16. Fair Hearings

16.1. Administrative Hearings

Reference: 8.308.15 NMAC Grievances and Appeals

Under managed care rules, the MCO must have a grievance process and an appeal process for members as described in the above rule. The MCO must be familiar with the provisions of the rule and have procedures in place that follow the rule.

All rules and requirements related to the appeal and hearing processes must be followed from the initial adverse determination, which would typically either be the denial or reduction of a requested service or LOC, or the discontinuation or reduction of an existing service or LOC. However, the right to an appeal and hearing process is also required when a new decision is made, even if that action is to increase or extend a benefit and, therefore, may not initially appear to be "adverse."

The Member may still appeal an action that has been taken to increase or extend the same benefit. For example, if the Member receives increased PCS hours, but the hours are less than what the provider requested or less than what the Member feels are needed, the Member can still appeal that action; in the sense that the action is considered an adverse action, if that is how the Member perceives it. When the notice is sent, it should be labeled as the Notice of Action.

Any instance for which an approval, authorization, LOC, frequency, or other amount is not approved to the extent requested by the provider or Member is considered an adverse action and may be referred to as such.

Time limits requiring advance notice prior to the MCO taking an adverse action against a Member's existing service or LOC, (including actions by a Member's receiving MCO that did not authorize the original service) are all important and must be followed. It is from that initial adverse action, and the adverse action that a receiving MCO may take, that all the remaining provisions of the notification, rights to continuation of a benefit, MCO appeal, and HCA administrative hearing process may follow. Therefore, all notices to the Member must accurately advise the Member of his or her appeal rights, and all notices must adhere to the time frames specified.

Grievances

The grievance process should not be confused with the appeal and administrative hearing processes. The grievance process is an internal resolution process within the MCO. The MCO must always make it clear to the Member when to file an appeal rather than to file a grievance. A Member may file an appeal if they are unsatisfied with the outcome of the grievance process as long as the Member is still within

the time requirement for filing an appeal. However, the appeal is made on the basis of the Notice of Action and not an appeal on the grievance resolution. Filing a grievance in no way alters or extends the time that the Member has to file an appeal.

Provider Appeal

The provider appeal process is included in the above rule. This process exists only within the Member's MCO. While the HCA does have a provider hearing process for some fee-for-service provider issues, the MCO provider appeal process **does not** lead to an HCA administrative hearing before the Office of Fair Hearings.

Member Appeal

The Member MCO appeal process is included in the above rule. The Member MCO appeal process can eventually lead to an HCA administrative hearing before the Office of Fair Hearings.

The MCO must assure that the Member is informed of all rights regarding the right to an appeal and the MCO appeal process, and as applicable, an HCA administrative hearing process. The MCO must follow all the requirements of the rule related to the MCO appeal process.

In order to consolidate the requirements of state and Federal rules, MAD has developed checklists for notices and letters contained in the Appendix.

16.2. The Member's HCA Administrative Hearing

Reference: 8.352.2 NMAC Claimant Hearings

When the Member has exhausted his or her MCO appeal process, and if the Member acts within the time frame specified in 8.308.15 NMAC and 8.352.2 NMAC, the Member has the right to file a request for an HCA administrative hearing with the Office of Fair Hearings. Within the HCA, the terms Administrative Hearing and Fair Hearing mean the same thing.

Once a Member receives an MCO appeal final decision and the Member elects to request an HCA administrative hearing, the Member and MCO are governed by the NMAC 8.352.2 rule. The process the Member and MCO are to follow for an HCA administrative hearing is detailed in this rule.

Once a Member's request for an HCA administrative hearing has been received by the Office of Fair Hearings, and if the Member was approved for a continuation of his or her benefit during the MCO appeal process, the Member's continuation of the benefit remains in place until the HCA administrative hearing final decision is rendered or the Member requests the termination of continuation of the benefit.

Once a Member notifies the Office of Fair Hearings, the Office of Fair Hearings acknowledges receipt of the request to the Member and notifies the MAD Fair Hearing Unit (FHU) and the MCO in writing of the request within relevant information about the Member, including the Member's self-identified issues. MAD FHU maintains a log of all HCA administrative hearing requests. Once the Office of Fair Hearings assigns an Administrative Law Judge (ALJ), the ALJ will send out a scheduling notice of the HCA administrative hearing date, time and call in number to all parties. Parties to the hearing may include legal counsel or other Authorized Representatives. Unless an accommodation is requested and approved by the ALJ, all HCA administrative hearings are conducted telephonically. The assigned ALJ is responsible for the oversight of the HCA administrative hearing process, including conducting the actual hearing.

The formal rules of evidence and civil procedure do not apply to the HCA administrative hearing proceedings. Relevant evidence is submitted into the hearing record and testimony is furnished during the proceedings in an orderly, but less formal, manner. However, the record created for the HCA administrative hearing is a legal document and is the record which forms the basis for decisions made by a New Mexico district court, if the Member should see redress after his or her HCA administrative hearing final decision has been rendered. The evidence and testimony entered into the hearing record forms the official HCA record and only information contained within the hearing record can be admitted into evidence in a New Mexico district court appeal; HCA, the Member nor the MCO cannot add to or delete from this hearing record after the close of the actual HCA administrative hearing. The State district court is allowed to set aside the HCA administrative final decision only if it finds the decision to be arbitrary, capricious or an abuse of discretion, not supported by substantial evidence in the hearing record as a whole, or otherwise not in accordance with the law.

