

Grievance and Appeals Process

In accordance with 42 CFR 457 part(s) 1120 – 1180, a HUSKY Plus applicant has the right to request an administrative review regarding a decision made on their HUSKY Plus application. Whenever possible, HPB will attempt to resolve grievances informally. However, parents and providers will be encouraged and supported in the filing of appeals without fear of compromised service. A copy of the appeals procedure, written in a manner easily understood by the lay public, will be distributed to every family at the time of their application to HPB.

The state ensures that all enrollees and applicants receive timely written notice of any determinations subject to review, as outlined below. Written notices at each level include the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review. However, the State will not provide an opportunity for review of a matter if the sole basis for the decision is a provision in this plan or in federal or State law requiring automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances

The following decisions can be appealed through the grievance process:

- Denial of eligibility;
- Failure to make a determination of eligibility within 21 days of application;
- Suspension or termination of enrollment in HPB for enrollees enrolled in Income Band One or Income Band Two of HUSKY B;
- Delay, denial, reduction, suspension or termination of goods or services, including determination regarding level of services;
- Failure to approve, furnish or provide payment for services in a timely manner;
- Medical necessity of a type of service or setting; and
- Choice of provider

While an appeal regarding suspension or termination of eligibility or enrollment is being considered, the enrollee will remain eligible for HPB and his or her services will be continued until the grievance is decided, so long as the child remains eligible for HUSKY B, Income Band One or Two.

While an appeal regarding delay, denial, reduction, suspension or termination of goods and/or services is being considered, the enrollee will continue to receive such goods and/or services until the appeal is decided, so long as the child remains in HUSKY B, Income Band One or Two.

Applicants or enrollees requesting to review their files or other information relevant to the appeal review will be provided access to their files at a mutually convenient date and time, but no later than 4 days prior to the decision being issued. *Additionally, the State will ensure that applicants or enrollees have opportunities to represent themselves or*

have representatives of their choosing in the review process, and to fully participate in the review process.

The HUSKY Plus Behavioral appeals process has two levels. The first level is conducted by management level program staff not involved in the original decision. Based on the first level review a recommendation will be forwarded to the Commissioner of the Department of Social Services. The decision rendered by the Commissioner will be mailed to the family within 90 days from the receipt of the first level appeal request.

Expedited Appeal:

Pursuant to 42 CFR 457.1160, the appeal process for HPB must allow for expedited review. This process applies to both eligibility and enrollment matters as well as for goods and/or services. If an enrollee requests an expedited review, the Department must determine within one business day of receipt of the request, whether to expedite the review or whether to perform the review according to standard timeframes. The review may be expedited if the DSS Commissioner or designee determines that the standard timeframe could seriously jeopardize life or health or ability to attain, maintain or regain maximum function. If it is determined that the appeal should be expedited, the review must be completed within 72 hours of receipt of the appeal request by the Department. The above time frame may be extended upon request of the parent up to a maximum of 14 days.

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The state ensures that all enrollees and applicants receive timely written notice of any determinations required to be subject to review, as outlined below. Written notices at each level include the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review. *However, the State will not provide an opportunity for review of a matter if the sole basis for the decision is a provision in this plan or in federal or State law requiring automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.*

The following decisions can be appealed through the grievance process:

- Denial of eligibility for Income Bands One and Two only
- Failure to make a determination of eligibility within 21 days of application;
- Suspension or termination of enrollment in HPP for enrollees enrolled in Income Band One or Income Band Two of HUSKY B
- Delay, denial, reduction, suspension or termination of goods or services, including determination regarding level of services;
- Failure to approve, furnish or provide payment for services in a timely manner;
- Medical necessity of a type of service or setting; and
- Choice of provider

While an appeal regarding suspension or termination of eligibility or enrollment is being considered, the enrollee will remain eligible for HPP and their goods and/or services will be continued until the grievance is decided, so long as the enrollee remains in Income Band One or Income Band Two. An enrollee who has been enrolled in Income Band Three of the HUSKY B program shall be disenrolled from HPP

While an appeal regarding delay, denial, reduction, suspension or termination of goods and/or services is being considered, the enrollee will continue to receive such goods and/or services until the appeal is decided, so long as the child remains in Income Band One or Income Band Two.

Applicants or enrollees requesting to review their files or other information relevant to the appeal review will be provided access to their files at a mutually convenient date and

time, but no later than 4 days prior to the decision being issued. *Additionally, the State will ensure that applicants or enrollees have opportunities to represent themselves or have representatives of their choosing in the review process, and to fully participate in the review process.*

The grievance and appeals process will have three levels of appeal: the first to HPP's medical director (who was not involved in the prior decision), the second to a sub-group of the Steering Committee, and the third to the Commissioner.

