Getting Kids the Care They Need:

PEACHCARE AND MEDICAID APPEALS MANUAL FOR ATTORNEYS

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Center for Law & Justice

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Manatt, Phelps & Phillips, LLP

Julian Polaris, Esq.

Cindy Mann, Esq.

Meghan K. McNamara, Esq.

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Polsinelli, PC

Laura Little, Esq.

R. Ross Burris, III, Esq.

Atlanta Legal Aid Society's Charles Bliss, Esq.

Georgia Legal Services Program's Vicky Kimbrell, Esq.

Georgia Appleseed's Getting Kids the Care They Need Manual Project Staff

R. Michael Waller, Esq., *Georgia Appleseed, Executive Director*

Caroline Durham, Esq., *Georgia Appleseed, Law and Policy Director*

Eloise Holland, *Communications Manager*

C. Talley Wells, Esq., *former Executive Director*

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INTRODUCTION

The **Medicaid program** and the **Children's Health Insurance Program (CHIP)** provide health coverage for children living in households with incomes up to 247% of the federal poverty level, as well as certain groups of low-income adults.[1] In the State of Georgia, nearly two million people—most of whom are children—receive health coverage through either Medicaid or CHIP, which is referred to locally as **"PeachCare for Kids"** or **"PeachCare."**[2] This manual will use CHIP, PeachCare for Kids, and PeachCare interchangeably.

These programs are governed by a complex array of federal and state statutes, regulations, and sub-regulatory guidance that define who is eligible to enroll and which benefits they may access. If an individual is deemed ineligible or is denied access to particular services, the individual has a right to challenge that decision. Depending on the circumstances, the individual may have access to appeal proceedings before a managed care plan, a state agency, and, ultimately, a state or federal court. This manual is a guide for advocates who assist with these types of Medicaid and CHIP appeals in Georgia.

Section I of this manual provides background information on Medicaid and CHIP, including a review of the federal and state laws that govern these programs and the federal and state agencies that play a role in administering them. Section I also discusses two different models of care delivery that Georgia relies on in these programs: fee-for-service (FFS), in which the state directly contracts with individual healthcare providers; and managed care, the dominant model in Georgia, in which the state contracts with health plans—called care management organizations (CMOs)—to perform various administrative and care delivery functions. This distinction is important because each model comes with its own set of appeal procedures.

ALWAYS CHECK THE CURRENT VERSION OF THE LAW

The state has substantially revised its Medicaid and PeachCare appeals procedures in recent years. This manual is current as of ***October 2020***, but may not reflect the current state of the law at a later date. Advocates who undertake a Medicaid or PeachCare appeal should take care to confirm all relevant authorities.

WHAT THIS MANUAL DOES AND DOES NOT COVER

This manual explains the appeals procedures that apply to the following types of adverse actions:

- A denial of eligibility for Medicaid or PeachCare for Kids
- A denial of coverage for a particular benefit under Medicare or PeachCare, whether in FFS or managed care
- The state or CMO's failure to act promptly on eligibility or coverage decisions

This manual does not address:

- Eligibility requirements or enrollment procedures for Medicaid or PeachCare
- The benefits covered under Medicaid or PeachCare or the procedures for requesting service authorization
- The special appeals rules that apply to decisions about care in a nursing home or intermediate care facility (ICF)

Section II provides a high-level introduction to the various appeal pathways that exist within Georgia's Medicaid and PeachCare for Kids programs. Broadly speaking, each program offers two sets of appeal procedures: a CMO review process for determinations regarding benefits for managed care enrollees, as well as a State Fair Hearing process that exists for various types of appeals in both managed care and FFS. Section II provides a rubric that advocates can use to determine which set (or sets) of appeal procedures will apply in a given instance to a given client.

Sections III and IV provide step-by-step guides to the CMO review process (Section III) and the State Fair Hearing process (Section IV), including discussions of which types of state or CMO actions may be appealed, when and how to file an appeal, and what hearing procedures to expect, with an emphasis on client rights under federal and state law. Although these appeals procedures are generally identical as applied to both Medicaid and PeachCare for Kids, there are certain program-specific details, as discussed in these sections.

Section V concludes with high-level strategic advice for advocates working in this space. Strategic pointers are also scattered throughout the manual in dark green text boxes (which offer background information and advocacy tips) and yellow text boxes (which highlight areas where Georgia's procedures are ambiguous or seem to conflict with federal law).

The manual also contains appendices that list important acronyms and sources of law.

