Please let us know if you are not happy with CHP+ HMO, our providers, your services, or any decisions that are made about your treatment.

- You have the right to express a concern about anything you are not happy with.
- You also have a right to appeal. This means you can ask for a review of a CHP+ HMO action or decision about what services you get.
- Call our grievance and appeals department at 303-751-9021, toll free 888-214-1101 or TTY for the deaf or hard of hearing at 720-744-5126 or toll free at 888-803-4494.

WHAT IS A DESIGNATED CLIENT REPRESENTATIVE (DCR)

A DCR is someone you choose to talk for you when you have a concern or appeal about your services. It could be a provider, an advocate, a lawyer, a family member, or any other person you trust.

If you decide to use a DCR, you must sign a form with the name, address, and phone number of your DCR. This is so we can contact him or her during the investigation or appeal process. This person will not see your medical records or get information about your situation unless you also sign a form to release medical information to him or her. A DCR can file an appeal, request a state fair hearing, and can also be the legal representative of a deceased member's estate. The Designated Client Representative Form is located in the back of this Booklet.

GRIEVANCES

If you are not happy with something other than a service decision, you can file a grievance. A grievance can be about anything other than a decision by CHP+ HMO to deny, limit, or change a service that you or your provider requested. This is your right. You do not need to worry that you will be treated badly for making a grievance. We want to make sure that you are treated fairly and receive the best service possible. This is one way you can stand up for yourself and your rights. It also helps us make our services better for you and others. To better assist you, there is a CHP+ HMO Member Grievance Form located in the back of this Booklet.

Examples of grievances might include:

- The receptionist was rude to you.
- Your provider would not let you look at your mental health records
- Your service plan does not have the things that you wanted to work on.
- You could not get an appointment when you needed one.

Who to contact to file a grievance:

- You or your DCR can call the CHP+ HMO Grievances and Appeals department, or
- You can fill out the CHP+ HMO Member Grievance Form at the end of this Booklet and send it to us, or
- You can write us a letter. Call us if you want help writing your grievance.
- Other people can help you or your DCR with a grievance, including:
    - Your provider can assist you on your behalf with any denial of services

- The Department of Health Care Policy and Financing. Their phone number is 303-866-3513 or toll free at 800-221-3943.

How to file a grievance with CHP+ HMO

You or your DCR can all or write to the Colorado Access Grievances and Appeals Department. You should do this within 30 calendar days from when the problem happened. To better assist you, there is a member grievance form at the end of this Booklet.

Colorado Access
Grievances and Appeals Department
PO Box 17950
Denver, CO 80217-0950

Phone: 303-751-9021, toll free 888-214-1101

Be sure to include your name, state identification (ID) number, address, and phone number.

What happens when I file a grievance?

- After we get your phone call or letter, we will send you a letter within two business days. The letter will say we got your grievance.
- We will review your grievance. We may talk with you or your DCR, talk to the people involved in the situation, and look at your medical records.
- Someone who was not involved in the situation you are concerned about, and who has the right experience will review your grievance.
- Within 15 business days after we get your letter, we will send you a letter saying what we found and how we fixed it. Or, we will let you know that we need more time. You will get a letter from us after we finish the review.
- We will work with you or your DCR to try to find a solution that works best for you. Sometimes we may not be able to fix a problem.

How to contact the Department of Health Care Policy and Financing

If you are unhappy with our review, you or your DCR can contact the Colorado Department of Health Care Policy and Financing. They will do another review. Their decision about your concern is final.

You or your DCR can call or write the Department of Health Care Policy and Financing and let them know that you have filed a grievance.

Department of Health Care Policy and Financing
CHP+ MCO Contract Manager
1570 Grant St.
Denver, Colorado 80203

Phone: 303-866-3586

Let them know that you are a CHP+ HMO member. Tell them what the problem is. Tell them how you want it fixed.

The Department of Health Care Policy and Financing will review your grievance. They will work with you to find a solution. You will get a letter from the Department of Health Care Policy and Financing. This letter will explain the results of the review. This decision is final.

APPEALS

An appeal is when you try to change a decision, called an "action" that CHP+ HMO makes about your services. You have this right. If CHP+ HMO takes an action, you and your provider will get a letter that tells you why. This letter also will explain how to appeal if you want to.

You can appeal any of the following actions:

- When we deny or limit a type or level of service you requested
- When we reduce, suspend, or stop a service that was previously approved
- When we deny payment for any part of a service
- When we do not provide or authorize (approve) services in a timely manner
- When we do not act within timelines required by the state to provide notifications to you
- If you live in a rural area and we deny your request to seek care outside of our network

If you or your DCR asks for an appeal, we will review the decision. Your provider may file an appeal for you or help you with your appeal as your DCR. For a DCR to get your medical records for an appeal, you or your legal guardian must give written permission to your provider.

You will not lose your benefits if you file an appeal. If you are getting services that have already been approved by CHP+ HMO, you may be able to keep getting those services while you appeal, if all of these requirements are met:

- Your appeal has been sent to us within the required timeframes by you or your provider;
- An in-network provider has asked that you get the services;
- The time period that the approval (authorization) of the services has not ended; and
- You specifically request that the services continue

You may have to pay for services that you get during the appeal if you lose the appeal. If you win the appeal, you will not have to pay. Please let us know when you ask for an appeal if you want to keep getting your services.

If you continue to get the approved services, they will continue for a certain time period. The services will continue until:

- You withdraw your appeal
- A total of 10 days pass after we mail the original notice to you that we are denying your appeal. If you request a state fair hearing within those 10 days, your benefits will continue until the hearing is finished

- The state fair hearing office decides that your appeal is denied
- The authorization for the services ends.

Examples of decisions that you could appeal include:

- You are told you are being discharged from the hospital and don't feel ready to go.
- Denial of continued services, such as physical therapy, that you feel are still needed.

