NOTICE AND HEARINGS PROCESS

Revised 02/01/2024 CHANGE NO. 04-24

Change No. 04-24:

- Subsection D. Federally Facilitated Marketplace (FFM) Determinations – Appeals, has been added to MA-2420 section V. Hearing Process.

- Subsection D. provides local agencies with policy and procedures for hearings requested by a beneficiary who was determined eligible for NC Medicaid by FFM.

I. INTRODUCTION

This section contains the regulations and procedures for notifying the applicant/ beneficiary (a/b) of case action/status and for local and state hearings.

II. POLICY PRINCIPLES

A. An a/b has the right to a written notice when:

1. There is an inquiry about Medicaid. Use the DHB-5095/DHB-5095S, Medicaid/Work First Notice of Inquiry, for inquiry documentation.

2. The local agency fails to complete all actions on an application by the application processing time standard (45th /90th calendar day). The NCF-20023-Notice Regarding the Status of Your Application for Medicaid, will be generated by the NC FAST system.

3. An application is approved.

4. An application is denied or withdrawn.

5. Benefits are changed, reduced, terminated, or continued in the current Medicaid program category.

B. An a/b has the right to appeal an action if they disagree with the local agency decision.

C. An a/b has the right to request an expedited hearing if it is determined a hearing held on a standard schedule could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

D. In certain situations, an a/b has the right to have their benefits continued until a hearing decision is rendered.

E. A local hearing must be held at the local agency for all appeals, except for those involving a determination of disability. For appeals involving disability issues, including terminations at the end of ex-parte reviews when the beneficiary indicates they are still disabled, request a state hearing.

F. An a/b has a right to a state hearing if they disagree with the local agency local appeal decision, or if the appeal involves a determination of disability. The right to a state hearing includes instances where presumptive SSI benefits have ended, no disability determination has been made and an ex-parte review determines that the individual is not eligible in any other Medicaid program category.

III. AUTHORIZED REPRESENTATIVES ENTITLED TO NOTICE

A. Hierarchy of Representatives

1. The authorized representative, power of attorney and guardian information must be keyed in NC FAST to ensure the individual receives Medicaid and Special Assistance notices.

2. Evidence fields have been created in NC FAST to allow for entry of a Program of All-Inclusive Care for the Elderly (PACE) or Community Alternative Program (CAP) case manager data in addition to Authorized Representative information. Key the PACE Agency or CAP Manager information in the designated field.

Refer to NC FAST Job Aid: Adding or Editing MA Authorized Representative Evidence

3. The following list of representatives is ordered by the highest priority representative first and the lowest last. When there is more than one type of representative, always choose the one with the higher priority.

   a. Legal Guardian (includes the local agency with custody or guardianship; if the individual has a Guardian of the Person and a Guardian of the Estate, choose the Guardian of the Person)

   b. Power of Attorney

   c. Health Care Power of Attorney

   d. Department of Social Services (placement responsibility only)

   e. Spouse (Not separated)

   f. Parent (for children under 21, a parent who is not the case head but who lives in the home)

g. Authorized Representative (An individual designated in writing by the a/b to assist with eligibility issues and who can have access to the information in the case file)

h. Authorized Representative as designated by Social Security Administration (SSA) on SDX

B. Representative Information for Applications

1. Contact the applicant and ask if they have any of the representatives listed in the hierarchy of representatives by reviewing the list with them. The applicant may have more than one representative, therefore do not stop the inquiry when the individual provides one name. An individual can also have more than one power of attorney; if they have more than one asks them to choose one to receive notices. Document the applicant's response. If the applicant is incapable of choosing, use the name of the Power of Attorney who has been helping with the case.

2. Ask the language preference for each named representative. Document the applicant's response.

3. If the application is being made by an informal representative, provide the representative with an authorized representative form, such as the DHB-5202C-ia/DHB-5202Csp-ia, Designation of the Authorized Representative Appendix C, for the applicant and the representative to sign.

4. Guardianship and/or power of attorney papers

   a. Request a copy of the guardianship and/or power of attorney document using the DHB-5097/5097S.

   b. If the applicant does not respond to the initial request, send a second request.

   c. If the applicant does not respond to the second request and all other necessary information has been received, process the application within the normal time frame.

   d. If the applicant has more than one representative and has supplied documentation for only one, enter the information for the one that has been verified, even if the unverified representative has a higher priority.

C. Hospital as Authorized Representative

A hospital may be an Authorized Representative for an applicant, but the authorization may be limited to the application process, the application process and any hearing and appeal following a denial, or for another specified time.

1. The hospital must identify hospital staff to serve as the Authorized Representative. If an a/b's name and contact number are not on the Authorized Representative form, contact the hospital and obtain this information.

2. If the a/b has a representative of a higher priority than the hospital, enter the higher priority representative in the representative field. Enter the hospital Authorized Representative information in the PACE Agency/CAP Manager field on the application, provided there is no PACE Agency or CAP Manager. If the individual has a representative of a higher priority and there is a PACE Agency or CAP Manager, the hospital's Authorized Representative information cannot be entered. If there is a higher priority representative and a PACE Agency or CAP Manager, send copies of all notices to the hospital.

3. If the application is approved and the hospital is listed as Authorized Representative for the application process only, remove the hospital from the Representative Field or PACE Agency/CAP Manager field the day after approval.

4. If the application is denied, maintain the hospital Authorized Representative information on the application.

D. Representative Information for Recertifications

1. No representative information in file

   a. Ask the beneficiary if they have a representative by reviewing the hierarchy of representatives list with them.

   b. If the beneficiary now has a legal guardian and/or power of attorney, request a copy of the guardianship and/or power of attorney document.