If you or your client have questions concerning Medicaid and PeachCare appeals, consider reaching out to legal aid organizations such as the Georgia Legal Services Program (phone number: 833-GLSPLAW) or Atlanta Legal Aid (phone number: 404-524-5811).

I. BACKGROUND ON MEDICAID & CHIP

A. Medicaid & CHIP are Federal-State Partnerships

Congress created the Medicaid program in 1965 to provide health coverage for certain groups of low-income children and adults and created CHIP in 1997 to extend coverage to middle-income children who do not qualify for Medicaid. Both programs are structured as federal-state partnerships: each state designs and administers its own Medicaid and CHIP programs within constraints established by federal law, relying on a combination of state and federal funds. The **Centers for Medicare and Medicaid Services (CMS)** oversees, administers, and enforces these federal standards.

The federal Social Security Act describes the mandatory parameters for each program while allowing plenty of room for states to make choices about program design.[3] CMS regulations add substantial detail about what states may or must do. Each state maintains a CMS-approved **state plan** describing the state's Medicaid and CHIP operations, including the list of covered populations and services. States may amend their plan by submitting **state plan amendments (SPAs)** for CMS approval.

In addition to the Social Security Act and CMS regulations, Georgia state laws govern certain aspects of the Medicaid and CHIP (i.e., PeachCare for Kids) programs. Within the executive branch, Georgia divides up program responsibility as follows:

- The **Department of Community Health (DCH)** administers Medicaid and PeachCare coverage.
- The **Department of Human Services (DHS)** oversees eligibility and enrollment. Key divisions and offices include:

- The **Division of Family and Children Services (DFCS)**, which has county-level departments that process applications for Medicaid and other benefit programs, receive appeal requests, and host appeal hearings; and
- The **Right from the Start Medical Assistance Group (RSM)**, which sits within DFCS and plays a role in the PeachCare for Kids appeals process.

- The **Office of State Administrative Hearings (OSAH) conducts the** State Fair Hearings process. OSAH is staffed by **Administrative Law Judges (ALJs)** who adjudicate challenges under several state administrative programs. Georgia law defines a set of default procedural rules for OSAH appeals, but Medicaid and CHIP appeals deviate from those default procedures in certain respects.

As advocates seek to gain familiarity with the various Medicaid and PeachCare appeals procedures, it will often be unnecessary to determine the particular source of governing law for this or that procedural requirement. In some instances, however, Georgia's policies have gaps or inconsistencies, and may even conflict with binding federal law. In such instances, advocates may find it useful or necessary to challenge *the process itself* in addition to challenging a particular adverse decision made with respect to a particular individual. To that end, this manual describes the overlay of federal and state authorities that govern each set of appeals procedures, including statutes, agency rules and interpretive guidance, and contracts with private entities. These sources are all listed in Appendix B.

B. Fee-for-Service & Managed Care

Federal law allows states to choose among a variety of care delivery models in their Medicaid and CHIP programs. These models fall within two general categories: **fee-for-service (FFS)** and **managed care**. Like many states, Georgia relies on a mix of both models, but heavily favors managed care: managed care plans are now responsible for all PeachCare beneficiaries and 75% of Medicaid beneficiaries.[4] Figure 1 provides additional detail on which groups of Medicaid beneficiaries are enrolled in each type of care delivery model.

In both models, the state establishes rules that describe which individuals are eligible to enroll in the program and which benefits those individuals are eligible to receive. Those state rules must comply with all federal laws, and they apply regardless of whether the care is delivered through FFS or managed care.

In a FFS model, the state relies on healthcare providers to make individualized determination about a person's medical need for a particular service, although in some cases the state may require that the provider seek "prior authorization" from the state. The state is responsible for reimbursing providers for all services rendered. Georgia relies on FFS for certain high-needs populations, including individuals in a hospice or nursing home, as well as children enrolled in the Georgia Pediatric Program (GAPP).

In a managed care model, the state delegates many of its functions to private health plans. Georgia has chosen to enter into comprehensive risk contracts with **care management organizations (CMOs)** for a broad set of administrative and care delivery functions. (Under federal law, this type of risk-bearing entity is referred to as a "managed care organization" (MCO)).

In exchange for a monthly per-member payment (often referred to as a "capitation payment"), these CMOs take on responsibility for building and credentialing a network of providers, educating members about their Medicaid/PeachCare benefits, staffing customer service lines, performing prior authorization activities,[5] and reimbursing providers. The details of this relationship are set forth in a CMS-approved contract between

the state and the CMO. For a list of the specific populations that Georgia enrolls in CMO managed care plans, see Figure 2.

