harrisburg, PA 17112-4603

C. Before the Fair Hearing

Once you have submitted your appeal, it will be reviewed by the Pennsylvania Department of Human Services or one of its agencies or contactors which was involved in the making of the decision (such as the Office of Long-Term Living, the County Assistance Office, or the Independent Enrollment Broker (Maximus)). The agency involved may offer a prehearing conference to determine if the issue can be resolved without a hearing. This process is optional and should not delay or replace the Fair Hearing process. You should not be pressured to withdraw your Fair Hearing request. If the matter is not resolved to your satisfaction, the appeal will go forward.

Separately, your appeal will be forwarded to the Bureau of Hearings and Appeals (“BHA”) of the Pennsylvania Department of Human Services within 3 business days after it is received. The BHA will assign the appeal to an Administrative Law Judge (“ALJ”) who will schedule a “Fair Hearing” and decide the appeal. Although ALJs work for the Department of Human Services, they must be impartial.

It is important that you prepare for the Fair Hearing. You are entitled to receive copies of all information used to make the decision, all documents that will be

presented by the other side, and the names of witnesses who will testify for the other side. If you do not receive that information, you should contact the Independent Enrollment Broker (Maximus) to ask for it and, if necessary, contact the BHA for assistance.

If you think that other information is needed from the Independent Enrollment Broker or the Department of Human Services, you can submit a request for records to them. If you believe information from other sources is needed (such as a doctor), you can ask the BHA to issue a subpoena to that person or organization to get those records. You can also ask the BHA to issue subpoenas to ensure that witnesses you need will appear at the Fair Hearing.

What information you will need for an appeal will depend on the reason you were denied eligibility. For instance:

- If you were determined not to be Nursing Facility Clinically Eligible, it will be important to show that you do meet that standard by presenting appropriate medical evidence from a doctor and evidence about your functional limitations from a doctor, from you, and/or those who know you and help you. You will want to review the Functional Eligibility Determination that was conducted when your eligibility was assessed and be prepared to say what it is inaccurate or incomplete.

- If you were determined not to be financially eligible, the denial notice should specify how your income and resources were calculated and why they were determined to exceed the permissible amount. You can then assess what information about your finances you need to put forward if the information is incorrect or determine whether the standards they used in counting or excluding income or resources is accurate.

D. The Fair Hearing and Decision

You should receive a notification of the date of the Fair Hearing at least 10 days before the hearing date unless you have requested expedited review. At the Fair Hearing, you can represent yourself or have a relative, friend, advocate, or attorney represent you. You can present evidence – witnesses and documents – and contest the other side's evidence, including cross-examining their witnesses. The other side will also present evidence.The ALJ may ask questions of witnesses, too.

You can object to testimony or other evidence. For instance, you should object if:

- the other side tries to change the reason for its denial from what was stated in the denial notice;
- the other side tries to submit testimony or other evidence that is related to a reason for denial that is not the same as the reason given in the denial notice;
- the other side tries to use documents that it did not provide to you before the hearing or present testimony from witnesses who it did not identify before the hearing.

At the end of the Fair Hearing, you can ask to submit a post-hearing letter to summarize the evidence and argument. You can also ask the ALJ at the end of the Fair Hearing to allow the hearing record to remain open for five working days if you want to submit additional information.

Once all the information is submitted, the ALJ will consider it. After the ALJ makes a preliminary decision, it must be reviewed by the Director of the Bureau of Hearings and Appeals who makes the final decision. The Bureau of Hearings and Appeals must send its final decision within 90 days of the date the appeal was filed (or within three business days after a request for Fair