2. Representative information in file

   a. Review the authorized representative information.

   b. Determine if the document is still valid. If the document has expired or will expire during the recertification process, request a new document using the DHB-5097/5097sp.

   c. If the beneficiary indicates they have one or more new representatives, find out the language preference of each representative.

d. If the beneficiary has an informal representative, mail a "Designation of Authorized Representative" form, such as the DHB-5202C-ia/DHB-5202Csp-ia, to the beneficiary for signature, using the DHB-5097/5097sp.

3. Guardianship and/or Power of Attorney documents

a. If there is a guardian or power of attorney document in the file, determine if it is still valid. If the document has expired or will expire during the recertification process, request a new document.

b. If the beneficiary has a new legal guardian and/or power of attorney, request a copy of the guardianship and/or power of attorney document using the DHB-5097/DHB-5097s.

c. If the beneficiary does not respond to the request for information, complete the recertification within the normal time frame. If the beneficiary provides the information after the recertification is completed, key the information when received.

E. SSI Cases

1 If there is no Authorized Representative information in NC FAST, Authorized Representative information from the SDX will automatically populate to the NC FAST case.

2. If there is Authorized Representative information in NC FAST, Authorized Representative information from SDX will not overlay the existing information. The Authorized Representative information from SSA is written to a report in NC XPTR.

a. If the Authorized Representative information in XPTR is the same as that contained in NC FAST, no change is needed.

b. If the Authorized Representative information in XPTR conflicts with the information in NC FAST, contact the beneficiary and ask which Authorized Representative is current. If the Authorized Representative has changed, request a copy of the new Authorized Representative document from the beneficiary. Key the new information into NC FAST when the documentation is received.

F. Keying Authorized Representative, PACE Agency and CAP Manager Information

Refer to NC FAST Job Aid: Adding or Editing MA Authorized Representative Evidence

IV. NOTICE PROCEDURES

A. DHB-5095/DHB-5095S– Medicaid/Work First Notice of Inquiry

The DHB-5095/DHB-5095S, Medicaid/Work First Notice of Inquiry, is used for documenting an inquiry interview. It notifies the applicant of the reason they chose not to apply for Medicaid and their right to appeal if they believe the local agency discouraged them from applying for assistance.

Complete the notice of inquiry during the intake interview. Refer to MA-2300, Application, for instructions on completing the DHB-5095/DHB-5095S, Medicaid/Work First Notice Of Inquiry. Give the original to the applicant and file a copy in the case.

Refer to Job Aid: Record a Notice of Inquiry (DHB-5095)

B. NCF-20023, Notice Regarding the Status of Your Application for Medical Assistance:

The NCF-20023, Notice Regarding the Status of Your Application for Medical Assistance, notifies the applicant that their application has not been processed by the 45th/90th calendar day processing time standard, and to contact their caseworker to find out the reason for the delay.

1. Automated Notice:

   The NCF-20023, Notice Regarding the Status of Your Application for Medical Assistance

   a. The notice will be automatically generated by NC FAST and mailed to the applicant when:

      (1) The Medicaid application has not been processed by the 45th/90th calendar day.

      (2) The stop processing time has been end dated by the caseworker in NC FAST on the 45th/90th calendar day and the Medicaid application has not been processed.

b. The notice will not be generated by NC FAST when:

(1) The Medicaid application has been processed by the 45th/90th day.

(2) The stop processing time begin date has been entered by the caseworker into NC FAST.

(3) The stop processing time has been end dated by the caseworker by the 45th/90th day calendar, and the Medicaid application processed.

(4) A DHB-5098, Your Application for Medicaid is Pending, was generated in NC FAST:

(a) The DHB-5098/DHB-5098S, Your Application for Medicaid is Pending, provides the applicant with information regarding the status of their application allows the county to stop the application processing time.

(b) Refer to MA-2300. IX. Requesting Information

2. The local agency cannot use the application processing time standards or use the NC FAST stop processing time option:

a. As a waiting period before determining eligibility,

b. As a reason for denying eligibility, or

c. As a reason to prevent the NCF-20023 notice from generating because the local agency has not determined eligibility within the application processing time standards.

3. Under certain circumstances, days may be excluded from the application processing time. The NC FAST stop processing time may be used when the only information needed to determine eligibility is one of the following:

a. The local agency is waiting on a Disability Determination Services (DDS), disability decision.

b. The applicant requests additional time to provide information.

c. Medical records needed to determine emergency dates for non-qualified aliens.

d. Awaiting receipt of the FL-2/MR-2.

e. Awaiting receipt of the CAP Plan of Care.

f. Awaiting receipt of undue hardship documentation.

g. Awaiting receipt of the Health Coverage for Workers with Disabilities (HCWD) enrollment fee and/or premium.

h. A waiting receipt of the North Carolina Health Choice (NCHC) enrollment fee.

i. A change in situation, which affects eligibility, becomes known after the exclusion of days begins. Request the new or additional information following procedures and continue the exclusion.

j. Awaiting U.S. citizenship and identity documentation.

k. The individual is notified of the information needed to determine Medicaid eligibility using one of the following:

1. DHB-5098/5098S, Your Application for Medicaid is Pending,

2. DHB-5099/DHB-5099S, Your Application for Medicaid is Pending for a Deductible, or

3. DHB-5113, Notice of Right to Request a Hardship Waiver or notice of date hardship waiver was mailed.

For keying instructions, refer to NC FAST Job Aid:
Entering a Begin Date on Stop Processing Time Record
Entering an End Date on Stop Processing Time Record

4. 60/90 calendar day Hearing Timeframe

Individuals have 60 calendar days from the date of the notice to request a hearing and ask that a decision be made on their Medicaid application. That period is extended to 90 calendar days for good cause.

C. NC FAST Automated Notices

1. DSS-8108, Notice of Application Approval

When the appropriate evidence is entered correctly into NC FAST, the automated notice is produced and mailed the next state business day after the application has been approved. This notice will automatically generate when:

a. Approving all Medicaid programs.

b. A beneficiary already receiving a Medicaid program and is approved for Long-Term Care (LTC), CAP, or PACE.

