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Member Appeals Rule Update Stakeholder Engagement Questions & Answers

This document summarizes:

- Unanswered stakeholder questions received during Colorado Department of Health Care Policy & Financing's (Department) stakeholder engagement on March 27, 2024 regarding updates to the Member Appeals rule.

Below each item, the Department has provided an *interim* response.

Important Note: There are several stages of policy development and implementation. Any responses in this document represent a snapshot of the Department's position as of May 9, 2024 and should not be read as final policy determination. Additional Department policy clarification will be published in May 2024.

Where can I find policy changes and updates shared in the stakeholder meeting, held on March 27, 2024?

- The March 27, 2024 Member Appeals Stakeholder Engagement meeting presentation and recording are posted on the event webpage.

The Notice of Action (NOA) indicates that members have 60 days to appeal, but it is unclear if the 60 days begin on the date of the eligibility determination or the notice of action date. Because these two dates often differ by a day or two, could you clarify when the 60 days to appeal begin?

- Clarifying language was added to the draft Member Appeals rule in Section 8.057.5.A.1. to indicate that members may file an appeal no later than 60 calendar days after the date of the Notice of Action (NOA), which is consistent with Colorado Revised Statute section 25.5-4-207(1)(a)(II): "The applicant or recipient has sixty days after the date of the notice of action to file an appeal."

How long is the current appeal timeline for members and will this rule change impact the appeal timeline?

- The current appeal timeline for members is 60 days after the date of the Notice of Action (NOA). Section 8.057.5.A.1. was updated in the proposed rule to indicate that members may file an appeal no later than 60 calendar days after the date of the Notice of Action (NOA).

Could a section be added to the rule clarifying that a member can appeal if their services stop, even if they did not receive a Notice of Action letter?

- Members and applicants already may appeal if their services stop without receipt of a Notice of Action or denial notice. *Please see* 8.057.3.A.2. ("An individual shall have an opportunity for a hearing where [ ] [t]he recipient requesting the hearing believes the action is erroneous." An "action" is defined in 8.057.1. as "a termination, suspension or reduction of Medicaid, eligibility or covered services").
- The Department will modify section 8.057.3.A.2. to read, "An individual shall have an opportunity for a hearing where [ ] [t]he recipient requesting the hearing believes the action is erroneous, **including a loss of coverage without notice**."

Could a section be added to the rule clarifying that only an appeal, not the county process, ensures continuation of benefits and the timeline by which that must be completed?

- Clarifying language was added to the rule in Section 8.057.5.A.2: "An informal dispute resolution does not extend the period of time within which a member can timely file a formal appeal pursuant to Section 8.057.4.B.; nor does a request for an informal dispute resolution conference result in a continuation of benefits. Filing a formal appeal pursuant to 8.057.4.B. is the only way to receive a continuation of benefits, if applicable." The timeline for filing an appeal, and thereby continuing benefits, is no later than 60 calendar days after the date of the Notice of Action, per Section 8.057.5B.1.

What is the Department's guidance around county Departments of Human Services advising members to dismiss their appeals, which may then result in members not withdrawing and missing their hearing?

- Department response forthcoming.

What is the Department's guidance around county Department of Human Services suggesting that a member appeal can be dismissed based on issue resolution without providing written documentation of issue resolution to members?

- Department response forthcoming.

With the current glitch in the system, case management agencies who are helping families with denials can't enter the level of care, resulting in cases being delinquent on their paperwork. What is the department's guidance around how members and their representatives should approach this issue?

- During the implementation of the Care and Case Management (CCM) system beginning July 1, 2023, Case Management Agencies had to complete Level of Care (LOC) Assessments on a PDF form. PDF LOC Assessments should all now be entered in the CCM as well as any LOC Assessment that was not completed on a PDF form during the implementation phase of the CCM.
- The process to distribute a LOC Certification to the appropriate County Department of Human Services did not change other than using a form provided by the Department rather than printing one from the system used by the Case Management Agency. The Department is not aware of a system issue that is preventing Case Management Agencies from entering LOC assessments or any Case Management Agencies that are out of compliance with LOC timelines.
- If there is a situation in which an applicant or their representative is unable to resolve a concern with their Case Management Agency, they may submit a County and Eligibility Site Member Complaint and Escalation Webform. The Department will review their concern and respond accordingly.

How can members save a record of the documents they've uploaded in the PEAK portal?

- Any documents that members upload successfully on PEAK can be found on the 'Submitted documents' tab of the 'Manage my documents' page. That page shows the type of document submitted, the date uploaded, and the member it is associated with (or the household).
- Users should also be able to view any documents uploaded to PEAK on the 'Submitted documents' tab of the 'Manage my documents' page as well. There have been some technical issues with that feature that should be resolved in May 2024.