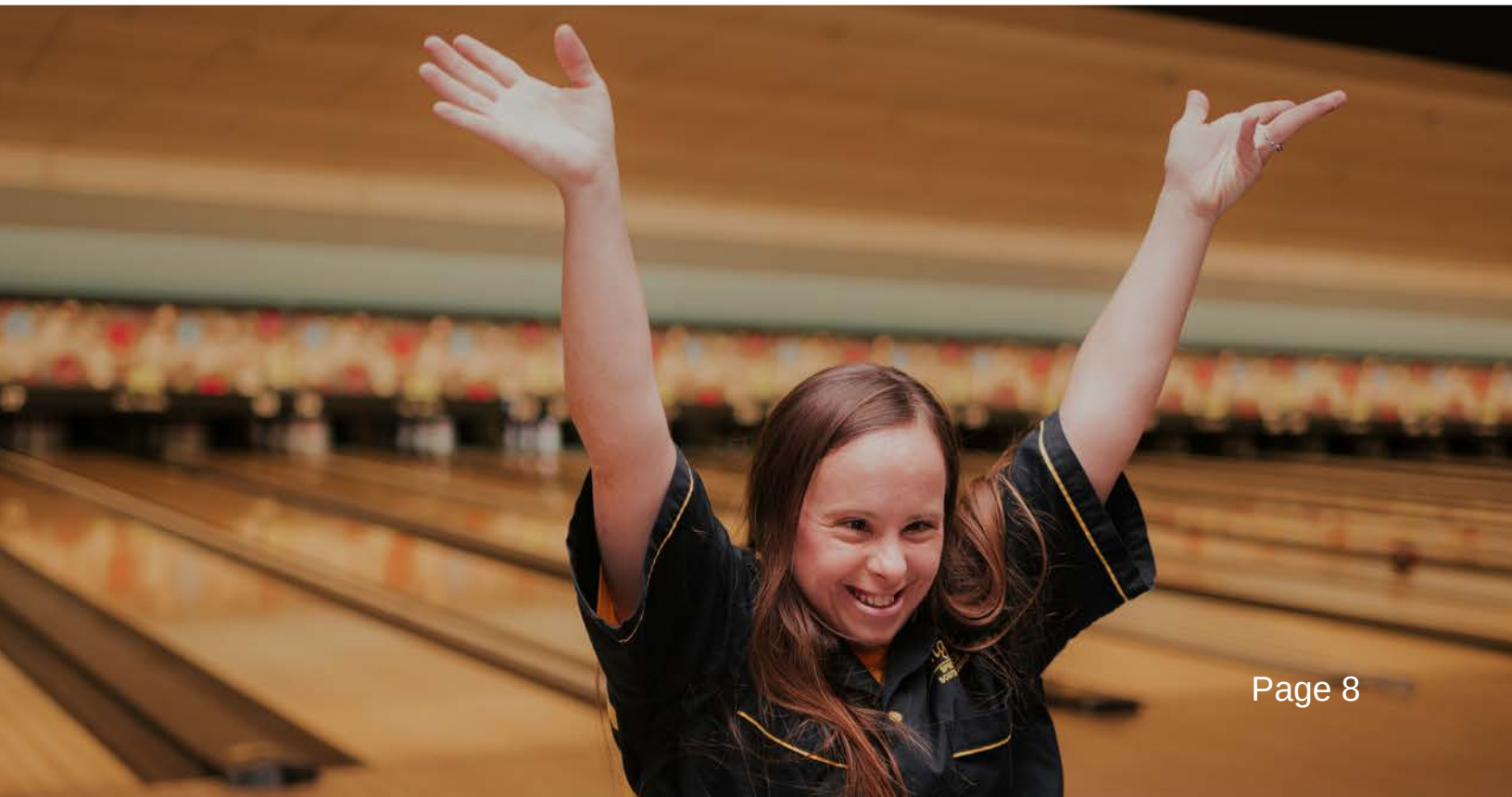
Hearing is filed if the individual seeks an expedited Fair Hearing and the ALJ agrees). If you asked for a postponement or continuation of the Fair Hearing, that time is not counted in calculating the 90-day period.

E. After the Fair Hearing Decision

If the Bureau of Hearings and Appeals rules in your favor, the decision must be implemented immediately.

If the Bureau of Hearings and Appeals rules against you, you can ask the Secretary of the Department of Human Services for “Reconsideration” of the decision. You must file a request for Reconsideration within 15 days of the date of the decision. The decision will include information on how to ask for Reconsideration.

You also have the right to file an appeal to the Pennsylvania Commonwealth Court if the Bureau of Hearings and Appeals rules against you. The appeal must be filed within 30 days of the date of the decision unless you requested Reconsideration, in which case the deadline is 30 days from the date the Secretary issues a decision on the request for Reconsideration.