2. DSS-8109– Notice of Denial or Withdrawal

When the appropriate evidence is entered correctly into NC FAST, the automated notice is produced and mailed the next state business day after the application has been denied or withdrawal.

a. NC FAST may require for the caseworker to select an appropriate denial reason when denying an application. It is important that the text on notices clearly explain the reason for the denial to the applicant.

b. NC FAST will automatically generate the notice based on the reason entered by the caseworker for the type of assistance being withdrawn and that the application is being withdrawn at the applicant's verbal or written request, whichever is appropriate.

(1) Carefully document in the case the reason for the applicant's withdrawal and all alternatives to withdrawal that were explained.

(2) Refer to MA-2300, Application, for specific documentation instructions for withdrawals.

d. NC FAST will enter the Medicaid policy manual section that supports the denial or withdrawal reason entered.

e. The NC FAST generated notice will include WHEN TO ASK FOR A HEARING section for the applicant. Begin counting the 60 calendar days on the day following the date of the notice. If the 60th day falls on a non-workday, the applicant has until the end of the next workday to request a hearing.

f. The local agency must ensure the notice generated and shows in NC FAST as (sent central print) to the beneficiary.

3. DSS-8110, Notice of {Modification, Termination, or Continuation} of Public Assistance

NC FAST automatically generates an DSS-8110 {Notice of Modification Termination, or Continuation} of Public Assistance when:

a. Medicaid was modified to a greater or lesser benefit.

b. Medicaid was terminated.

c. Medicaid benefit will continue.

(1) The DSS-8110, Notice of {Modification, Termination, or Continuation} of Public Assistance will have the word "TIMELY" or “ADEQUATE” printed on the notice when a timely or adequate reason has been entered.

The local agency must ensure the notice generates and is listed in NC FAST as (sent central print) to the beneficiary.

(2) When the appropriate evidence is entered correctly into NC FAST, the automated notice is produced and mailed the next state work day after the change processes.

D. Manual Notice Requirement

When the automated DSS-8108, Notice of Application Approval Notice, DSS-8109, Notice of Denial or Withdrawal, or DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance are unavailable, or the notice needs to be overridden, the caseworker must:

1. Generate a new pro forma communication from NC FAST and mail the notice to the beneficiary, or

2. Access the form on the NCDHHS Policies and Manual website and send:

   a. DHB-5002/DHB-5002S, Important Notice About Your Medicaid or Special Assistance Approval or DHB-5003/DHB-5003S, Notice About Your Medicaid or NC Health Choice Approval when approving an application.

   b. DSS-8109/DSS-8109S, Your Application for Benefits when denying or withdrawing an application.

   c. DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance when there is a:

      (1) Change, no change, terminated or continuation of benefits.

      (2) Language on the NC FAST automatic generated notice with inappropriate reason.

      (3) Change in deductible at recertification or Change of Circumstances (COC) before the deductible has been met.

3. When a caseworker enters a change in the NC FAST system on the behalf of the beneficiary, the caseworker is required to complete and mail a DSS-8110

(NC FAST pro forma communication) to the beneficiary. This includes when there is no change in the beneficiary's current Medicaid category program.

4. Manual Notice General Requirements:

   a. If the notice is handwritten, the writing must be legible.

   b. Use language that is clear and understandable.

   c. Include month, day, and year. Example: September 15, 2011 or 9/15/2011.

   d. Keep a copy of each manual notice in the case.

E. Adequate Notice

The beneficiary must be informed in writing of a change in benefits prior to the change. The effective date of an adequate notice is the day that it is mailed.

1. Use an adequate notice only in the following situations:

   a. The change is beneficial to the beneficiary.

   b. The agency has factual information confirming the death of a beneficiary.

   c. A beneficiary is admitted to a public institution and no longer qualifies for assistance.

   d. A beneficiary signs and dates a written statement to have their assistance terminated or reduced. The request must specifically request Medicaid termination. Document that the beneficiary understood that they may still be eligible for Medicaid and chose not to continue.

   e. A beneficiary begins to receive nursing home level of care in a nursing facility or swing/ inappropriate level of care bed in a hospital. Refer to MA-2270, Long Term Care Need and Budgeting for procedures.

   f. The beneficiary's physician prescribes a change in level of medical care, i.e., skilled or intermediate nursing care or long-term hospitalization.

   g. A beneficiary's whereabouts are unknown, and the post office returns two local agency mail correspondence indicating no forwarding address.

2. Review all other programs for reported address and attempt to contact the applicant by phone, mail, and electronic means, prior to termination of benefits. Exception to the following:

   a. A beneficiary begins to receive assistance in another state, territory, or commonwealth with no break in benefits.

b. A North Carolina Health Choice beneficiary becomes eligible for Medicaid.

F. Timely Notice

1. Use a timely notice any time assistance is reduced or terminated except for the situations described in Section IV.D.2.c.(2),(3).

2. The beneficiary must be informed in writing of the intended change or termination prior to taking the action.

3. Do not reduce or terminate benefits until 10 workdays following the date the notice is mailed.

   Key the change/termination on the first workday following expiration of the 10-day notice.

G. Automated Notice Effective Dates

1. Timely Notice

   a. When you enter a timely reason in NC FAST, the date of the automated timely notice is the first state workday after the change successfully processes in NC FAST. The notice is also mailed on this date.

      Example: The timely reason is entered in NC FAST August 2nd (Friday). The notice is dated and mailed on August 5th (Monday).

   b. The 10-workday timely notice period begins the first state business day after the day the notice is mailed.

