

## Requesting a Budget Appeal

### Step 1:

Medicaid makes decisions about you, including:

- Whether you qualify for Developmental Disability (DD) services
- The level of care (LOC) you receive from direct care staff
- Your budget for DD services

When a decision is made, you will get a letter in the mail that tells you what Medicaid decided. If you do not agree with the decision Medicaid makes about you, then you, your guardian (if you have one) or a person of your choosing can ask Medicaid to review the decision and for a hearing. At the hearing, you will be able to tell your side of the story, or why you do not agree with Medicaid's decision.

You can get a hearing by sending an appeal form to Medicaid, which is included with the letter. Anyone you want to ask can help you fill out the appeal form. If you don't know who to ask for help, you can contact your Targeted Service Coordinator or Support Broker.

Appeal forms can be mailed or faxed to:

**Administrative Procedures Section**

**Department of Health and Welfare**

**P.O. Box 83720-0036**

**450 West State Street**

**Boise, Idaho 83720**

**Fax: 208-334-6558**

If you do not agree with your budget, you can ask for a hearing in one of two ways. First, you can send an appeal within twenty-eight (28) days from the letter that tells you what your budget is. Or second, if you do not appeal within 28 days of the letter, you can instead develop your service plan. If the services in your plan cost more than your budget, you can fill out an exception review form when you ask Medicaid to approve your plan. Medicaid can allow services that cost more than your budget if you have a health or safety need. If Medicaid does not approve your plan, you will get a letter about that decision and will have 28 days to appeal that decision. If Medicaid approves your plan, services can begin.

If you have questions about asking for an appeal or the exception review or health and safety forms, you can ask your Targeted Service Coordinator or Support Broker or call Medicaid at **1-844-793-1286**.

**Step 2:**

When you mail your appeal to Medicaid, an Appeals Specialist at the Bureau of Developmental Disability Services (BDDS) will review it. If you asked for the records used to make the decision, Medicaid will send them to you. The Appeals Specialist will call your Targeted Service Coordinator or Support Broker, you or your guardian (if you have one) if they need more information.

### **Step 3:**

The Appeals Specialist will work with you to find a solution to your appeal. If you agree with the solution, the Appeals Specialist will send you a letter to sign. This letter is called, "Appeal Withdrawal Proposal." Signing this letter means that you agree not to have a hearing, but to instead withdraw your appeal and move forward with the solution. You have ten (10) days to return this letter.

If you do not find a solution with the Appeals Specialist, the Appeals Specialist will send you a letter called: "Proceed to Hearing Notice." If you get this letter, it means that you will go to hearing with Medicaid so that you can tell your side of the story, or why you disagree with Medicaid's decision.

**Please Note- Initial Applicants and Certain Renewals:** This section applies to initial applicants and participants whose budget for the upcoming year is more than their budget from last year. If you are new to the adult DD program, you are an initial applicant.

If you are an initial applicant, or if your budget for the upcoming year is more than your budget last year, and you do not agree with your budget, you can also ask for a hearing in one of two ways. First, you can send an appeal within twenty-eight (28) days from the letter that tells you what your budget is. Or second, if you do not appeal within 28 days of the letter, you can instead develop your service plan.

If the services in your plan cost more than your budget, you can fill out an exception review form when you ask Medicaid to approve your plan. Medicaid can allow services that cost more than your budget if you have a health or safety need.

When you ask Medicaid to approve your plan, Medicaid can approve services that cost up to your budget amount. If Medicaid does not approve your plan for an amount over your budget, you will get a letter about that decision and can appeal the amount that was denied. You will have 28 days to appeal your budget, if you have not already done so. Even if you appeal the amount denied by Medicaid, the services that Medicaid approved costing less than your budget can start right away.

**Step 4:**

When you appeal your budget, your case will be assigned to a Hearing Officer. You will receive a letter called: “Notice of Scheduling Pre-Hearing/Hearing” from the Hearing Officer. This letter tells you the date/time and phone number to call on the day of the hearing. The letter will tell you about having witnesses for your case and the process for sending any exhibits (items/information that show your side of the case) you want to show at the hearing to support your side of the story, or why you disagree with Medicaid’s decision.

**Step 5:**

The Hearing Officer will listen to your side and Medicaid's side. The Hearing Officer will decide if Medicaid followed their processes to support the decision they made. Based on the hearing, these things might happen:

- The Hearing Officer may agree with Medicaid's decision (affirm); or
- The Hearing Officer may not agree with Medicaid's decision (not affirm); or
- The Hearing Officer may decide there is not enough information. Medicaid may update your assessment, budget or find a solution to the service denial (remand).

**Step 6:**

After the hearing, the Hearing Officer will write down his/her decision about whether Medicaid's decision about you was right or wrong. The Hearing Officer must make a decision within thirty (30) days after the hearing. You will receive a letter with the Hearing Officer's decision. This letter is called the "Findings of Fact, Conclusions of Law, and Preliminary Decision." The letter will tell you what happened at the hearing and what the Hearing Officer decided.

If the Hearing Officer agrees with Medicaid's decision about:

- A denial of eligibility: You will not be eligible to receive DD services.
- A calculated budget: You will need to submit a plan that is not over your assigned budget.

- A denial of services: You may modify your plan to use a different service to meet that need or you can choose not to use DD services.

### **Step 7:**

If you do not agree with the Hearing Officer's decision you can request a Director's Review. You have fourteen (14) days from the date of the Hearing Officer's decision to request a Director's Review. A Director's Review is when the Director of Health and Welfare reviews your case after the Hearing Officer. The Director (or the Director's designee) will agree or disagree with the Hearing Officer's decision. If Medicaid does not agree with the Hearing Officer's decision, Medicaid can also request a Director's Review.

### **Step 8:**

If you do not agree with the Director's decision you can file an appeal with the District Court. If Medicaid does not agree with the Director's decision, Medicaid can file an appeal with the District Court.

**Note:** The Department cannot extend a plan while an appeal is pending in District Court.

**\*\*If you want to withdraw your appeal or wish to proceed directly to hearing, please call 1-844-793-1286.**