Summary of Evidence (SOE)

The MCO must provide MAD FHU with a SOE within 7 calendar days after receipt of a request, but no later than 15 business days prior to the initial scheduled hearing. The SOE must contain copies of all documentation used to make the decision, and it must explain the reasons for the benefit determination and address all of the Member's concerns.

Within the specified time frames, the MCO must submit an electronic copy of the SOE to the MAD FHU through the DMZ. The SOE must include relevant NMAC rules, demographic information, summary of

issues, clinical and administrative documentation, correspondence, etc. MAD will be responsible for completing the Member demographic section of the summary.

The SOE must refer to all relevant State and Federal statutes, rules, and other criteria used to make the decision. Upon request and no later than 7 calendar days after receiving the request, the MCO must provide the Member and/or the Member's representative (with written consent of the Member) the Member's case file and provide copies of documents contained therein without charge.

Final Decision

At the conclusion of the HCA administrative hearing, the ALJ prepares a summary of facts and his or her recommendation and submits this and the entire hearing record to MAD FHU. The record of the HCA administrative hearing is reviewed by the Director of MAD, or his or her designee, and the final decision rests with the Director, or his or her designee. Under Federal law, the entire HCA administrative process must be completed within 90 calendar days of the date the Member requested the HCA administrative hearing. The Member and other parties to the hearing are provided with the HCA administrative hearing final decision.

The Member has 30 calendar days to file an appeal of the HCA administrative hearing final decision with the appropriate New Mexico district court. The filing of a Notice of Appeal shall not stay the enforcement of the HCA administrative hearing final decision. The Member may seek a stay upon a motion to the court or the Member may request the MAD Director or designee to stay the HCA administrative hearing final decision while the adverse action is on appeal in a New Mexico district court. If the court orders a stay, the MCO will maintain the benefit at issue in accordance with the State district court's order. If the New Mexico district court's final decision is in favor of the HCA and the Member continued utilizing his or her benefit during the district court appeal process, see 8.352.2.19 NMAC for the repayment process.

Important Aspects of the Process

One of HCA's primary goals related to its administrative hearings is to have all MCO's implement procedures that are consistent with NMAC and MAD rules that will be practiced and adhered to by all parties involved. The following are focus points for process improvement:

- Timeliness in all phases of the process;
- Maintain Member confidentiality and protect PHI;

- Emphasize maintenance of complete and organized files;
- Emphasize importance of documentation; and
- Accountability

The MCOs are key players in this process; therefore, MCO participation to assist with the process is required. As part of this initiative, and in order to maintain organized and complete files, HCA is requesting all MCOs use a standardized HCA SOE form. Each SOE shall contain four separate titled sections. The MCO must provide the information listed on each titled section of the SOE to MAD FHU in a timely manner so it may meet the HCA administrative hearing and federal CFR requirements.

Special Situations

There have been questions related to whether both the relinquishing and receiving MCOs are to respond to their members' appeals and participate in the HCA administrative hearing when a Member is transitioning from one MCO to another.

Each MCO is responsible for its own process while still following the instructions for continuation of benefits for the initial 30 calendar days after transfer; the Member's right to request an MCO appeal, and for a continuation of his or her benefits.

Questions and Answers

- If a Member requests an MCO appeal or an HCA administrative hearing for a service that has not been provided, and it is found they will be transferring to another MCO while the Member's MCO appeal process or his or her HCA administrative hearing is underway, how should we proceed?
    - For a requested benefit that has not been provided:
        - The relinquishing MCO must still complete the MCO appeals process even if the appeal decision or HCA administrative hearing takes place after the Member has transferred. However, if the decision comes after the Member has transferred, it may be reasonable for the MCO's final appeal decision to be that the Member is no longer enrolled in the MCO so the service cannot be provided through the relinquishing MCO. Even then, the Member may appeal the decision to the HCA, but likely the finding would be the same.
        - The Member needs to file a new request for services with the receiving MCO because that will be the MCO responsible for providing the service. If the receiving MCO denies the service, then a new appeal process begins with the receiving MCO.

- If a Member is still in the MCO when the decision is made, the MCO decision must be based on the information provided during the MCO appeal process and not denied on the basis that the Member will be transitioning to a new "receiving" MCO soon.

- For an existing benefit which is being provided subject to a continuation of benefit request:
  - The relinquishing MCO must still complete the MCO appeals process even if the appeal decision or HCA administrative hearing takes place after the Member has transferred. This is essential because a final determination must be made to determine if the Member is responsible for payment for services that were "continued" under the relinquishing MCO for the time period the Member was enrolled with the relinquishing MCO.
  - When the relinquishing MCO makes a final decision on the Member's appeal, or when the HCA administrative hearing final decision is rendered, it is applicable only for the time period that the Member was enrolled in the relinquishing MCO.
  - Because a receiving MCO issues its own notice of adverse action concerning the same benefit, the receiving MCO's appeal process and possible subsequent HCA administrative hearing is applicable only for the time period that the Member is in the receiving MCO. Therefore, it is possible that there may be concurrent appeals and administrative hearings for the same Member for the same benefit but for different time periods. The different time periods correspond to the relevant dates that the Member was enrolled in each MCO.

