



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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MEMORANDUM

DATE: November 19, 2010

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Daniese McMullin-Powell, Chairperson
Dmp/klp

RE: 14 DE Reg. 361 [DMMA Proposed Medicaid & CHIP Quality Assurance Reg.]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to adopt a "Delaware Medicaid and CHIP Managed Care Quality Strategy" published as 14 DE Reg.361 in the November 1, 2010 issue of the Register of Regulations. SCPD has the following observations.

First, on p. 3, Quality Strategy Overview, last paragraph, there is a reference to providing quality care ..."through increased address and appropriate and timely utilization of health care services. The word "address" is erroneous.

Second, on p. 6, DMMA describes a QII Task Force which includes "representatives from all CHIP funded programs and waivers, MCO's, Health Benefits Manager, Pharmacy Benefits Manager (PBM), the External Quality Review Organization (EQPO), State agencies receiving Medicaid and CHIP funding, and the MMDS leadership team." DMMA may wish to consider whether the Task Force could be strengthened through addition of a representative from the SCPD, CLASI, or similar organization.

Third, on p. 8, the chart lists "Division of Child Mental Health Services". The reference should be updated to "Division of Prevention and Behavioral Health Services".

Fourth, p. 10 describes the MCOs under the Diamond State Health Plan. It omits the Division of Prevention and Behavioral Health Services which serves as an MCO under the Plan. This is a major concern with the entire document. There are simply no references to the Division. For example, performance data is only generated for Unison and DPCI. See pp. 65-67. The Plan should address quality assurance within the Division acting as an MCO.

Fifth, on p. 11, CHIP section, second paragraph, there is a reference to “infants (under age 1) under 200% covered through a Medicaid expansion program...” SCPD believes the reference should be to “under 200% of the Federal Poverty Level (FPL)”.

Sixth, on p. 11, last paragraph, there is a reference to a 5 year bar on child eligibility if the child entered the United States after 8/22/96. SCPD believes DMMA rescinded that bar earlier this year. See 13 DE Reg. 1540 (June 1, 2010).

Seventh, p. 17 recites that MCOs are required to develop a treatment plan for all beneficiaries qualifying as persons with special health care needs, including those with a “serious or chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally”. Does DMMA have a template for such plans or does each MCO have its own criteria? If DMMA does not have a template or standards, it could consider adopting them.

Eighth, on p. 22, it appears that information on “grievances” and “appeals” is reviewed. It is unclear if fair hearing results are included in this assessment. If not, SCPD recommends that DMMA include such review in assessing MCOs.

Ninth, p. 22 refers to an MCO requirement of ensuring the availability of a no-cost second opinion from a qualified health care professional. SCPD has not seen this aspect of MCO coverage advertised. Are there standards which define eligibility for a second opinion? If so, SCPD respectfully requests a copy.

Tenth, p. 33 refers to the following MCO duty: “(s)atisfactory methods for ensuring their providers are in compliance with Title II of the Americans with Disabilities Act”. Title II covers public agencies. Title III covers private entities. It would be preferable to amend the reference to read “Titles II and III of the Americans with Disabilities Act”. Consistent with the attachments, the accessibility of health care provider offices and equipment (e.g. height adjustable examination tables) has historically been a barrier to effective health care, particularly for persons who must transfer from a wheelchair or use a restroom. How does DMMA assess MCO compliance with the mandate. Do MCOs survey their providers on accessibility, provision of interpreters for the Deaf, etc?

Eleventh, p. 35, Notice of Adverse Action section, contains the following sentence: “The MCO’s notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.” The attached 42 C.F.R. §438.404 does not contain an exemption from the written notice requirement for notices to providers. DMMA may wish to reassess the accuracy of the sentence.

Twelfth, on p. 40, Confidentiality section, second bullet, some words appear to have been omitted. The second “sentence” reads as follows: “And shall be afforded access within thirty (30) calendar days to all members’ medical records whether electronic or paper”.

Thirteenth, on p. 45, General Requirements section, last bullet, second “sentence”, some words appear to have been omitted and the 59-word “sentence” is awkward and difficult to understand. The second “sentence” reads as follows: “And who if deciding an appeal of a denial that is based upon lack of medical necessity...disease.”