Why are peer-to-peer consultations conducted with primary care providers or pediatricians rather than specialists?

- Department response forthcoming.

What options exist for providers if they feel like a clinician reviewer is inappropriately denying services based on a training issue?

- Department response forthcoming.

Given that Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal requirement, how does the Department ensure that EPSDT is included in evaluation of pediatric member needs?

- The Department ensures that EPSDT is included in evaluation of pediatric member needs in several ways. The Department trains vendor staff on EPSDT. Many vendors require employees pass a competency test to work on Health First Colorado utilization management.
- The Department works with external review agencies, like Health Services Advisory Group (HSAG), to monitor practices and policies.
- Members can email HCPF_EPSDT@state.co.us with questions about EPSDT.
- Members may appeal adverse actions and can follow the appeal process detailed on their Member Appeal Rights on the back of the notice.

Where did the term "service delivery agency" as included in the rule language come from and why is it being used here?

- The term "service delivery agency" was first coined in legislative updates to Colorado Revised Statutes 25.5-4-207, which codified the requirement for county and service delivery agency informal dispute resolution conferences. The phrase was not defined in the statute, and was not used elsewhere in Title 25.5, or by the Department, at the time of the statutory update. The Department has since used the phrase internally to refer to Medical Assistance (MA) Sites, which are contracted, designated organizations that assist applicants and members to apply for and renew their Medicaid eligibility.
- This undefined term has been a source of confusion. As a result, the Department now proposes to codify in rule the definition of "service delivery agency" consistent with the definition for MA Sites.
- The Department of Human Services statutes in Title 26 also contains the phrase “service delivery agency” and has a similar function and definition for "local service delivery

agency" in the Code of Colorado Regulations (CCR) at 9 CCR 2503-5, Section 3.500 Adult Financial Programs: "'Local service delivery agency' means an agency operating on behalf of the county department or State Department to determine all or part of a client's eligibility for Adult Financial programs." 9 CCR 2503-5, Section 3.510 (Definitions).

What is the Department's guidance around seeking recoupment of benefits for monetary damages if the member's appeal is lost? How does the proposed rule address this?

- Section 8.057.5.B. of the proposed Member Appeals rule has been removed in its entirety to reflect that the Department will not ask the member to pay back the cost of services received during an appeal if the member loses the appeal.

When should members and their representatives receive exhibit packets from the Department after an appeal is filed? What if an evidence packet is not received in a timely manner?

- The Department mails evidence packets 10 days prior to the hearing, in alignment with the information the Office of Administrative Courts (OAC) includes in the Notice of Hearing which states: "Mail or e-mail a copy of this evidence packet to the Appellant, and to the ALJ (e-filing also accepted and preferred or by email to oac-gs@state.co.us) no later than ten days prior to hearing."
- There have been issues with the OAC's e-filing system, where the Department did not receive notice of the Appellant's court filings or the Appellant's evidence packet in some instances, which may have necessitated a late filing of an exhibit in response to the Appellant's evidence.
- If an evidence packet is not received in a timely manner, it is up to the member how they want to address it with the Court. The OAC has a procedural rule guide and a non-lawyer guide on its website with some information about non-compliance with the rules.
- Additional Department response forthcoming.

Do attorneys and non-attorneys receive different time allotments during the appeal process?

- The Office of Administrative Courts (OAC) hearing length does not change whether the member is represented by themselves, an attorney, or non-attorney representative.
- OAC does avoid scheduling more complex hearings on trailing dockets, which means it doesn't double or triple schedule those hearings in the same time slot.

Electronic filing with the Office of Administrative Courts (OAC) is not user-friendly. Are there any plans to improve this system?

- Stakeholder feedback was shared with the Office of Administrative Courts (OAC).
- OAC shared that they are in the early stages of planning system upgrades, but they do not yet have a timeline to share of when the system changes will be implemented.
- OAC is considering longer term options for a new case management system.

What actions can members take if a provider submits a Prior Authorization Request (PAR) that isn't accurate or comprehensive?

- Both informal reconsideration processes and peer-to-peer consultations are available to providers to address PAR errors, missing information, or disagreements with the utilization management vendor PAR determination.
- Members may follow-up with their provider to discuss the partial approval or denial reasons, provide additional information, and discuss next steps.
- A member may seek a second opinion or transfer to another provider if the member disagrees with the provider about next steps regarding the prior authorization request.

Has the Department considered expanding access to informal dispute resolution conferences, including when members receive prior authorization request (PAR) denials?

- The Department thoughtfully evaluated the cost of expanding access to informal dispute resolution conferences to all benefit determinations and published a Cost Benefit Analysis. The Department cannot absorb the additional cost of this expansion. It would require additional analyses, vendor discussions, and federal and state budgetary authority and approval.