      Example: The timely reason entered August 2nd (Friday). The notice is dated August 5th (Monday). The 10-day period begins on August 6th. Therefore the 10th business day is August 19th (Monday).

   c. The change in the case will process on the night of the first state workday immediately following the 10-business day period unless the action is cancelled. Refer to instructions in IV.G.5 for cancelling timely action.

   In the example above, NC FAST is updated with the changed information on August 20th (Tuesday night), unless the action cancelled.

2. Timely Notice with Override of Automated Notice

   a. When you enter a timely reason and you override the automated notice, NC FAST will count 10 business days and update the system on the same schedule as it does when the notice is not overridden.

b. Overriding the automated notice does not prevent NC FAST from processing the timely action on the night of the first state workday following the 10-business day period.

3. Adequate Notice

a. When you enter an adequate reason, the date of the automated adequate notice is the first state business day after the adequate reason processes. The notice is also mailed on this date. NC FAST is updated with the changed information the night the change is entered.

b. When you enter an adequate reason and you override the automated notice, NC FAST will process the action that night. Therefore, the manual adequate notice must be dated and mailed on the same day the action is entered in NC FAST.

4. In certain case situations, you may choose to use a combination of timely and adequate actions.

a. Complete and mail a manual timely notice to the beneficiary. On the workday following the 10th business day of the manual notice, enter in NC FAST an adequate reason and override the automated notice. The beneficiary has already been notified; therefore, another notice is not required, or

b. On the workday before the manual timely notice is mailed, enter the correct timely reason and override the automated notice. If the beneficiary comes in during the 10-day period and establishes ongoing eligibility with no change. Document and send appropriate notice.

5. Cancelling Timely Action

If you use a timely reason and the beneficiary responds within the 10 business days, and eligibility continues with no change in benefits. Document and send appropriate notice.

6. Demographic Changes During the Timely Notice Period

You can enter in NC FAST case changes during the timely notice period. These include address changes and any changes to individual data such as deletions, add-individual, or date of death.

7. If the change is entered too late in the month (after pull cutoff/pull check) to make the termination or change effective the next calendar month, NC FAST automatically changes the effective date.

Example: NC FAST Product Delivery Case (PDC) showing a termination effective date of March 31st and a timely reason is entered on March 14th. The day after the 10th workday is March 30th. Because the action effective day falls after pull cutoff/pull check, NC FAST will change the termination effective date to April 30th.

8. Schedules of Timely Actions Pending in NC FAST

a. Automated Timely Notice Schedule When NC FAST Issues a Notice

FRI Mar 13	MON Mar 16	TUES Mar 17	MON Mar 30	TUES Mar 31	Night of March 31
Workday #1 Change entered	Workday #2 Notice is mailed	Workday #3 Notice day #1	Workday #12 Notice day #10 - 10 days expires	Workday #13 Notice day #11 5:00 deadline to cancel action.	Night of Workday #13 NC FAST updated

b. Processing Schedule When You Override a Notice

FRI Mar 13	MON Mar 16	FRI Mar 27	MON Mar 30	Night of March 30
Workday #1 Change entered with override case worker mails notice	Workday #2 Notice day #1	Workday #10 Notice day #10 - 10 days expires	Workday #12 Notice day #11 5:00 deadline to delete or cancel the action	Night of Workday #12 NC FAST updated

F. Automated Notice

NC FAST displays a copy of each individual notice the system generates and mails. It also displays cases when the notice was overridden or cancelled.

V. HEARING PROCESS

A. Purpose

1. Local Hearing

   The purpose of the local hearing is to allow the local agency to explain the action in question and give the a/b (a/b) or designated authorized representative an opportunity to explain why they feel the action should not have taken place.

2. State Hearing

   The state hearing safeguards the interest of the a/b and ensures fair and equitable administration of assistance programs.

B. Applicant's/Beneficiary's Rights

1. The a/b has the right to appeal when:

   a. The local agency denies an applicant the opportunity to make an application on the day they first appear at the agency and wish to apply.

   b. The a/b alleges they were discouraged for any reason from applying for assistance. See MA-3200, Application for the definition and examples of discouragement.

   c. The a/b alleges the local agency improperly withdrew their application. See MA-3200, Application for the definition of improper withdrawals.

   d. The a/b alleges the local agency improperly denied their application. See MA-3200, Application, for the definition of improper denials.

   e. Assistance is approved, denied, modified, or terminated.

      Do not conduct a hearing when either state or federal law requires automatic adjustments for classes of beneficiaries, unless the reason for the hearing is incorrect computation or there is a factual issue regarding whether the change is applicable.

   f. The a/b disagrees with the amount of their deductible or patient monthly liability amount.

   g. The local agency fails to act within the required time standards.

   h. The local agency fails to act promptly on a request for a review of the case situation.

   i. The a/b disagrees with the determination of:

      (1) The community spouse income allowance, or

(2) The amount of monthly income available to the community spouse, or

(3) The computation of the community spouse resource allowance, or

(4) The resources determined available to the institutionalized spouse after deducting the community spouse resource allowance.

j. The beneficiary disagrees with the establishment of an overpayment. See MA-3535, Beneficiary Fraud and Abuse Policy and Procedures.

2. The a/b may request the hearing verbally or in writing.

1. Via the ePass Portal

(a.) Hearing requests submitted via the ePass portal will arrive as a task in the queue titled: NC FAST <County Name> Online Appeal Request.

(b.) The queue is managed by the NC FAST case owner's supervisor or the agency designated representative.

The supervisor or the agency designated representative must monitor this queue **periodically** throughout the day on the daily basis.

(2) The local agency must review the hearing requests to determine whether the individual meets the criteria for a standard or expedited hearing.

(3) The hearing request date is the date received if during the agency's normal business hours. If the hearing request is received after the agency's normal business hours, the request date is the next business day.