Fourteenth, on p. 40, Duration of Continued or Reinstated Benefits section, the reference to “within 10 days from when the MCO mails an adverse MCO decision” is not the correct timeframe. The federal regulation [42 C.F.R. 438.420(c)] and 16 DE Admin Code, Part 5000, §5303 clarify that the relevant period is “the period between the date a notice is mailed and the effective date of the action”. Thus, if an MCO provides 15 days notice prior to the effective date of an action, there are 15 days to request a hearing and maintain benefits. The reference could be amended to read “within the timely notice period between mailing of the notice and the effective date of the action”.

Fifteenth, p. 55 addresses oral interpreter services for foreign languages. It would be preferable to also include a reference in the document to interpreter services for the Deaf.

Sixteenth, the data on p. 67 suggest a significant disparity in mental health inpatient and outpatient services between DPCI and Unison. Moreover, pp. 68-69 contain the following recital:

The benchmark for Antidepressant medication management has not been met for either MCO. DPCI showed a decrease in compliance with effective acute phase treatment from 2008 (46.92 percent) to 2009 (45.58). Unison, on the other hand, made some progress toward the benchmark with an increase from 2008 (41.84) to 47.64 percent in 2009. Effective continuation phase treatment showed a slight decline for DPCI from 2008 (31.51 percent) to 28.05 percent in 2009 (sic “2009”) while Unison stayed steady at 27.55 percent in 2008 and 27.95 percent in 2009.

SCPD respectfully requests more specifics on mental health treatment data since it appears that MCOs may be “falling short”.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: Ms. Rosanne Mahaney
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

14reg361 dmma-mco 11-10

Disabled Patients Win Sweeping Changes From HMO

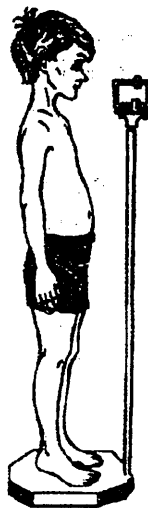
By Tamar Lewin

Excerpt from New York Times, April 13, 2001

The nation's largest nonprofit H.M.O. agreed yesterday to revamp all its California health centers and policies to ensure that people with disabilities have access to the full range of health care.

The agreement will settle a class-action lawsuit, the first of its kind in the nation, that was filed last year against the health maintenance organization, Kaiser Permanente, on behalf of all its California members with disabilities. The lawsuit argued that Kaiser discriminated against disabled patients by giving them inferior medical care. Part of the problem, the lawsuit said, is inaccessible medical equipment, like examination tables that do not lower and scales and mammography machines that cannot be used by people in wheelchairs.

The three named plaintiffs are all Kaiser members who use wheelchairs. One of them, John Metzler, had pressure sores on his buttocks for a year, but his doctor had not visually examined them because the examination table was inaccessible.



Incitement

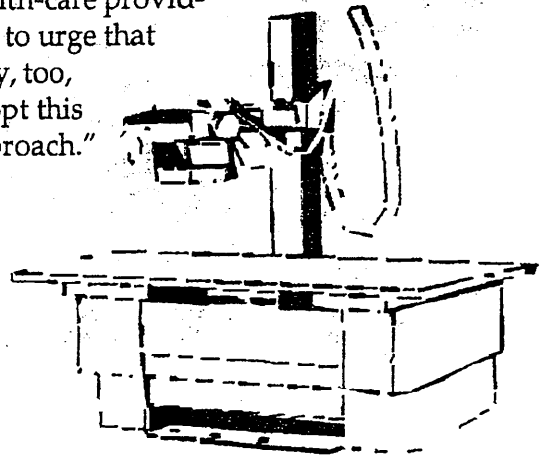
Another, Johnnie Lacy, had not had a gynecological examination in more than 15 years because of the same problem. The third, John Lonberg, was not weighed for 15 years because there was no scale accessible to a wheelchair at his Kaiser doctors' office.

"My first reaction was, 'Oh, my God, we have a lawsuit,'" said Richard Pettingill, president of Kaiser's California division, "but it only took about

five minutes before it was apparent to me that we needed to step up and provide some leadership."

The settlement Kaiser agreed to is far-reaching, covering not only the installation of accessible medical equipment and the removal of architectural barriers, but also a broad commitment to develop training programs, handbooks and a complaint system to meet the needs of the disabled. Kaiser also agreed to consider developing specialized clinical programs in disability care and to review all its policies to ensure that they meet the needs of people with vision, hearing, cognitive, speech and mobility disabilities.