- What happens in the case when the receiving MCO does not agree with the relinquishing MCO's decision?
  - If the relinquishing MCO makes a decision for a benefit for a time period the Member is still enrolled in the relinquishing MCO, the receiving MCO must accept that as the benefit the Member has in place at the time of the transfer to the receiving MCO. The service must initially be continued through the receiving MCO under the transition of care provisions. The receiving MCO can notify the Member of its intent to take an adverse action against the Member's benefit provided it is given 10 calendar days prior to ending the service (Notice of Action). See 8.308.11 NMAC Transition of Care for specific services that may allow for other considerations.
  - However, the receiving MCO must initially continue to provide the relinquishing MCO's approved benefit. The Member and the receiving MCO essentially begin the process of notice and right to appeal again. The receiving MCO must follow the same process with regard to time and notice. The receiving MCO would notify the Member of its intent to take an adverse action

concerning the Member's existing benefit, LOC, or service within 10 calendar days prior to the date of the intended adverse action. The Member must file a new appeal request with the receiving MCO. The Member has the right to make a new request for a continuation of the benefit from the receiving MCO and must do so in order for the benefit to continue during an appeal process. The Member's request for a continuation of benefits to the relinquishing MCO does not carry over to the receiving MCO. This process must be made clear to the Member.

  - The HCA wants to emphasize the contract provision for the 30 calendar day coverage of the Member's benefit by the receiving MCO is an HCA contract requirement, but it does not replace the responsibility of the MCO to follow Federal and State laws, statutes, regulations and rules for Member notification when it intends to take an adverse action against the Member, the Member's right to appeal, and the right for continuation of the Member's benefit.

- How will each MCO's Medical Director fit into the scenario? Are they going to have to work with the new MCO to handle a re-review if there is a disagreement?
  - See the answer above. Each MCO handles the issue separately.
- Will the Member need to know this is going on and who would be responsible to let the Member know this is occurring?
  - The Member does need to be informed. The Member is entitled to a notice of adverse action from the receiving MCO, as they received from the relinquishing MCO. The communication to the Member must be clear about the need to file a new MCO appeal request and make a new request to his or her receiving MCO for a continuation of his or her benefit during the MCO appeal process.
- Is the current MCO's decision binding regardless of the other MCO's opinion?
  - The only sense in which it is "binding" is that if a benefit was provided by the relinquishing MCO, even if that benefit was provided through an appeal or administrative hearing process, that Member is considered to have that benefit at the time of transfer to the receiving MCO. As for any benefit which the Member is receiving when they transfer into a receiving MCO, the receiving MCO must initially provide the benefit, but it is subject to a new notice of adverse action or re-authorization.
- Will each receiving and relinquishing MCO need to continue to do this process anytime a Member changes MCO?

  - Yes, when a Member is transitioning to another MCO, and the receiving MCO is intending to take an adverse action effecting a benefit against a Member (that is, discontinue or reduce the existing service). The relinquishing and receiving MCOs each make their decisions separately for the time period that the Member is in their MCO; however, the receiving MCO still has the responsibility for new notification of its intent to take an adverse action against the Member.
- How will each MCO's Appeal Unit be notified when a Member has changed MCO?
  - The relinquishing MCO would know when the Member leaves. Its appeal unit should review the enrollment status of the members that have an ongoing appeal on a monthly basis.
  - The receiving MCO knows when it receives a transitioning new Member. When a provider is rendering an existing benefit approved by the relinquishing MCO, and that benefit requires authorization or a LOC, a provider may need to report when requesting an authorization to the receiving MCO that the Member has already been receiving the benefit. The notification that goes to a Member upon denying an existing benefit is significantly different from the notice that denies a new benefit. The receiving MCO's Member services unit may be the first to learn about this issue by receiving a call from a Member. Several receiving MCO units would likely be aware of its transitioning Member's rights through the relinquishing MCO to request a continuation of his or her benefit and of the Member's request for a MCO appeal of the adverse action, as well as which benefits the relinquishing MCO is covering under a continuation of benefits.

Information to Consider Regarding Member Notices and Letters

All MCOs are required to produce a simple, clear notice or letter that includes the mandated information detailed in the checklists accompanying this Manual section.

It is the MCO's choice on how to address this issue. Some MCOs have been handling this requirement by creating multiple distinct letters and notices that include necessary topics, but exclude any irrelevant information. For example, if the issue is the denial of an authorization for a new service, it is not necessary to include "Continuation of Benefits" information in the letter or in the accompanying packet. If the adverse action is a benefit that is not currently being provided, there is no need to include information about Continuation of Benefits in the letter or packet.

Each checklist allows for some variations in the letters and notices that the MCO must have, but the MCO is not limited to the variations specified in the checklists. The MCO may have as many letters and notices as necessary to clearly and effectively communicate to its members.

There must be recognition and use of the standard terms: “Grievance”, “Appeal”, and “HCA Administrative Hearing”. The MCO may use the term “Formal Complaint” instead of “Grievance”; however, the letter should clarify that a Formal Complaint is equivalent to the Grievance process, so a Member can relate the terms in the MCO’s notice to the terms used in the HCA rules. Notices, letters, forms, and information on the Member’s rights should always be clearly labeled.

A Notice of Action is required when a new decision is made, even if the action is to increase or extend a benefit. Therefore, MAD uses the term “Notice of Action”, not “Notice of Adverse Action”.

It is important the Notice of Action be clear in distinguishing between what was requested and what was approved. If everything that was requested is approved, the Notice of Action should state that fact. In such instances, it would be inappropriate to refer to the action as an adverse benefit determination or an adverse action.