(4) Refer to NC FAST Job Aid: Getting Tasks from Work Queues

b. Telephonically

The hearing request date is the date of the telephone request if received during the agency's normal business hours. Hearing requests received by voice messages left after the agency's normal business hours the request date is the next business day.

c. In-person

The hearing request is the date received in the agency (including outpost locations) during their normal business hours.

d. Through all electronic data sources

The hearing request is the date received in the agency during their normal business hours. If the hearing request is received after the agency's normal business hours, the request date is the next business day

e. Written

The hearing request date for a written and signed request from the a/b/designated authorized representative is the date received in agency during their normal business hours. If the hearing request is received after the agency's normal business hours, the request date is the next business day.

3. Expedited Hearing Request at the Local Hearing Level

An applicant or beneficiary may request an Expedited Hearing if the standard timeframe for adjudicating a local agency hearing could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

a. The a/b must provide documentation that includes but is not limited to those listed below on the day of the request:

(1) Doctor certifies in writing that it is in their professional opinion that a standard hearing timeframe for adjudicating a hearing could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

(2) Statement from a professional who has knowledge of their situation (for example: nurses, or social workers).

(3) Statements from family and friends are not-acceptable.

b. The a/b provides documentation to meet the criteria for an expedited local agency hearing on the day of the request. The caseworker must:

(1) Notify the a/b on the day the expedited hearing request is received that the expedited hearing request is granted.

(a) Notice must be provided orally or through electronic means.

(b) If oral notice is provided, the agency must follow up with written notice, which may be through electronic means, if consistent with the individual's choice to receive notices electronically instead of by mail.

c. The a/b does not provide documentation to meet the criteria for an expedited local agency hearing on the day of the request; the caseworker must:

(1) Notify the a/b on the day the expedited hearing request is received that the expedited hearing request is denied and will proceed on a standard hearing schedule.

(a) Notice must be provided orally or through electronic means.

(b) If oral notice is provided, the agency must follow up with written notice, which may be through electronic means, if consistent with the individual's choice to receive notices electronically instead of by mail.

d. In cases involving issues other than disability, the a/b has the right to request a state hearing only after a local hearing has been held and a decision has been rendered.

(1) Expedited hearing requests for non-disability requests can only be held at the local level.

(2) If a state hearing is requested after a hearing was held at the local level and a local hearing decision has been rendered, the state hearing is handled on a standard schedule.

4. Expedited Hearing Request at the State Hearing Level for issue of disability

An applicant or beneficiary may request an Expedited Hearing if the standard timeframe for adjudicating an issue of disability at the state hearing level could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

a. The a/b must provide documentation on the day the expedited appeal request is made to the local county agency by providing medical records that document the a/b's urgent health need for an expedited hearing.

(1) The medical records **must** consist of physical examinations, signs, symptoms, laboratory findings, etc.

(2) Submission of only a letter/note from a doctor giving an opinion of diagnosis/disability status/functional ability is **not** sufficient to document the need for an expedited state level hearing.

(3) Statements from family and friends are not acceptable.

b. The a/b provides medical records (physical examinations, signs, symptoms, laboratory findings, etc.) on the day the expedited appeal request is made to the local county agency. The caseworker must follow the expedited hearing procedures and submit the request for an expedited appeal to the DHHS Hearings & Appeals Section.

The DHHS Hearings & Appeals Section will notify the a/b if the expedited hearing request is granted.

c. If the a/b does not provide medical records on the day of the expedited appeal request is made to the county, the caseworker must:

(1) Notify the a/b on the day the expedited hearing request is received that the expedited hearing request is denied and will proceed on a standard state hearing schedule.

(a) Notice must be provided orally or through electronic means.

(b) If oral notice is provided, the agency must follow up with written notice, which may be through electronic means, if consistent with the individual's choice to receive notices electronically instead of by mail.

5. The applicant/ beneficiary must request a hearing within 60 calendar days from the date the notice of action is mailed or given, unless they can show good cause for a later request. If good cause exists, the request must be no later than 90 calendar days from the date of the notice of action.

a. For appeals based on allegation of discouragement, improper withdrawal, or improper denial, the time limit for requesting a hearing shall be 60 or 90 calendar days with good cause from the date the applicant became aware or should have known that incorrect or incomplete information given by the local agency caused them not to apply, caused them to withdraw their application, or that the denial was improper.

b. Good cause is defined as:

(1) Failure of the a/b to receive the notice of action, or

(2) Extended hospitalization of the a/b, spouse, child, or parent of the a/b, or

(3) Failure of a representative acting on the a/b's behalf to meet required time frames, or

(4) Illness resulting in incapacity, incompetence, or unconsciousness of the a/b and there is no representative acting on their behalf, or

(5) Death of the a/b or their representative, or

(6) Failure of the local agency to provide sufficient or correct information regarding appeal rights.

c. The a/b must provide evidence of good cause, which includes but is not limited to:

(1) Physician's written statement, or

(2) Hospital bill, or

(3) Written statement of a/b, their representative, or other individual knowledgeable of situation.

6. In cases involving issues other than disability, the a/b has the right to request a state hearing only after a local hearing has been held and a decision has been rendered.

(a) Expedited hearing request for non-disability requests can only be held at the local level.

(b) If a state hearing is requested after a hearing was held at the local level and a local hearing decision has been rendered, the state hearing is handled on a standard schedule.

7. In cases involving a question of disability, an a/b has the right to request a state hearing even when the disability decision is an SSA/SSI adoption.

This includes appeals requested on ex-parte reviews when SSA denied for no longer being disabled and the beneficiary is ineligible for any other Medicaid programs and the beneficiary states they are still disabled.

Within five (5) calendar days of the request for a hearing, the county agency director or their designee must forward the DSS-1473, Request for State Appeal to the Chief Hearing Officer to schedule a state hearing.

A State Hearing Officer will hold a state hearing and render a state hearing decision.