How to ask for an appeal (another review) of a decision or action:

- If the appeal is about a new request for services, you or your DCR must request an appeal within 30 calendar days from the date on the letter saying what action CHP+ HMO has taken or plans to take.
- You or your DCR can call the Colorado Access Grievance and Appeals department to start your appeal. The phone number is 303-751-9021, toll free 888-214-1101. Tell them you are a CHP+ HMO member. Tell them you want to appeal a decision or action. If you call to start your appeal, you or your DCR must send us a letter after the phone call unless he or she requests expedited resolution. The letter must be signed by you or your DCR. We can help you with the letter, if you need help. The letter must be sent to:

  Colorado Access
  Grievance and Appeals Department
  PO Box 17950
  Denver, CO 80217-0950

- You or your DCR can request a "rush" or expedited appeal if you are in the hospital, or feel that waiting for a regular appeal would threaten your life or health. See the section for more information about expedited appeals.
- If you are getting services that have already been approved by CHP+ HMO, you may be able to keep getting those services while you appeal. You may have to pay for those services that you get during the appeal if you lose the appeal. If you win the appeal, you will not have to pay. Please let us know when you ask for an appeal if you want to keep getting your services.

Continuation of benefits

- If you appeal an action to lower, change, or stop an authorized service, you must file your appeal on time. On time means within 10 days of receiving a notice of action.
- If you want to continue receiving previously approved benefits while going through the appeals process, you will have to file within 10 business days after receiving the notice of action.

What happens with an appeal:

- After we receive your phone call or letter, you will get a letter within two business days. This letter will tell you that we got your request for an appeal.
- You or your DCR can tell us in person or in writing why you think CHP+ HMO should change its decision or action. You or your DCR can also give us any information or records that you think

would help your appeal. You or your DCR can ask questions, and ask for the criteria or information we used to make our decision. You or your DCR can look at our records that have to do with your appeal.
- If the decision or action you are appealing is about a denial or change of services, a doctor will review your medical records and other information. This doctor will not be the same doctor who made the first decision.

CHP+ HMO will make a decision and notify you within 10 business days from the day we get your request, unless it is expedited (rushed). We will send you a letter that tells you the decision and the reason for the decision.

If we need more information from your doctor, we will send you a letter to let you know we are extending our review for no more than 14 calendar days.

EXPEDITED ("RUSH") APPEALS

If you feel that waiting for an appeal would seriously affect your life or mental health, you may need a decision from CHP+ HMO fast. You or your DCR can ask for an expedited "rush" appeal. For a rush appeal, a decision would be made within three business days, instead of 10 business days for a regular appeal.

We will make our decision on an expedited appeal within three business days. This means that you or your DCR have a short amount of time to look at our records, and a short amount of time to give us information. You can give us information in person or in writing. During this time, your services will stay the same.

If your request for a rush appeal is denied, CHP+ HMO will call you as soon as possible to let you know. We will also send you a letter within two calendar days. Then we will review your appeal the regular way. You will get a letter that tells you the decision of the appeal and the reason.

If you are not happy with the outcome of the expedited appeal, or any appeal, you have the right to request a state fair hearing.

HOW TO REQUEST A STATE FAIR HEARING

A state fair hearing means that a state administrative law judge (ALJ) will review the CHP+ HMO decision or action. You can ask for a state fair hearing:

- Instead of using CHP+ HMO's appeal process;
- At any time during your appeal with CHP+ HMO; or
- If you are not happy with the CHP+ HMO decision about your appeal

A request for a state fair hearing must be in writing.

You will not lose your CHP+ HMO benefits if you express a concern, file a grievance, an appeal, or request a state fair hearing. It is the law.

- If your request is about a treatment that has not been approved before, you or your DCR must make the request within 30 calendar days from the date on the letter that tells you the action that CHP+ HMO has taken, or plans to take.
- If you request the state fair hearing before a decision regarding your appeal has been made, then you shall be allowed to make the request within 30 calendar days from the date of the notice of action that lead to the appeal.
- If your request is about treatment that has been approved before and you would like to continue this treatment while awaiting a state fair hearing, you or your DCR must make the request within 10 calendar days from the date on the letter that tells you the action that CHP+ HMO has taken, or plans to take, or before the effective date of the termination or change in services, whichever is later.
- If you or your DCR want to ask for a state fair hearing, you or your DCR may call or write to:

    Office of Administrative Courts
    1525 Sherman St., 4th Floor
    Denver, CO 80203

    Phone: 303-866-2000

    Fax: 303-866-5909

The Office of Administrative Courts will send you a letter that explains the process and will set a date for your hearing.

You can talk for yourself at a state fair hearing, or you can have a DCR talk for you. A DCR can be a lawyer, a relative, an advocate, or someone else. The judge will review the CHP+ HMO decision or action. Then the judge will make a decision. The decision of the judge is final.

We encourage you to file with the administrative law judge (ALJ) at the same time that you file your appeal with CHP+ HMO. This will keep you within the calendar day deadline, and protect your right to an ALJ hearing. The ALJ contact information is provided above. You must make your request for an ALJ hearing in writing and you must sign your request.

If you are getting services that have already been approved by CHP+ HMO, you may be able to keep getting those services while you are waiting for the judge's decision. But if you lose at the state fair hearing, you may have to pay for services that you get while you are appealing. If you win, you will not have to pay. If you win the state fair hearing and you were not getting services while waiting on the decision, we will promptly approve those services for you.

If you want help with any part of the appeal process, please contact us. We can help you with any questions you have or help you file an appeal. Call us at 303-751-9021, toll free 888-214-1101 or TTY for the deaf or hard of hearing at 720-744-5126 or toll free 888-803-4494.