When the checklist instructs the MCO to provide a “contact” for the Member, it does not have to be the name of a specific individual. The MCO may follow its own process for setting up a contact system.

MCO notices should indicate that a Member may request a “quick decision” when the Member believes their health or life is endangered while awaiting a decision. This is an important provision so a Member whose condition has changed or who need immediate attention can be assisted by the MCO.

Additional Aspects of Approvals and Denials Leading to Appeals

It is important that the Notice of Action be based on the most complete information available. Therefore, when considering a LOC or approval of a new item or service, an MCO may ask for additional or clarifying information from the provider requesting the LOC or service in order to arrive at the most appropriate decision and avoid an unnecessary appeal.

An MCO is not required to hold any kind of conference or pre-appeal decision discussion with the requesting provider or the Member; however, if the MCO believes this may help resolve the issue, the MCO may schedule such conferences. Failure on the Member’s part to attend such a conference cannot be used as a reason to dismiss the appeal.

Before an appeal turns into an HCA Administrative Hearing, it is important to be clear what is in dispute regarding the benefit.

If the Notice of Action is related to a PASRR determination, the Member should not be asked to file an appeal with the MCO. Instead, the Member should file for an Administrative Hearing; the proper

agencies will then become involved in the consideration. If the benefit is already being used, the Continuation of Benefits is automatic and the Member never pays for using the continued benefit.

Important Timelines

- **Response to Request for Authorized Service or Other Approval**

  A decision on a standard authorization request must be issued as expeditiously as the Member's health condition requires, but no later than 14 calendar days following receipt of the request for new services, and no later than 10 calendar days following receipt of a request to continue ongoing services.

  Note that the checklist contains information about a "quick decision" even though that term is not found in rules or contracts. It is important that an MCO be able to assist any Member who believes that their health or life is endangered while awaiting a decision; therefore, a Member is allowed to change a request for a Standard authorization request to an Expedited authorization request at any time during the appeal process. The Member is also able to contact the MCO and express the need for a "quick decision" so that the MCO is informed of any developing medical issues or conditions and can react, as necessary, to that situation. An extension of up to 14 calendar days is allowed when following the HCA MCO contract provisions.

- **Notice of Action Letter**

  A Notice of Action of reduction, increase, or termination of any benefit or LOC, or budget amount must be sent to the Member at least 10 calendar days prior to the date the intended action will take effect. The same timeframe and requirement for a Notice of Action is necessary following a review or re-determination; when a benefit is extended with no change from the current benefit; or, if a new benefit is approved as requested.

  Special provisions apply for members in NFs. Federal regulations in 42 CFR 483.15 require NFs provide a 30-day notice to the Member in many instances related to a transfer or discharge. There are exceptions provided. The MCO must be certain the NF has followed Federal requirements and cannot provide a date for the discharge or transfer of a Member in an NF that is earlier than the date the NF states in their notice to the Member. The MCO Notice of Action does not replace the need for the NF to comply with the Federal requirement. See: Notice Of Action letter to Member regarding VAS.

- **Continuation of Benefits may be established using the following process**

  The Member may request a continuation of a current benefit any time prior to the date the adverse action goes into effect; or within 10 calendar days of the Notice of Action, whichever is later.

- **MCO Appeals**

  The Member has 60 calendar days from the date of the Notice of Action to file an appeal. If the Member appeal is a Standard Appeal and the request is made verbally, the Member must submit the appeal in writing within 13 calendar days of the verbal appeal.

  If the Member appeal is an Expedited Appeal, a verbal request is sufficient; it does not need to be followed up in writing.

  MCO Acknowledgement of Member Appeals

  The MCO acknowledges the Standard Appeal within 5 business days of the receipt of the appeal. It is important that an MCO be able to assist any Member who believes that their health or life is endangered while awaiting a decision: therefore, a Member is allowed to change a request for a Standard Appeal to a request for an Expedited Appeal.

  MCO Member Appeal Final Decision Letter

  The MCO provides an appeal decision letter within 30 calendar days of the receipt of the appeal for a Standard Appeal, or within 72 hours for an Expedited Appeal; unless a notice of the need for an extension is sent within these same time frames.

  The MCO must provide notice to the Member within 2 calendar days of any decision to extend the timeframe necessary to provide a decision. See Letter Informing the Member of a Delay for an Appeal Decision.

- **MCO Grievance**

  A Grievance may be filed at any time. An MCO cannot change a requested Appeal into a Grievance without written consent from the Member.

  Acknowledgement of Receipt of a Member-Filed Grievance

  An Acknowledgement of a Member grievance must be sent within 5 calendar days of receipt by the MCO.

  Member Grievance Final Letter

  A Resolution of Grievance Letter must be provided within 30 calendar days of the date of receipt of the grievance or as expeditiously as the Member's health require.

- **HCA Administrative Hearing**

The Member may request a HCA administrative hearing within 90 calendars days of the MCO appeal final decision letter. For an Expedited Hearing, the request must be within 30 calendar days.

16.3. Appendices

The following pages contain checklists for specific information that must be contained in the Notice of Action to a Member, and the other letters and notices associated with steps relating to grievances, appeals, and a final decision letter.

The MCOs are to review their notices and letters, revise them as necessary, and submit them to MAD for final approval.