8. Right to Continued Benefits (Not Applicable to NC Health Choice)

A beneficiary whose benefits are changed or reduced may be entitled to continued benefits while awaiting a hearing decision. Continuation of benefits applies only to beneficiary. It does not apply to applicants who are denied assistance, because there are no benefits to continue.

a. Beneficiaries Who Receive Timely Notice

(1) If a beneficiary appeals a reduction or termination of benefits on or before the effective date of the change (10 business after the notice is mailed or given to the beneficiary),

(2) The beneficiary has the right to continued benefits until the end of the month in which the local hearing decision is rendered,

(3) Except when the reduction or termination involves a disability determination, or the beneficiary waives their right to continued benefits.

(4) If the reduction or termination involves a disability determination, the beneficiary who meets all other eligibility factors has the right to continued benefits until the end of the month in which the:

(a) State hearing decision is rendered, or

(b) Social Security Administration Appeals Council's final decision is rendered with no right to further review, whichever occurs later.

(5) The beneficiary is not entitled to continued benefits if the appeal is requested after the 10-business period.

(6) When the beneficiary requests the hearing, advise the beneficiary:

(a) If the reduction or termination of benefits is affirmed by the Local or State Hearings Officer, the beneficiary may be required to repay the benefits received while awaiting a decision, or

(b) If the appeal involves a disability determination and the Social Security Administration affirms the reduction or termination of benefits, they will not be required to repay the benefits. This applies even if a state appeal also affirms the county's action to terminate, and

(c) The beneficiary has the right to choose not to continue to receive benefits.

(7) In some cases, a hearing decision upholding the local agency's action will be rendered prior to the termination of benefits. In these situations, no additional action is necessary.

(a) If benefits must continue for an additional period, administratively reopen the Medicaid case for one month at a time until the hearing decision is rendered, if the appeal is related to a non-disability issue.

(b) Refer to MA-2525, Disability for continuation of benefits procedures when the appeal involves a disability determination.

b. Beneficiaries Who Receive Adequate Notice

Beneficiaries who receive adequate notice and appeal do not have the right to continued benefits.

9. The a/b must request a state hearing within 15 calendar days of the mailing of the local hearing decision, unless they can show good cause for a later request as outlined in IV.B.4.

10. The a/b has the right to be represented at the hearing by the person of their choice, including an attorney obtained at their expense.

11. If at any point, the a/b does not exercise their right to a hearing or the right to continued benefits, the a/b still has the right to reapply.

C. Request for a Hearing

How the local agency handles the a/b's request for a hearing depends on the action in question and whether a standard or expedited hearing has been requested.

1. Local Hearing Request

(a) Immediately notify the appropriate county staff when an a/b requests a local hearing. Inform the a/b that the Local Hearing Officer will be contacting them regarding their request.

(b) The local hearing must be held:

Standard Hearing	Expedited Hearing
Within five (5) calendar days after the request is received	Within three (3) calendar days after the request is received

2. State Hearing Request

a. When the a/b requests a state hearing that does not involve a question of disability:

Standard Hearing Procedures:	Expedited Hearing Procedures:
Within 5 calendar days of the day the a/b requests a state appeal, the local agency must submit a completed DSS-1473, Request for State Appeal form along with applicable required information as stated on the DSS-1473 form, to the Chief Hearing Officer, Hearing and Appeals Section: a. Attach a copy of the local hearing appeal summary decision. b. Attach a copy of the DSS notification letter that prompted the appeal. c. The local agency must contact DHHS Hearing and Appeals to follow up on the status of the request, if there has been no response from a State Hearing Officer within 45 calendar days of the date the DSS-1473, Request for State Appeal was sent. DHHS Hearing and Appeals can be reached at (919) 855-3260.	Do not apply, since a local agency hearing was held, and a local agency decision was rendered. Request for a state hearing are handled on a standard hearing schedule. Follow standard hearing procedures.

b. When the a/b requests a state hearing that involves a question of disability:

Standard Hearing Procedures:	Expedited Hearing Procedures:
Within five (5) calendar days of the day the a/b requests a state appeal, the local agency must submit a completed DSS-1473, State Appeal Request. In addition to the form include all applicable required information as stated on the DSS-1473. Submit the form and applicable information to the Chief Hearing Officer of the DHHS Hearings and Appeals section: a. Attach a copy of the DSS notification letter that prompted the appeal. b. Attach a copy of D-4037, Medical Disability Determination Transmittal from DDS and a copy of all medical records returned by DDS, including records from determinations within the past two (2) years. c. If there has been no response from a State Hearing Officer within 45 calendar days of the date the DSS-1473, Request for State Appeal was sent, the local agency must contact DHHS Hearing and Appeals to follow up on the status of the request. DHHS Hearing and Appeals can be reached at (919) 855-3260.	On the day the a/b requests an expedited state appeal, the local agency must fax a completed DSS-1473, State Appeal Request form and a completed DSS-1473B Addendum for Expedited MAD Medical Determination form. Also include all applicable required information as stated on the DSS-1473 and 1473B. Submit the form and applicable information to the Chief Hearing Officer of the DHHS Hearing and Appeals Section. a. Fax both the DSS-1473, the 1473B Addendum and all applicable required information to 919-715-1910. b. Must fax a copy of the medical records provided by the a/b, documenting the a/b's urgent health need for an expedited hearing. Medical records consist of physical examinations, signs, symptoms, laboratory finding, etc and cannot just consist of a doctor's letter giving an opinion of the medical condition. Thus, if medical records are not provided by a/b on the day the appeal request is made, proceed to c. below. c. Include a copy of D-4037, Medical Disability Determination Transmittal from DDS and a copy of all medical records returned from DDS. Include a copy of the DSS notification letter that prompted the appeal. Include a copy of the relevant documents related to the appeal. d. If the a/b does **not** provide medical records to support the request for an urgent need for an expedited appeal, then the caseworker must:

	Contact the appellant on the day the expedited hearing request is received and inform the appellant that the expedited hearing will transition into a standard fair hearing time frame and standard hearing procedures apply. (A DSS-1473B will **not** be completed.) e. On the day the a/b requests an expedited state appeal, the caseworker must call the DHHS Hearings and Appeals Section at (919) 855-3260 to confirm that the expedited appeal request has been received by fax. f. The local agency must contact DHHS Hearings and Appeals if there has been no response from a State Hearing Officer within five (5) days of the date the DSS-1473 and 1473B Addendum, Expedited MAD Medical Determination were sent. The local agency must contact DHHS Hearing and Appeals to follow up on the status of the expedited appeal request. DHHS Hearing and Appeals can be reached at (919) 855-3260.