II. Challenging Service Decisions and Delays After You Enroll in the Community HealthChoices HCBS Waiver

If you are determined to be eligible for the Community HealthChoices HCBS Waiver, you will select one of the Managed Care Organizations ("MCOs") which contract with the Pennsylvania Department of Human Services to administer the Community HealthChoices HCBS Waiver. If you are dissatisfied with a decision made or action taken by the MCO or a service provider, you will be able to file a complaint or a grievance with the MCO and then, as appropriate, can take further steps if you are not satisfied with the outcome. Generally, you must first file a complaint or grievance with your MCO before you seek other relief.

A. Differences Between Complaints and Grievances

A complaint is a dispute or objection regarding a health care provider or about the coverage, operations, or management of the MCO. Complaints can be used to challenge many types of actions and inactions by MCOs or service providers as well as conduct which you think is inappropriate. Complaints can be filed when:

- the MCO denies a requested service or item on the basis that it is not covered;
- the MCO approves a requested service or item, but you have not received it in a timely manner;
- the MCO does not decide a complaint or grievance you filed within the required timeframes;
- you are not satisfied with a provider or the quality of care you received from the provider:

- you cannot find a qualified provider in the MCO's network who can meet your needs;
- the MCO denied payment to a provider for a service or item because either the MCO subsequently determined that the service or item is not covered or because the MCO had not authorized the service or item before it was delivered;
- you want to dispute a financial charge for a service or item (including, for instance, co-payments).

A grievance is a request to have the MCO reconsider a decision concerning medical necessity and/or appropriateness of a service or item that is covered. Grievances can be filed when:

- the MCO denies, in whole or in part, a service or item you requested;
- the MCO only issues a limited authorization for a requested service or item;
- the MCO denies a service or item you requested, but approves a different service or item;
- the MCO reduces the amount of, suspends, or terminates a service or item that it previously had authorized you to receive.

If the MCO denies services because it says they are "not covered," you should file a complaint. If the MCO denies services because it says they are not "medically necessary" or are not "appropriate," you should file a grievance.

B. General Rules for Filing Complaints and Grievances

Complaints and Grievances Can Be Filed by Phone or in Writing – You can file a complaint or grievance with your MCO either by phone or in writing. Your MCO's Member Handbook should have a contact number to call to file a complaint or grievance by phone and postal address, fax number, and/or email address where you can submit a written complaint or grievance. If you file your complaint or grievance by phone, be sure to get the name of the person you spoke to and ask the person for a "reference number." Keep that information as well as the day and time of the call for your records. All complaints and grievances filed by phone must be put in writing by the MCO and you must sign it. You can sign it at any time during the process and the process may not be delayed because it is not signed. If you submit a written complaint or grievance, make sure to make copies and to send them in a way that allows you to confirm delivery.

You Can File a Complaint or Grievance Before You Receive Written Notice from the MCO – The MCO must send you written notice when they deny, reduce, or terminate services. But sometimes you may hear about this decision – for instance from a Service Coordinator or service provider -- before you receive the written notice. You do not need to wait until you get the written notice to file a complaint or grievance. You can call the MCO and tell them you want to file a complaint or grievance.

You Can Have a Representative File the Complaint or Grievance – You can have a representative or (in some cases) a provider file a complaint or grievance for you if you provide written consent. If, however, you need assistance from another person as a reasonable accommodation due to your disability, you should ask the MCO for that accommodation. For instance, if you have a disability that impedes your speech, you should be able to have another person communicate on your behalf as a reasonable accommodation.

You Have the Right to Receive Information from the MCOs – The MCO must provide you or your representative with all documentation about the subject of the complaint or grievance. This information must be provided at no cost to you and sufficiently in advance of the date for review. The information provided may depend on the nature of your complaint or grievance, but typically should include: (a) your medical records; (b) any documents or records the MCO relied on in connection with the complaint or grievance, including any medical necessity criteria used to make the decision and any information supporting coverage limits which the MCO used to make the decision; and (c) any new or additional evidence the MCO considered, relied upon, or generated in connection with the grievance or complaint.

You Have the Right to Present Testimony, Documents, and Arguments – When you file a complaint or grievance, you must be given an opportunity to present documents and testimony and to make legal and factual arguments in person and in writing.Unless your complaint or grievance is expedited, the MCO must provide you with at least 10-days' written notice of the date your complaint or grievance will be heard. If you cannot appear in person, the MCO must provide you the opportunity to appear by telephone or videoconference. The MCO should be flexible in scheduling the date to give you an opportunity to participate.