16.3.1 MCO Checklist – Acknowledgement of Receipt of a Member-filed Grievance

16.3.2 MCO Checklist for Member Grievance Final Letter

16.3.3 MCO Checklist for Notice of Action Letter to Member

16.3.4 MCO Checklist for Notice of Action Letter to Member Regarding Value-Added Services

16.3.5 MCO Checklist for the Acknowledgements of Member Appeals

16.3.6 MCO Checklist for Letter Informing the Member of a Delay for an Appeal Decision

16.3.7 MCO Checklist for the MCO Member Appeal Final Decision Letter

16.3.1. MCO Checklist – Acknowledgement of Receipt of a Member--Filed Grievance

MCO Checklist - Acknowledgement of Receipt of a Member-filed Grievance

The Acknowledgement must include:

- ☐ The date that the Grievance was received.
- ☐ The MCO's understanding of the issue.
- ☐ When the Member may expect a resolution or other response to the Grievance, not to exceed 30 calendar days from the receipt of the Grievance.
- ☐ That the Member has the right to present evidence and testimony and make legal and factual arguments on the issue before the MCO determines the resolution of the Grievance. This presentation may be made by the Member, a spokesperson or any designated or authorized representative. The Member or authorized individual must make a request for this presentation and the MCO must schedule this presentation prior to making a determination on the Grievance. The MCO must tell the Member of the limited time the Member has to make this request in order for the MCO to provide a resolution within the required timeframe.

  If the Grievance is related to a response to a Notice of Action for which there could be a Member Appeal, include the following:

- ☐ Information on the difference between a Member Grievance and an Appeal, including if they want to file an Appeal they must do so within 60 calendar days of the Notice of Action; and that a Grievance is not considered an Appeal and does not extend the timeframe in which an Appeal must be filed.
- ☐ A Member may file a Grievance to express dissatisfaction about any matter or aspect of his or her MCO's operation. A Member files an Appeal to begin a process for reconsidering an adverse action as described in a Notice of Action.
- ☐ Instructions on how to file an MCO Member Appeal if the issue is better resolved through an MCO Member Appeal instead of an MCO Grievance.

- ☐ A statement the Member cannot request an MCO Member Appeal on the issue if they do not agree with the final Grievance decision, unless the timeframe for an Appeal following a Notice of Action is met and the Appeal is based on the Notice of Action, not on the Grievance decision.
- ☐ A MCO Grievance contact that includes email and mail addresses, fax and telephone numbers. Include the hours this contact is available, as well as an emergency number. Inform the Member to use this contact information if they have any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter ability.

16.3.2. MCO Checklist for Member Grievance Final Letter

MCO Checklist for Member Grievance Final Letter

The letter should include the following:

- ☐ The date of the letter, which should be the date the letter will be mailed.
- ☐ A summary of the Grievance.
- ☐ If an action was taken or is going to be taken, include a description of the action.

OR

- ☐ An explanation of why no action will be taken to resolve the issue or why no action is necessary. This explanation must be based on rules and requirements or established MCO policies and procedures.
- ☐ A statement that the MCO grievance decision letter ends the MCO Member Grievance process.

16.3.3. MCO Checklist for Notice of Action Letter to Member

MCO Checklist for Notice of Action Letter to Member

The following sections, at a minimum, should be included in the written Notice of Action Letter. There may be two versions as necessary:

1. Notice regarding an existing benefit;
2. Notice regarding a newly requested benefit;
   - Notice of Action letter;
   - Notice of the Right to file a Grievance;
   - Notice of the Right to request an Appeal
   - Notice of the Right to file a Grievance and request an MCO Appeal concurrently; and/or
   - Notice of the Right to a Continuation of Benefits.

Notice of Action should include:

☐ The date of the Notice, which must be the date the Notice will be mailed. If the Notice is to terminate an existing benefit, the date must not be less than 10 calendar days prior to the date the benefit will end.

☐ A description of what action the MCO intends to take or has taken to terminate, suspend, change or reduce the current benefit, allocation or budget, including a reduction in LOC, or transfer or discharge of a Member residing in a residential facility. If applicable, cite NMAC rules or other criteria that support the basis of the decision. Include the date the benefit will stop or otherwise change. A letter is required even if the change is to increase a benefit or if there has been a new review and the same benefit is extended.

OR

☐ If the action is a denial, in whole or in part, of a new benefit or service for the Member, describe what was requested and what has been denied or otherwise limited. If applicable, cite NMAC rules or other criteria that support the basis of the decision.

☐ An MCO contact, including email and mail addresses, fax and telephone numbers. Include the hours this contact is available, as well as an emergency number. Inform the Member to use this contact information if they have any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.

Notice of the right to file an Appeal should include:

- ☐ If the Member disagrees with the Action, they have the right to appeal the decision to the MCO.
- ☐ If the Member would like to Appeal the decision, the Appeal must be requested within 60 calendar days of the date of the Notice of Action. Include information that if the Member misses the deadline, they may lose their right to appeal. Offer to assist the Member in requesting or filing for an Appeal and tell them how they can obtain that assistance.
- ☐ Describe the Standard Appeal process, including the request may be made by phone, but a written request will need to be completed within 13 calendar days of the verbal request.
- ☐ Describe the Expedited Appeal process, and that such a request may be made by phone.
- ☐ Describe the criterion that merits an Expedited Appeal.
- ☐ Inform the Member of his or her right to a timely Appeal decision (not longer than 30 calendar days from the request for a Standard Appeal or 72 hours for an MCO Expedited Appeal) and the anticipated date of the Final Appeal Decision.
- ☐ Provide appropriate forms for an Appeal that has the Member identify how they would like to be contacted.