3. Request for Hearing when Applicant is Deceased

When the applicant dies during the application process, an Authorized Representative may request the hearing. In the absence of an Authorized Representative, a family member may request the hearing. If there is no family member identified in the case, a hospital where the decedent received services during the ongoing or retroactive period covered by the application may request the hearing.

D. Federally Facilitated Marketplace (FFM) Determinations - Appeals

An applicant has the right to appeal any Medicaid decision that they disagree with. This includes determinations made by the FFM. The applicant may choose to have the appeal held at the FFM or with the state.

1. The applicant must request a hearing within 60 calendar days from the date the notice of action is mailed, unless they can show good cause for a later request. If good cause exists, the request must be no later than 90 calendar days from the date of the notice of action.

2. If the applicant chooses to appeal the FFM determination and have the hearing held at the FFM, instruct the applicant to request the appeal via the Healthcare.gov website.

3. If the applicant requests the appeal be held with the state, follow the policy in this section applicable to state hearings. Local hearings are not applicable to FFM Determination of eligibility.

E. Scheduling the Hearing

1. The Local or State Hearing Officer assigned to the hearing will give reasonable notice to the county and the a/b of the time and place of the hearing.

2. The local hearing must be held:

Standard Hearing	Expedited Hearing
Within five (5) calendar days after the request is received	Within three (3) calendar days after the request is received

3. The a/b may request and is entitled to receive a postponement of the scheduled hearing if good cause exists.

   a. Local Hearing

   If the a/b has good cause, the local hearing may be delayed for up to 10 more calendar days. A local appeal hearing may never be held more than 15 calendar days after the request for a hearing is received.

b. State Hearing

The postponement of a state hearing may not exceed 30 calendar days from the date the hearing was originally scheduled.

c. The a/b has good cause to postpone the hearing when:

(1) There is a death in the a/b's family.

(2) The a/b or someone in their family is ill.

(3) The a/b is unable to obtain representation.

(4) The a/b's representative has a conflict with the scheduled date.

(5) The a/b is unable to obtain transportation.

(6) The Hearings Officer determines that the hearing should be delayed for some other reason.

F. Location of a Hearing

Hold the local and/or state hearing in the local agency office or telephone unless the a/b is bedfast or has great difficulty moving. In such cases, the hearing may be held where the a/b lives.

G. Examination of the Case Record

Prior to and during the hearing, the appellant or their personal representative may examine the contents of their case file together with portions of other public assistance or social services case files that pertain to the appeal. They may also examine all other documents and records to be used at the hearing. The appellant or their representative may obtain copies of these materials without charge to the extent that confidentiality and redisclosure regulations/laws/rules will allow.

H. Preparatory Summary

1. The caseworker must prepare an original and two copies of the hearing summary discussing the local agency action and the reasons for that action.

2. Cite the specific regulations substantiating the action.

3. Attach to the summary copies of pertinent documents.

4. Give the original to the Hearing Officer. Give one copy to the a/b and file a copy in the eligibility record.

I. Attendance at the Hearing

Attendance at the hearing is limited to the a/b, the designated representative, appropriate representatives of the local agency and/or State, and any witnesses that the a/b or the local agency wish to call upon for testimony.

J. Conducting the Hearing

1. Local Hearing

   Refer to the "Local Appeal Hearing Officer's Handbook."

   a. The county director or their designee presides at the local hearing and ensures that the oath or affirmation is administered to all participants.

      (1) The designee can include another county employee, a board member, or an employee of a social services agency in another county.

      (2) The Local Hearing Officer must not have been directly involved in the initial decision that resulted in the appeal.

   b. There is no requirement for the local hearing to be recorded. However, a written summary of the hearing must be maintained in the case file.

2. State Hearing

   a. A State Hearing Officer from the DHHS Hearings and Appeals Section presides at the hearing and administers the oath or affirmation to all participants.

   b. The State Hearing Officer will also record the hearing. A transcript will not be prepared unless a petition to Superior Court is filed.

3. The a/b and the local agency may be represented by attorneys or other individuals obtained at their expense.

4. The local agency and the a/b must each designate someone to present their testimony and to call as witnesses. Any person testifying must be sworn in.

5. The local agency representative must read the summary and explain the county's action or call upon someone to do so. They may call witnesses, one at a time. The State Hearing Officer may question witnesses during their testimony. When the county's testimony has ended, the a/b or their representative may question the county's witnesses or representative.

6. The a/b or their designated authorized representative may then explain why they feel the local agency's action should not be implemented. They may call witnesses, one at a time. The State Hearing Officer may question witnesses during testimony. When the a/b's testimony has ended, the local agency representative may question the a/b, witnesses, or representative.

7. Representatives for the local agency and the a/b may present closing statements summarizing their view of the situation in question.

