MAP Appeal and Complaint Process

- **Appeal**: A disagreement with a decision made by CPHL regarding your services. You can ask us to review that decision by filing an appeal and we will decide if the action taken was appropriate. Some examples of actions that may be appealed include, but not limited to:
    - *denied or limited services requested by you or your provider*
    - *decided that a requested service is not a covered benefit*
    - *reduced, suspended or terminated services that we already authorized*
    - *denied payment for services*

Appeal Process:

You will have sixty (65) calendar days from the date on the notice sent to you regarding the action taken by CPHL to file an appeal. If you want services to continue while the appeal is being reviewed, you must request the appeal as "aid continuing" within 10 days of the date we sent you the notice or the effective date of the action. The appeal may be made verbally or in writing.

An appeal will be decided as quickly as possible, but no later than 30 calendar days from your appeal request. When a delay would significantly increase the risk to your health, your appeal will be expedited and will be decided as fast as enrollee's condition requires, but no more than 72 hours from your appeal request. We may request up to 14 additional days to review your appeal if we need more information and the delay is in your interest. We will notify you in advance if we require more time.

For Standard, non-expedited appeals, CPHL will send you a letter within 15 business days to acknowledge we received your appeal, unless the appeal is resolved in less than 15 business days. When the appeal is resolved, CPHL will send you a resolution letter within the time frames discussed above, describing how your appeal was resolved.

- **Expedited Appeal Process**

If you or your provider feel that taking the time for a standard appeal could result in a serious problem to your health or life, you or your designee may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you written notice of our decision to deny your request for an expedited appeal within 24 hours of the decision.

- **State Fair Hearings**

  If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from the **Integrated Administration Hearing Office (IAHO**), New York State within 120 days of the date we sent you the notice about our decision on your appeal.

  If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the IAHO issues a hearing decision that is not in your favor, whichever occurs first.

  If the IAHO reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer. Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

- **The Complaint Process**

  You may file a complaint to us anytime, orally or in writing. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. Within 15 business days, we will send you a letter informing you that we received your complaint, and a description of our review process. We will review your complaint and give you a written answer within one of two-time frames:

  - If a delay in our response would be a risk to your health, we will respond within 24 hours from receipt of the complaint.

  - For all other types of complaints, we will notify you of our decision within 30 calendar days.

  The review period of a complaint can be extended for up to 14 additional calendar days if you request it, or if we need more information and the delay is in your interest. Our answer will describe what we found when we reviewed your complaint and our decision about your complaint