Briefly describe the Appeal process:

- ☐ Tell the Member that they may file a Grievance even if he or she does not request an Appeal. Clarify that the Grievance does not act as Appeal of any adverse action. Tell the Member how to file a Grievance.
- ☐ Tell the Member that he or she may file a Grievance and request an Appeal concurrently.
- ☐ Provide an MCO Appeal contact which includes email and mail addresses, fax and phone numbers. Include the hours that this contact is available, as well as an emergency number. Inform the Member to use this contact information if they have any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter ability.
- ☐ Tell the Member that if he or she requests an Appeal, he or she can obtain assistance from an authorized representative, authorized provider, designated spokesperson, or legal counsel. Provide the appropriate form and describe the process to the Member.

Tell the Member when the he or she requests an Appeal:

- ☐ He or she the right to designate an authorized representative. The authorized representative can have access to the case information and may make medical decisions on behalf of the Member.
- ☐ He or she has the right to designate an authorized provider who agrees to assist him or her. The authorized provider can have access to the case information, but does not have the authority to make medical decisions on behalf of the Member.
- ☐ He or she has the right to designate a spokesperson. The spokesperson may have access to case information and may speak for the Member, but does not have the authority to make medical decisions on behalf of the Member.
- ☐ He or she has the right to present evidence and testimony and make legal and factual arguments on the issue before the MCO makes a final determination on the Appeal. This presentation may be made by the Member, a spokesperson or any designated or authorized representative. The Member or authorized must make a request for this presentation and that the MCO will schedule this presentation prior to making a final decision on the appeal. The MCO must tell the Member of the limited time the Member has to make this request in order that the MCO can provide the decision within the required time frame; and of the Member's option to extend the time frame for up to an additional 14 calendar days.
- ☐ Neither an MCO or HCA can be held responsible for any fees or costs incurred by the Member during the MCO Expedited or Standard Appeal process.

Notice of the Right to Continuation of Benefits when there is an Adverse Action:

If the Action is to terminate, suspend, or reduce the current benefit, allocation or budget, including a reduction in LOC, or transfer or discharge of a Member residing in an NF, the letter must include a notice of the right to a continuation of benefits:

- ☐ If the benefit is already being provided, inform the Member that they can request a continuation of benefits at any time prior to the date the benefit will be terminated based on the Notice of Action. (Note that if the Appeal is initiated by the MCO, the continuation of benefits is automatic and the Member never pays for using the continued benefit.)
- ☐ Inform the Member if they request a continuation of benefits, the Member will continue to receive his or her disputed current benefit during the Appeal process, but the Member may

choose to end his or her continued disputed benefit at any time during the MCO Appeal process or HCA Administrative Hearing.

- ☐ Explain the process to request a continuation of their disputed current benefit including time frames.
- ☐ Provide a phone number to verbally request a continuation of the disputed current benefit and a mailing or email address, or fax number to submit a written request for a continuation of the disputed current benefit.

  Provide the MCO Member with contact information, the type of disputed current benefit, the number of times a day, week or month the Member receives the disputed current benefit, the length of time the benefit is delivered, the LOC of the benefit, or the allocation or budget amount received.
- ☐ Include information on the recoupment of the cost of the Member's continued disputed current benefit if the MCO's final decision upholds, in whole or in part, its adverse action; and state that if the Member later requests a HCA Administrative Hearing in which the final decision upholds the adverse action, in whole or in part, the Member will be financially responsible for paying for the services they used.

When the MCO is initiating an MCO Expedited Member Appeal on behalf of the Member, in addition to all other requirements, the MCO must:

- ☐ Inform the Member of the process of an MCO-initiated- Expedited Member Appeal.
- ☐ Inform the Member that the MCO is continuing the Member's disputed current benefit throughout the MCO-initiated Expedited Appeal process and that the Member is not obligated- to repay the continued disputed current benefit if the MCO Member Appeal Final Decision upholds the action.

16.3.4. MCO Checklist for Notice of Action Letter to Member Regarding VAS

MCO Checklist for Notice of Action Letter to Member Regarding Value-Added Services

Notice of Action should include:

☐ The date of the Notice, which should be consistent with the date the Notice will be mailed. If the Notice is to terminate an existing benefit, the date must be no less than 10 calendar days prior to the date the benefit will end.

Describe what action the MCO intends to take or has taken to terminate, suspend, change or reduce the current value-added benefit. If applicable, cite NMAC rules or other criteria which may support the basis of the decision. Include the date the benefit will stop or otherwise change. A letter is required even if the change is to increase a benefit or if there has been a new review and the same benefit is extended.

OR

☐ If the action is the denial, in whole or in part, of a new benefit or service for the Member, describe what was requested and what has been denied or otherwise limited. If applicable, cite NMAC rules or other criteria which may support the basis of the decision.

☐ Include a statement that an MCO VAS adverse determination cannot be appealed through the MCO or reviewed through an HCA Administrative Hearing.

☐ If applicable, describe alternative MAD benefits that the Member may utilize to replace the terminated VAS.

☐ Provide MCO contact, including email and mail addresses, fax and phone numbers. Include the hours that this contact is available, as well as an emergency number. Inform the Member to use this contact information if he or she has any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.