"We believe this will be revolutionary in terms of its impact on health care for people with disabilities," said Sid Wolinsky, litigation director of Disability Rights Advocates, the Oakland group that brought the lawsuit. "The agreement with Kaiser provides a comprehensive blueprint that could be used by any health provider anywhere in the country. We intend to use this as a template to present to other major health-care providers, to urge that they, too, adopt this approach."



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October 17, 2001

The Honorable Rick Santorum
United States Senator
Suite 250 Landmarks Building
One Station Square
Pittsburgh, Pennsylvania 15219

Dear Senator Santorum:

This is in response to your inquiry on behalf of your constituent, xxxxxxxxxxxxxxxxxxxxxxxx, who asks whether the Americans with Disabilities Act of 1990 (ADA) requires that hospitals and doctors' offices provide adjustable examining tables for patients with disabilities who cannot use standard-height tables. Please excuse our delay in responding.

Title II of the ADA prohibits discrimination on the basis of disability by public entities, and title III of the ADA prohibits discrimination on the basis of disability by public accommodations. Hospitals and doctors' offices may be either public entities or places of public accommodation. Under the ADA and the Department's implementing regulations, the issue of adjustable examining tables may be addressed under the "policy modification," "barrier removal," and "program accessibility" standards.

Under the policy modification standard, entities subject to the ADA are required to make reasonable modifications in their policies, practices, and procedures if necessary to afford a person with a disability an equal opportunity to participate in the services, facilities, or activities that the entity provides. The regulations provide an exception for modifications that result in a fundamental alteration in the nature of the services, facilities, or activities that are offered. The determination of whether a particular modification meets the conditions of the policy modification standard must be made on a case-by-case basis.

Whether provision of an adjustable examination table is necessary and reasonable and would not fundamentally alter the nature of the services provided is a fact-specific inquiry. Relevant facts include the needs of the patient and the resources of the hospital or doctor's office. Use of a nonadjustable examining table, of suitable height, is another possible policy modification that would alleviate the difficulty that persons with mobility impairments have in using standard examining tables.

Under the barrier removal standard of title III of the ADA, which applies to hospitals and doctors' offices that are public accommodations, a standard-height, nonadjustable examining table constitutes an architectural barrier to persons with certain mobility impairments. Therefore, an adjustable table must be provided if it is readily achievable to do so (that is, easily accomplished and able to be carried out without much expense). If it is not readily achievable to obtain such a table, then an alternative means, such as a lowered height table, must be provided if that means is readily achievable. With respect to hospitals and doctors' offices that are public entities, the "program accessibility" standard of title II of the ADA requires that covered entities make their programs, such as medical services, readily accessible to and usable by persons with disabilities unless to do so can be shown by the covered entity to cause a fundamental alteration in the nature of a service or an undue financial and administrative burden. Once again, under these standards, the Department of Justice makes the determination of whether a particular action is required on a case-by-case basis.

Your constituent's letter addresses the needs of "handicapped and elderly" persons. To be entitled to

the protection of the ADA, a person must have a physical or mental impairment that substantially limits one or more of his or her major life activities. Whether an impairment limits a major life activity is a fact-specific inquiry. Old age is not, in and of itself, such an impairment. In the event that your constituent would like to file a complaint against a specific hospital or doctor's office, we have included complaint forms.

We hope this information will be helpful to you in responding to your constituent. Please do not hesitate to contact the Department if we can be of assistance in other matters.

Sincerely,

Ralph F. Boyd, Jr.
Assistant Attorney General
Civil Rights Division



September 17, 2007

Your Health

Medical Care Often Inaccessible to Disabled Patients

by Joseph Shapiro



Joseph Shapiro, NPR

Rosemary Ciotti came to see Dr. Sandy Caskie because her clinic has an exam table that can be raised and lowered, making it easily accessible to patients who use wheelchairs, such as Ciotti.

Morning Edition, September 13, 2007 · Take a moment to consider a basic part of a doctor's office: the exam table. What if you weren't able to climb up on that hard, plastic table with the crinkly, white paper? Frail elderly people often can't, and they need the most medical care. Younger people with disabilities often can't climb onto the exam table, either.

There is a lot of medical equipment that requires patients to stand or climb, and the inability to use that equipment can keep people from getting the medical care they need.

Rosemary Ciotti was diagnosed with thyroid cancer in 2005. It took awhile for the cancer to be discovered, in part because Ciotti uses a wheelchair and can no longer get up on the exam table.

Sometimes a doctor would call in a couple of strong nurses to try to lift her out of her wheelchair and onto the three-foot-high table. But she got dropped and twisted — and a couple of times, she got hurt.