Whenever a decision is made regarding an enrollee's eligibility, enrollment or goods and/or services, a letter is sent from the HPP Center to the parent describing the decision. Letters, which deny, reduce, suspend or terminate eligibility or enrollment, or goods and/or services (as listed above), will also include a one page Appeal Form and a copy of the Appeals Procedure Summary. To begin the appeals process, the parent or provider should complete the Appeals Form. The form should be mailed or delivered to the HPP Center but must be received by the Center within 45 days of the date of the letter describing the decision that is being appealed.

Level One Appeal:

The HPP Center will send a letter that acknowledges receipt of the appeal form to the parent or provider. The letter will identify a HPP staff member as the Appeals Manager. The Appeals Manager will track the appeal, act as the contact person for questions and updates, and will attempt to resolve the appeal within ten days. If the appeal is resolved to the satisfaction of the parent or provider by the Appeals Manager, a letter will be sent describing the resolution, and there will be no further action. If the appeal cannot be resolved at this level, the Appeals Subcommittee will review the appeal.

Level Two Appeal:

The Appeals Subcommittee of the Steering and Advisory Committee for Children with Special Health Care Needs and HUSKY Plus Physical (SASH) for HPP has three members, one each from:

- The Department of Social Services (DSS)
- The Department of Public Health (DPH) and

- The Connecticut Children's Medical Center

No one directly involved in the decision being appealed will be a member of this subcommittee. The Appeals Manager is not a member of this subcommittee but will attend to provide needed information.

A letter will be sent to the parent or provider that gives the time and date of the Appeals Subcommittee meeting. The meeting will be scheduled to occur within 10 business days

of receipt of the written appeal. The parent or provider may reschedule this meeting, for any reason, once. However, the Appeals Committee meeting must occur within 25 business days of the receipt of the appeal.

The parent or provider may bring support persons to the Appeals Subcommittee meeting, including legal counsel, a person with special knowledge or training with respect to the problems of the enrollee, and one or two individual for support.

In the Appeals Subcommittee, the Appeals Manager will present the appeal; along with any documents involved in the initial decision. The Appeals Manager will also present a summary of the efforts to this point to resolve the appeal. The parent, provider or accompanying support persons may also present arguments and documents, which support the appeal. Once all appeal arguments are completed, the Appeals Subcommittee will either make a decision regarding the appeal, or if necessary, continue the case until more information is obtained or until documents are reviewed. The Appeals Subcommittee must render a final decision by no later than 30 days from the date of the Appeals Subcommittee meeting. The Appeals Subcommittee chairperson will send the parent or provider a letter describing the Appeal Committee's decision by no later than 30 days from the date of the Appeals Subcommittee meeting.

Level Three Appeal:

If the parent or provider does not agree with the Appeal Subcommittee's decision, he/she may continue the appeal process by writing a letter to the Commissioner of the Department of Social Services (DSS) or designee. In this case, the parent or provider must send a copy of the original Appeal Form, the Appeals Subcommittee letter and any other pertinent documents to the Commissioner or designee within 10 business days of the date of the Appeals Subcommittee letter. The Appeals Manager will continue to help the parent or provider with this next step. The DSS Commissioner or designee shall make a determination and provide a written decision to the parent within 90 days of the initial request date.

If the enrollee has been enrolled in the HPP program and is found to be ineligible for HPP, and this decision is appealed, the enrollee will continue to be eligible for HPP services so long as the child remains eligible for and enrolled in HUSKY, Part B, Income Bands One and Two, until the appeal process is completed. Enrollees of HUSKY, Part B who are in Income Band Three are not eligible for the HUSKY Plus Program and shall be immediately disenrolled from HPP

Expedited Appeal:

Pursuant to 42 CFR 457.1160, the appeal process for HPP must allow for expedited review. This process applies to both eligibility and enrollment matters as well as for goods and/or services. If an enrollee requests an expedited review, HPP must determine within one business day of receipt of the request, whether to expedite the review or whether to perform the review according to the standard timeframes. The review may be

expedited if the Medical Director of HPP determines that the standard time frame could seriously jeopardize life or health or ability to attain, maintain or regain maximum function. If the Medical Director of HPP determines that the appeal should be expedited, the Level One review must be completed within 72 hours of receipt of the appeal request by HPP. A Level Two review of an expedited appeal must be completed within 72 hours after completion of the Level One review. An expedited Level Three review must be completed within 72 hours after completion of the Level Two expedited review. The above timeframe may be extended upon request of the parent up to a maximum of 14 days.