Decision-Makers – Complaints may be decided by one or more persons who work for the MCO while grievances must be decided by a committee of at least three people. No one who reviews a complaint or grievance can do so if he or she was involved in the challenged decision or action. Additionally, at least one-third of the committee that decides a grievance must be composed of individuals who are not employees of the MCO. If the complaint or grievance involves a clinical issue, the complaint or grievance must be decided by a licensed physician in the same or similar specialty area.

You Can Ask to Expedite a Complaint or Grievance – You can ask the MCO to expedite review of a complaint or grievance if waiting 30 days for a decision (the standard timeframe) would jeopardize your life, physical or mental health, or your ability to attain, maintain, or regain maximum function. The MCO must expedite the review if you submit a signed certification from your doctor to support the request or if the MCO determines that waiting would be harmful. If no doctor's certification is submitted within 72 hours of your request to expedite, the MCO can follow the standard timeframes to decide complaints and grievances.If your complaint or grievance is expedited, the MCO must issue a decision within 48 hours of receiving the doctor's certification or 72 hours of receiving your request for expedited review, whichever is shorter, although you can request an extension of the time frame by up to 14 days. You will still have the right to present documents and testimony and make arguments, but the time to do so will be very limited if the complaint or grievance is expedited.

Language and Disability Accommodations – During the complaint and grievance process, you are entitled to receive from the MCO at no cost to you any necessary language interpreter services and any reasonable accommodations for your disability (such as written materials in large print, sign language interpreters, or an individual to assist you to present information).

C. Filing Complaints with the MCO

If you are filing a complaint about any of the following actions, it must be filed within 60 days of:

- the date you received a notice from the MCO that it: (a) denied a service or item on the basis it is not covered; (b) denied payment after a service or item had been provided; or (c) denied your request to dispute a financial charge;
- the date the MCO should have provided the service; or
- the date the MCO should have decided the complaint or grievance.

You can continue getting services while a complaint is being considered if you act quickly: If the MCO reduced, changed, or terminated a service or item you previously were receiving, you can continue to receive the service or item until the MCO makes a decision on the complaint IF you make a complaint verbally or it is hand-delivered or postmarked within **10 DAYS** of the date on the written notice (NOT the date you received the written notice).

There is no deadline for filing a complaint about any other matter (such as dissatisfaction with a provider's services).

The MCO must decide complaints within 30 days after you filed the complaint, although you can request an extension of that time frame for up to 14 days. The MCO must send you a written notice of the decision.

If the MCO decides the complaint in your favor, it must authorize or provide the disputed service or item no later than 72 hours after the date it received notice of the decision.

If you are not satisfied with the outcome of your complaint, you may file a request for External Review or a request for a Fair Hearing or both – without filing a “Second Level Complaint” – if the complaint involved one of the following issues:

- denial of a service or item on the basis that it is not covered;
- failure to provide a requested service or item in a timely manner;
- failure to decide a complaint or grievance within the required timeframes;
- denial of payment to a provider for a service or item because either the MCO later determined it was not covered or because the MCO had not authorized the service or item before it was delivered;
- a dispute about a financial charge to you for a service or item.

If your complaint related to another type of issue (such as dissatisfaction with service by a provider), you must file a “Second Level Complaint” within 45 days of the date of the initial complaint decision to dispute the initial complaint decision. The MCO must give you a reasonable opportunity to present documents and testimony and to make any legal and factual arguments and must give you at least 15-days’ notice of the date of the review of the Second Level Complaint. The Second Level Complaint must be decided within 45 days. If you are dissatisfied with the Second Level Complaint decision, you can file a request for External Review within 15 days after the decision on the Second Level Complaint.

Information about External Review and Fair Hearings, including timelines, is discussed in Section II.E below.

D. Filing Grievances with the MCO

You must file a grievance within 60 days of the date you receive notice of the MCO's decision that you want to challenge.

You can continue getting services while a complaint is being considered if you act quickly: If the MCO reduced, changed, or terminated a service or item you previously were receiving, you can continue to receive the service or item until the MCO makes a decision on the complaint IF you make a complaint verbally or it is hand-delivered or postmarked within **10 DAYS** of the date on the written notice (NOT the date you received the written notice).

The MCO must decide the grievance within 30 days of the date you filed it, although you can request an extension of that timeframe for up to 14 days. The MCO must send you a written notice of the decision.
If the MCO decides the grievance in your favor, it must authorize or provide the disputed service or item no later than 72 hours after the date it received notice of the decision.