"It was undignified, humiliating," Ciotti says, "and you get to a point where you no longer are as proactive with your health as you should be, even knowing better." Knowing better because, she was a nurse by profession.

Going Without Care

Ciotti started skipping routine doctors exams. The doctors she did see simply stopped giving the woman sitting in a wheelchair the kind of thorough exams she had gotten before she became disabled by an autoimmune disorder.

Research shows that disabled women are less likely to get mammograms and Pap tests. Another study found that those who get breast cancer are less likely to receive standard treatments and are more likely to die.

June Isaacson Kailes studies the issue. She's the associate director of the Center for Disability Issues and the Health Professions at the Western University of Health Sciences in Pomona, Cali.

"For people with a variety of limitations, the old instructions to hop up, look here, read this, stay still, can be extremely difficult to impossible, which means people don't get the procedures done they need," she says.

Kailes did a national survey and found that people with disabilities have trouble using X-ray machines, rehab equipment, scales and scanning devices, like MRIs.

But the most common problem was getting onto a doctor's exam table. Kailes says the tables are particularly

Finding Accessible Care

When Mary Lou Breslin was about to begin chemotherapy for breast cancer, she was told she couldn't get the usual outpatient treatment because she uses a wheelchair. Breslin, a disability rights advocate, fought to get the care she needed.

Read Breslin's advice on how to get accessible health care.

troublesome for elderly patients. She says that doctors often think, mistakenly, that they can thoroughly examine a person who is sitting in a wheelchair.

"You're missing half of a person's body when you're only looking at them sitting in a chair," Kailes says. "You wouldn't be getting a thorough examination of your skin, looking for beginning skin changes or small cancers, if you're sitting down. You wouldn't be getting a thorough clinical breast exam. That needs to be done while you're prone."

Kailes has cerebral palsy and uses a power scooter. She has trouble with balance and coordination, which makes the exam table trouble for her. But she goes to the gym three times a week and she can pull herself to a standing position on a treadmill. Unlike a doctor's exam table, it has grab bars.

Finding Accessible Clinics

Federal civil rights laws require medical offices be accessible. But few are, and those rare offices are hard to find. There is no one "clearinghouse of information," says Dr. Kristi Kirschner of the Rehabilitation Institute of Chicago. But people need sources of information to find doctors and hospitals that have accessible equipment, such as exam tables that go up and down.

Instead, Kirschner says, patients are left to figure it out on their own.

"Lot of times (it's) word of mouth and often just calling and talking to providers about whether they work with people with disabilities," she says.

Kirschner helped start a reproductive health clinic at the Rehabilitation Institute of Chicago, specifically for women with physical disabilities. She had heard stories from her patients of how they had stopped going to the doctor because they couldn't get in the door or use the medical equipment.

Kirschner tells her patients to call doctors' offices before an appointment and to ask a lot of questions — the more specific the better.

That's how Rosemary Ciotti found her new obstetrician-gynecologist in Arlington, Va. She made more than a dozen phone calls.

"I asked specifically, 'Do you have an exam table that lowers to ... at least 20 inches?' — which is the minimum that you would need to transfer easily from a wheelchair. This receptionist actually put me on hold and measured it," Ciotti says.

That story makes her new doctor, Sandy Caskie, smile.

"Well that's the kind of people I have working here," Caskie says. "But ... remember, too, that they've seen other people be accommodated. So they knew that we do this all the time."

In an exam room in her office, Dr. Caskie shows the procedure table she now uses for Ciotti and other disabled and elderly patients. With a flick of a switch, a motor raises or lowers the table.

It costs a few thousand dollars extra for a doctor to buy something like this. But Caskie says it's also easier on her: She doesn't have to twist around so much to examine her patients. And, most important, she knows her patients will get the health care they need.

Getting Access to Health Care

by Joseph Shapiro

When Mary Lou Breslin was about to begin chemotherapy for breast cancer, she was told she couldn't get the usual outpatient treatment. Instead of going to the clinic, getting treatment and leaving, she'd have to check in overnight at the hospital. The cancer center explained that theirs was an "ambulatory center" and Breslin, who uses a wheelchair, didn't fit the definition of being ambulatory. Breslin noted that although she couldn't "walk," she got around Berkeley and Oakland in her power wheelchair.