16.3.5. MCO Checklist for the Acknowledgements of Member Appeals

MCO Checklist for the Acknowledgements of Member Appeals

The MCO should have, at a minimum, six separate but similar letters:

- Acknowledgement of a written Standard Appeal;
- Acknowledgement of a verbal Standard Appeal;
- Acknowledgement of a Standard Appeal, but the MCO or Member changes it to an Expedited Appeal;
- Acknowledgement of an Expedited Appeal;
- Acknowledgement of an Expedited Appeal but Denying the Expedited Status; and/or
- Notice of an MCO initiated Expedited Appeal and Continuation of Benefits.

Requirements

An Appeal request must always be followed by an acknowledgement within 5 business days of receipt of an Appeal. Copies of the acknowledgement and any associated documents must be sent to the Member, any authorized representative, and to the provider who requested the disputed benefit.

☐ If the acknowledgement letter is in response to a verbal request for a Standard Appeal, the acknowledgement must: contain information about the 13 calendar day requirement to submit a written Appeal, include the fact that if the Member misses that deadline, they may lose their right to an Appeal, and an offer to assist the Member with the written Appeal.

☐ The MCO must provide the Appeal form and offer to assist the Member if they need help completing it. (A request in writing from the Member is not required for an Expedited Appeal.)

The Appeal acknowledgement must include the following:

☐ The date of the acknowledgement, which should be consistent with the date the acknowledgement letter will be mailed.

☐ The date the Expedited or Standard Appeal request was received by the MCO and a brief statement of the MCO's understanding of the issue the Member is appealing.

☐ The anticipated date of the Appeal decision, which may be in the form of "no later than."

☐ The date of any scheduled informal conference to help clarify or settle the issue. Inform the Member they must adhere to the date or contact the MCO to change the date, if necessary. The scheduling of an informal conference is not mandatory, but may be requested by the MCO.

- ☐ A MCO Appeal contact which includes email and mail addresses, fax and phone numbers. Include the hours that these contacts are available, as well as any other emergency number that may be available. Inform the Member to use this contact information if he or she has any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.
- ☐ Inform the Member of his or her right to have someone with them or to represent them in their Appeal and that if they would like someone to represent them, they must make a request in writing. Provide the appropriate form and describe the process to the Member.
- ☐ Inform the Member of how to submit additional information regarding the issue, if the Member or provider has more information to provide.
- ☐ Inform the Member of his or her right to a continuation of benefits if the benefit is already being provided and the Member has not already requested a continuation of the disputed current benefit. (This information should have also been previously provided in the Notice of Action.) Inform the Member that he or she can request a continuation of benefits at any time prior to the date the benefit will be terminated, based on the Notice of Action, or within 10 calendar days of the date of the notice, whichever is the longer period of time. (Note that if the Appeal is initiated by the MCO, the continuation of benefits is automatic and the Member never pays for using the continued benefit.)
- ☐ Inform the Member if he or she requests a continuation of benefits, the Member will continue to receive his or her disputed current benefit during the Appeal process. Include information on the recoupment of the cost of the Member's continued disputed current benefit if the MCO's final decision upholds, in whole or in part, its adverse action; and state that if the Member later requests a HCA Administrative Hearing if the final decision upholds the adverse action, the Member will be financially responsible for paying for the services they used.
- ☐ Provide the Member with contact information for requesting a continuation of benefits.
- ☐ Inform the Member that he or she may choose to end his or her continued disputed benefit at any time during the MCO Appeal process or HCA Administrative Hearing process.

Include a statement of the Member's rights that includes the following:

- ☐ The Member's right to a timely decision on the Appeal; a decision must be provided within 30 calendar days from the request for a Standard Appeal or 72 hours from the request for an Expedited Appeal, unless notice is provided by the Member or the MCO that additional time is required.

- ☐ That either the Member or the MCO have the right to extend the time frame up to 14 calendar days if necessary, but if the MCO extends the time frame, the Member has the right to file a Grievance with the MCO, if he or she disagrees with the extension.
- ☐ That if the Member believes that their health or life is endangered while awaiting a decision, the Member at any time during the appeal process can ask for a "quick" decision by requesting the Appeal be changed to an Expedited Appeal, in which a decision is usually made within 72 hours; or if it is an emergency, the decision will be made as soon as possible.

Outline the process that can occur if the Appeal decision is not in the Member's favor:

- ☐ State that after the MCO Appeals process, if the Member would like to continue the Appeal, he or she may do so by requesting:
  - ☐ A HCA Expedited Administrative Hearing within 30 calendar days of the date of the MCO Member Appeal Final Decision;
  - ☐ A HCA Standard Administrative Hearing within 90 calendar days of the date of the MCO Member Appeal Final Decision; and/or
  - ☐ That more information on requesting an HCA Administrative Hearing will be included in the Appeal Decision Letter if the decision is not in favor of the Member.
- ☐ Inform the Member that he or she may also request for a HCA Administrative Hearing, if the decision on their Appeal is not timely.
- ☐ Inform the Member that he or she may file a request for a HCA Administrative Hearing if the Member requested an Expedited Appeal, but the MCO denies the expedited status. The HCA Administrative Hearing will be limited to the issue of expediting the MCO Appeal decision.

The acknowledgement must be in clear and simple verbiage. If the MCO has a packet of information accompanying the letter, some of the detailed information may be in the packet rather than in the letter, as long as the letter directs the Member to look there.