K. Hearing Decision

1. Local Decision

The Local Hearing Officer must make a decision on the case, based on appropriate regulations and evidence presented at the hearing. Those factors must be cited in a written statement of decision:

Standard Hearing:	• Within five (5) calendar days of the date of the local hearing. Retain a copy in the case. • The decision may be sent electronically if the individual elects to receive electronic communication. Retain a copy in the case.
Expedited Hearing:	• The Local Hearing Officer must first attempt to contact the a/b with the decision on the day the decision is rendered. • Sent to the a/b by certified mail within two (2) calendar days of the date of the local hearing. Retain a copy in the case. • The decision may be sent electronically if the individual elects to receive electronic communication. Retain a copy in the case.

2. State Hearing

The State Hearing Officer must render a decision on the case, based on appropriate regulations and evidence presented at the hearing. Those factors must be cited in a written statement of decision:

Standard Hearing:	• Not more than 90 calendar days from the date of the state appeal request unless the hearing was delayed at the a/b's request.
Expedited Hearing:	• Not more than 7 working days from the date of the state appeal request unless the hearing was delayed at the a/b's request.

a. If the hearing is delayed at the a/b's request, the hearing decision can only be delayed for the length of time allowed for the a/b's delay.

b. If a state hearing has been held and the county has not received a response the worker needs to contact DHHS Hearings and Appeals Section to check the status of the decision:

Standard Hearing:	• After 14 calendar days, the worker needs to contact DHHS Hearings and Appeals to check the status of the decision.
Expedited Hearing:	• After five (5) working days, the worker needs to contact DHHS Hearings and Appeals to check the status of the decision.

c. The hearing officer will prepare a tentative decision, which will be sent by mail to the a/b, the local agency and representatives. Decisions reversing the local agency's action are sent by certified mail to the local agency. Decisions affirming the local agency's action are sent certified mail to the a/b. Decisions are sent by regular mail to representatives. The tentative hearing decision becomes a **final decision** 10 calendar days from the date of the Notice of Decision if the tentative decision is **not** contested.

d. The local agency or the a/b may contest a tentative hearing decision by presenting oral and/or written arguments, for or against the Notice of Decision, no later than 10 calendar days from the date of the Notice of Decision. Both must contact the Chief Hearing Officer to present arguments. No new evidence will be accepted at this level of the appeal process.

e. If no written argument, a request for a time extension to submit a written argument, or a request for oral argument is made within 10 calendar days of the date of the tentative decision, the tentative hearing decision becomes final.

g. If the party that requested oral argument fails to appear for the scheduled oral argument, or the party failed to timely submit a written argument, the tentative decision becomes final.

h. If contested timely, then a Final Decision is issued by a designated official of the Hearings & Appeals Section and sent by certified mail to both the a/b and the local agency. The Final Decision is sent by regular mail to representatives.

L. Implementation of Decision:

1. Local

a. Applications

The local agency must implement a state appeal decision within:

Standard Hearing:	• Five (5) business of the date the Notice of Decision, **becomes final.**
Expedited Hearing:	• Two (2) business of the date the Notice of Decision, **becomes final**.

b. Terminated/Modified Cases

The local agency must implement a state appeal decision within:

Standard Hearing:	• Fourteen (14) calendar days of the date the, Notice of Decision **becomes final**.
Expedited Hearing:	• Two (2) business of the date the Notice of Decision **becomes final**.

c. The local agency or the a/b may present oral and/or written arguments, for or against the Notice of Decision, no later than 10 calendar days from the date of the Notice of Decision. Both must contact the Chief Hearing Officer to present arguments. No new evidence will be accepted at this level of the appeal process.

d. If no written argument, a request for a time extension to submit a written argument, or request for oral argument is made within 10 calendar days of the date of the tentative decision, the tentative hearing decision becomes final.

e. If the party that requested oral argument fails to appear for the scheduled oral argument, or the party fails to timely submit a written argument, the tentative decision becomes final.

3. Remanded Appeals

   A remanded appeal decision is a written instruction to the local agency to reconsider the county's determination of eligibility based upon new evidence that was presented at the hearing or upon policy that may not have been considered. It is not a reversal of the county's action. Instead the hearing officer remands the case to the local agency for reconsideration.

   Once the reconsideration is completed, the local agency must render a new determination of eligibility which may or may not be the same as the original determination.

4. Refer to MA-3200, Application, for instructions on re-opening and processing applications and terminated cases due to local/state appeal reversals or remanded appeal decisions.

5. If eligibility is approved for any period for which the time limit for filing claims has expired, the county agency must submit a request for an override of the time limit. Refer to MA-3530, Corrective Actions and Responsibility for Errors, for override instructions.

M. Recovery

1. Local Hearing

   If a reduction or termination of assistance is affirmed, any benefits received during the time of the local appeal may be subject to recovery.

2. State Hearing

   If a reduction or termination of assistance is affirmed, any benefits received during the time of the state appeal may be subject to recovery unless the issue involves a disability determination.

   a. For state appeals involving a disability determination, any benefits received during the time of the state appeal may be subject to recovery unless the beneficiary has also filed a timely appeal of the Social Security/SSI denial or termination.

   b. If the beneficiary does not file a timely appeal of the Social Security/SSI denial or termination, any benefits received during the time of the state appeal may be subject to recovery.

N. Further Appeal

1. Local Hearing

If the a/b is not satisfied with the local hearing decision, they may request a state hearing through the local agency. The state hearing request must be made within 15 calendar days of the mailing of the local hearing decision or within 90 calendar days of the date of the original notice of action, if good cause as defined in IV.B.3. exists.

2. State Hearing

a. A/b

If the a/b is not satisfied with the **final** decision following the state hearing, they may file a petition for judicial review in Superior Court within 30 calendar days of the receipt of that decision. For appeals filed after 30 calendar days, a Superior Court judge may issue an order permitting a review if the judge believes good cause exists for the delay in filing.

b. Local Agency and State

Neither the local agency nor the State may appeal a final hearing decision to Superior Court.