Breslin is a world-famous disability rights advocate and a founder of the Disability Rights Education and Defense Fund. As an advocate, she knew the health care system providing her care had already been sued for violating the Americans with Disabilities Act. Breslin knew, too, that, as a result of a legal settlement, the system had hired ADA compliance officers, trained to help people with disabilities.

Breslin contacted that patient representative, who helped her navigate the care she needed and helped train employees on how to accommodate a woman in a wheelchair. Breslin's doctors still worried that on rare occasions patients have a bad reaction to chemotherapy and if that happened they would need to lift Breslin onto a bed or exam table. Even then, the solution in Breslin's case was simple. The patient representative had a mechanical lift brought to the chemotherapy center on the four days Breslin had her treatments. Employees were trained in the proper way to use it. As it turned out, Breslin never needed the lift, but she got her chemotherapy as an outpatient.

Once doctors have experience with patients with disabilities, they better understand how to provide care for the next patient with a disability. After Breslin completed her chemotherapy, she needed to start five weeks of radiation therapy. This would be at a new facility and, once again, she worried that she would have to use her legal knowledge to get what she wanted. So she was surprised by the very different reaction this time from the oncologist.

"She immediately said, 'We have to get you on the table every day. What's the best way to do it? Would you prefer we provide a lift and someone knowledgeable how to use it? Would you prefer your own person (to do any lifting)? You tell us what you want and we'll do it.' I

must have looked astonished. I said, 'I had no idea this would be made so simple for me.' And she said, 'Well, of course, this is what we do and this is how we manage anybody with a particular need. It's not a problem for us.' I was very happy."

Here are some things that Breslin and others with disabilities have learned to do to get proper access to health care:

Contact a Patient Representative

Call a hospital and ask if it has an Americans with Disabilities Act compliance officer or a patient representative. If so, they can work with a patient to figure out what barriers there might be to health care and how to surmount them. If you're just visiting a doctor's office, ask for the office manager or someone else who can answer questions or act as a patient representative.

Word of Mouth

You can benefit from finding a doctor that already knows how to help patients with disabilities. But it's not like looking up a restaurant online and looking for a symbol that shows whether the place is "handicapped-accessible." There's no such clearinghouse of information on health care facilities. (Breslin has worked with a few health care systems in California to start such directories.) As a result, it's often left to the patient to do the work of finding doctors who are set up to work with patients with disabilities. Make a lot of phone calls to doctors and to other people with disabilities. One place to start is to call a local "independent living center," an education and advocacy center that is run by people with disabilities. There are more than 300 around the country and often someone there will know a provider who has experience caring for people with disabilities. You can find a local independent living center through the [National Council on Independent Living](#).

Be Specific

When you talk to a patient representative or call a doctor's office, ask a lot of questions — the more specific the better, says Dr. Kristi Kirschner of the Rehabilitation Institute of Chicago. If you have difficulty getting onto an exam table, ask if there are exam tables that lower to 20 inches, or if there is a mechanical lift and trained

personnel to operate it. Someone who is deaf should ask if the doctor will provide a sign language interpreter or another means of communication. People who are blind can ask to get forms and information on tape or in other formats. Kirschner says people with disabilities can also ask a doctor to give them extra time for an appointment.

Know Your Rights

Breslin says that although health care providers are required to comply with the ADA and other federal laws, many have been slow to follow through. Some doctors complain that it's unclear what they're required to do. Sen. Tom Harkin is trying to clarify that by sponsoring legislation — the Promoting Wellness for Individuals with Disabilities Act of 2007 — that would help establish accessibility standards for medical diagnostic equipment like examination tables, weight scales, mammography equipment, X-ray machines and other radiological equipment. Harkin became a key author of the ADA after seeing his brother, who was deaf, be ignored by nurses at a hospital. Since the passage of the disability civil rights law in 1990, the Department of Justice has settled more than a hundred cases against doctors' offices and health care facilities that were not accessible. In addition, there have been private lawsuits, including ones against major hospitals in California and Washington, D.C.

Related NPR Stories

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Digest of Response (February 23, 2000)

Physicians May Have To Provide And Pay For Auxiliary Aids

A physician may be required to provide appropriate auxiliary aids unless it would "fundamentally alter the service or benefit that the physician is providing or result in an undue hardship." While a physician may select the auxiliary aid, the physician is also obligated to select an aid that will ensure effective communication. Further, a physician must provide an interpreter without charge to the patient unless this would constitute an undue burden. The costs of interpreting services must be considered in relation to the overall financial resources of the practice, not in comparison to revenues generated by the office visit.