16.3.6. MCO Checklist for Letter Informing the Member of a Delay for an Appeal Decision

MCO Checklist for Letter Informing the Member of a Delay for an Appeal Decision

The Letter should include:

- ☐ The date of the letter, which should be consistent with the date the letter will be mailed. If the pending Appeal Decision is regarding termination of an existing benefit, the date must not be less than 10 calendar days prior to the date the benefit will end. It is also a requirement to make a reasonable effort to provide the Member with information regarding the delay orally, in addition to the written Acknowledgement.
- ☐ Describe what action the MCO intends to take or has taken to terminate, suspend, change or reduce the current benefit, or for a new benefit, intends to deny or limit.
- ☐ Include the new date the benefit will terminate or otherwise change, if a delay in a decision is going to delay the date of the benefit change or termination. A letter is required even if the change is to increase a benefit or if there has been a new review and the same benefit is extended.
- ☐ State the date a decision was due and the length of time the decision will be delayed. Include the date a final decision is expected. Include the justification of why the decision is being delayed.
- ☐ Tell the Member that if he or she disagrees with the delay, they have the right to file a Grievance. Describe the process on how they do so, including any forms that are necessary.
- ☐ Provide an MCO contact, including email and mail addresses, fax and phone numbers. Include the hours that this contact is available, as well as an emergency number. Inform the Member to use this contact information if he or she has any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.
- ☐ Tell the Member that if the MCO does not provide a decision within the required 14 calendar day extended time frame, the Member has the right to request a HCA Administrative Hearing which will result in the Administrative Hearing process making the final decision on the issue being appealed.

16.3.7. MCO Checklist for the MCO Member Appeal Final Decision Letter

MCO Checklist for the MCO Member Appeal Final Decision Letter

The MCO should have, at a minimum, three separate but similar letters:

- Reversal of MCO Adverse Action;
- Partial Reversal of MCO Adverse Action; and
- No Reversal of MCO Adverse Action.

1. **Letter for Reversal of MCO Action and Approval of the Benefit. Include in the notice of the reversal of the MCO's adverse action:**

☐ The date of the letter, which should be consistent with the date the letter will be mailed.

☐ The date that the disputed benefit will start if the benefit was not continued or supplied during the appeal process.

☐ A MCO contact in case the Member has any questions. Include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number if one is available. Inform the Member to use this contact information if he or she has any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.

2. **Letter for partial reversal of MCO Adverse Action.**

Approved Benefit:

☐ Inform the Member of the date the disputed benefit will start if the benefit was not continued or supplied during the appeal process.

☐ Provide an MCO contact in case the Member has any questions. Include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number if one is available. Inform the Member to use this contact information if he or she has any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.

Denied Benefit:

☐ Inform the Member what disputed benefit was denied. State the date the denied benefit will be terminated if it is currently being supplied.

☐ Include a statement describing any rationale for the decision to deny the disputed benefit.

☐ If applicable, cite NMAC rules or other reasoning used to make the final decision.

☐ If the Member had a continuation of benefits, inform the Member what the recoupment cost is and how the MCO will start recoupment.

- ☐ Provide an MCO contact who can explain the recoupment process and who can assist the Member to request a HCA Administrative Hearing if the Member chooses to do so. Include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number. Inform the Member to use this contact information if he or she has any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.
- ☐ Include Member Rights and Information to Request a HCA Administrative Hearing: Include the same information in that letter as described below, under the "Letter Upholding the Action."

3. Letter Upholding the Action:

- ☐ Include a statement describing the rationale to deny the disputed benefit.
- ☐ If applicable; cite NMAC rules or other reasoning used to make the final decision.
- ☐ Inform the Member of the date the denied benefit will be terminated if it has been continued during the Appeal.
- ☐ If the Member had a continuation of benefits, inform the Member what the recoupment cost is and how the MCO will start recoupment.
- ☐ Provide an MCO contact who can explain the recoupment process and who can assist the Member to request a HCA Administrative Hearing if the Member chooses to do so. The contact information must include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number. Inform the Member to use this contact information if he or she has any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter capability.
- ☐ Inform the Member that he or she may choose to end his or her continued disputed current benefit at any time prior to and during the HCA Administrative Hearing process.
- ☐ Inform the Member that they may request a HCA Standard Administrative Hearing within 90 calendar days of the date of the MCO Expedited or Standard Member Appeal Final Decision letter.
- ☐ Inform the Member they may request a HCA Expedited Administrative Hearing within 30 calendar days of the date of the Appeal Final Decision letter. The request for a HCA Expedited Administrative Hearing may be made verbally or in writing.
- ☐ Provide the Member with the HCA Fair Hearing Bureau email and mail addresses, fax and phone numbers, HCA toll-free numbers with TTY/TTD and interpreter capability.

- ☐ Inform the Member that if they request a HCA Administrative Hearing, the MCO will not take steps to recoup the cost of the Member's current disputed benefit until the HCA Administrative Hearing process is over, unless requested to do so by the Member.
- ☐ Inform the Member he or she may choose to end his or her continued disputed current benefit at any time prior to and during the HCA Administrative Hearing process.
- ☐ Inform the Member of the recoupment of the cost of the Member's continued disputed current benefit if the HCA Administrative Hearing Final Decision letter upholds the MCO's Action.

All letters must be in clear and simple verbiage. If the MCO has a packet of information accompanying the letter, some of the detailed information may be in the packet, as long as the letter directs the Member to look there.