If you are not satisfied with the outcome of your grievance, you may file a request for External Review, for a Fair Hearing, or both. Information on pursuing those options is discussed in Section II.E below.

E. External Review and Fair Hearings

If you are dissatisfied with the MCO's decision on a complaint that is not subject to a Second Level Complaint review (as described in Section II.C) or

with a decision on any grievance, you can file a request for “External Review,” for a “Fair Hearing,” or both. The written notice of the decision on your complaint or grievance should include the procedures and timelines for seeking External Review and a Fair Hearing.

An External Review is a review by a doctor chosen by the Pennsylvania Department of Health (“DOH”) who is not affiliated with the MCO. You must file a request for External review within 15 days from the date you received the MCO’s decision. You can ask to expedite the External Review if you submit the request within 2 business days of receipt of the decision. You can file a request for External Review by sending a letter to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health & Welfare Bldg., Room 912
Harrisburg, PA17120-0701
1-888-466-2787

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
1-877-881-6388

The Pennsylvania Department of Health handles complaints involving how a provider delivers services. The Pennsylvania Insurance Department handles complaints that involve MCO’s decisions, policies, procedures, and practices. But if the request for External Review is sent to the wrong department, it will be sent to the correct department and will not harm or delay your request.

After a request for External Review is made, the MCO will submit the file on the complaint or grievance. You, as well as the MCO or your health care provider, can also submit additional information for the reviewer to consider, but you must do that within 15 days of filing the request for External Review. If you submit additional information, you should send copies to the MCO. The doctor must decide the request for External Review within 60 days of the date of the request.

A Fair Hearing is a review by an impartial Administrative Law Judge (“ALJ”) at the Pennsylvania Department of Human Services’ Bureau of Hearings and Appeals (“BHA”). You must file a request for a Fair Hearing within 120 days from the date on the written notice of the MCO’s decision (not the date of receipt). You may seek to expedite the Fair Haring by submitting a signed certification from your doctor that delay would jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function.

A Fair Hearing Request Form should be included with the written notice of decision from the MCO which you can complete and submit to request a Fair Hearing or you can submit a letter asking for a Fair Hearing. The letter should include your name, your date of birth, a telephone number where you can be reached, a statement of whether you want an in-person or telephonic hearing, the reasons for the appeal, and you should include a copy of the written notice of decision (unless the MCO did not provide a written decision within the required time frames). The form or letter should be submitted to:

Department of Human Services
OLTL/Forum Place 6th Floor
CHC Complaint, Grievance, and Fair Hearings
P.O. Box 8025
Harrisburg, PA 17105-8025

The process governing Fair Hearings is explained more in Sections I.C and I.D above.Importantly, your MCO must provide you, at no cost, with records, reports, or other documents that are relevant to the hearing and, as explained above, you can request additional information from the MCO or other parties if necessary.

The Bureau of Hearings and Appeals generally must issue a decision within 90 days of the date you filed your complaint or grievance (or within 3 business days after you filed a valid request for an expedited Fair Hearing). If the Fair Hearing has not been decided within 90 days and you have not been receiving the services that are the subject of the Fair Hearing, you can file a request for Interim Assistance from the MCO. Interim Assistance entitles you to receive the requested services during any delay in a Fair Hearing decision. If you are responsible for delaying the hearing process (for instance, if you requested a continuance or postponement), that time period will be excluded in calculating the 90-day period for purposes of eligibility for Interim Assistance.

You can continue getting services while your requests for External Review and/or a Fair Hearing is being considered if you act quickly: If the MCO reduced, changed, or terminated a service or item you previously were receiving, you can continue to receive the service or item while your requests for External Review and/or a Fair Hearing are being considered IF your request for External Review and/or a Fair Hearing are hand-delivered or postmarked within 10 DAYS of the date on the written decision on your complaint or grievance (NOT the date you received it).If you want to pursue both External Review and a Fair Hearing, you MUST submit BOTH the request for External Review and the request for a Fair Hearing within 10 days of the date on the MCO's decision.

Reconsideration or an appeal to the Commonwealth Court is described in Section I.E above.

If you have questions or need additional help understanding Community HealthChoices HCBS Waiver eligibility, services, and/or appeals, please contact Disability Rights Pennsylvania (DRP).