This is in response to your inquiry on behalf of your constituent, Dr. [] of Harrisonburg, Virginia. Dr. [] is a physician who is concerned that the Americans with Disabilities Act of 1990 (ADA) requires him to provide a sign language interpreter for patients needing the service and further expects him to absorb the costs associated with the interpreter services.

We understand Dr. []'s concern, but we believe that he may not be aware of the flexibility provided to him under the ADA. Title III of the ADA was enacted to ensure that people with disabilities are not excluded from receiving the benefits and services provided by covered entities, including physicians. However, in enacting title III, Congress carefully struck a balance between the rights of people with disabilities to participate fully in activities of daily life and the legitimate economic needs of the service providers.

The ADA does require physicians to ensure effective communication with patients (and, for pediatric patients, with their parents or guardians.) When one of these individuals has a disability that affects communication (e.g., a hearing impairment), the ADA may require a physician to provide a sign language interpreter or other appropriate auxiliary aid to ensure effective communication, unless the physician can prove that providing the auxiliary aid will fundamentally alter the service or benefit that the physician is providing or result in an undue burden.

Ensuring effective communication does not necessarily require a physician to provide a sign language interpreter each time that a patient requests one. The physician has the right to select the auxiliary aid that will be provided and also the obligation to ensure that the selected method of communication is effective. In making this determination, the physician should consult with the patient to learn what auxiliary aids may be effective in the specific circumstances. For example, if a patient can communicate effectively in writing, then written communication through the exchange of notes or using a com-

puter to facilitate conversation may be effective when a physician is explaining a simple procedure. However, if the information to be conveyed is lengthy or complex, or the patient has difficulty communicating in writing, then the use of written notes may be ineffective. The use of an interpreter may be the only effective form of communication. Thus, Dr. [] may not need to provide an interpreter for a routine office visit where paper-and-pen communication is sufficient to provide effective communication between him and his patient.

If an interpreter is necessary to provide effective communication, a physician must provide the interpreter without charge to the person with a disability unless it is an undue burden. The term "undue burden" means "significant difficulty or expense." The evaluation of whether the cost of an auxiliary aid is an "undue burden" may not be based solely on a comparison of the interpreter costs to the revenue generated by the office visit at which the interpreter is present. Instead, the interpreting costs must be considered in relationship to the overall financial resources of the practice and other mitigating factors such as the ability to spread costs throughout the general clientele and the availability of tax credits.

The Internal Revenue Code permits eligible small businesses to receive a tax credit for certain costs of ADA compliance. An eligible small business is one whose gross receipts do not exceed \$1,000,000 or whose work force does not consist of more than 30 full-time workers. Qualifying businesses may claim a credit of up to 50 percent of eligible access expenditures that exceed \$250 but do not exceed \$10,250. Eligible access expenditures may include the costs of providing auxiliary aids and services to persons with disabilities. Further information on the tax credit can be obtained from a local Internal Revenue Service office, or by contacting the office of Chief Counsel, Internal Revenue Service. The enclosed booklet also provides general information about the tax credit.

I hope this information will be helpful to you. Please do not hesitate to contact the Department if we can be of assistance in other matters.

19 NDLR ¶ 63

Letter Re: Hotel Accessibility

Digest of Inquiry [Date Not Provided]

- Is a hotel required to provide open-frame beds in order to ensure accessibility for individuals with disabilities?

Digest of Response (June 13, 2000)

Provision Of Open-Frame Beds In Hotels Is Reasonable Modification

The DOJ indicated that it would appear to be a reasonable modification for a hotel to

[Home Page](#) > [Executive Branch](#) > [Code of Federal Regulations](#) > [Electronic Code of Federal Regulations](#)

Electronic Code of Federal Regulations

e-CFR

TM

e-CFR Data is current as of November 4, 2010

Title 42: Public Health

PART 438—MANAGED CARE

Subpart F—Grievance System

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§ 438.404 Notice of action.

(a) *Language and format requirements.* The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding.

(b) *Content of notice.* The notice must explain the following:

(1) The action the MCO or PIHP or its contractor has taken or intends to take.

(2) The reasons for the action.

(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.

(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.

(5) The procedures for exercising the rights specified in this paragraph.

(6) The circumstances under which expedited resolution is available and how to request it.

(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO or PIHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).

(4) If the MCO or PIHP extends the timeframe in accordance with §438.210(d)(1), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and

no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d).

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