As of the time of writing, Georgia contracts with four CMOs: Amerigroup Community Care, CareSource, Peach State Health Plan, and WellCare of Georgia, Inc.[6] WellCare and Peach State Health Plan are in the process of merging, but for now, beneficiaries will continue to receive coverage from each organization.[7] All CMOs serve the "Georgia Families" managed care program, which covers most Medicaid and CHIP beneficiaries, as well as the "Planning for Healthy Babies" program for pregnant women. In addition, Amerigroup alone serves the "Georgia Families 360" program, a separate program for certain high-risk youth—including children in foster care in the legal custody of the Georgia Department of Human Services.

II. OVERVIEW OF THE APPEALS PATHWAYS IN GEORGIA MEDICAID AND CHIP

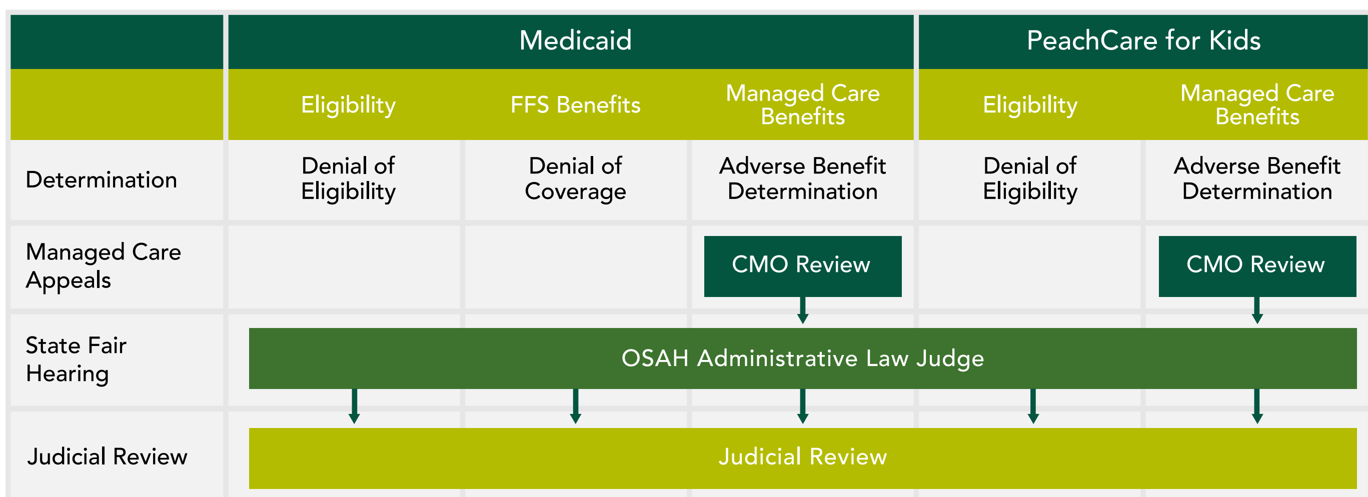
Federal law requires states to establish processes by which Medicaid/CHIP applicants and enrollees may appeal adverse decisions about program eligibility and coverage made by the state and by managed care plans.[8] Building on the constitutional due process recognized in 1970 by the Supreme Court's decision *Goldberg v. Kelly*,[9] federal rules define procedural rights to, for example:

- Receive timely and adequate notice of adverse actions and hearing dates;
- Review the evidence on which the adverse decision was based;
- Present evidence before an impartial arbiter;
- Be represented by a lawyer or other individual; and
- In some circumstances, request to expedite the hearing process or to continue benefits while the appeal is being resolved.

Although certain basic procedural rights apply across all types of appeals, Georgia has designed distinct appeals pathways that vary depending on the program (Medicaid or PeachCare for Kids), the delivery system (FFS or managed care), and the subject of the appeal (eligibility or coverage). These pathways are shown in Figure 1.

Figure 1

Overview: Appeals Pathways in Medicaid and PeachCare for Kids



Section A briefly introduces the two main types of appeals procedures: (1) CMO review of managed care benefits determinations; and (2) the State Fair Hearing process. Each of these processes receives its own step-by-step guide later in the manual. Section B explains how to determine which procedures apply to a given appeal.

A. Two Sets of Appeals Procedures: CMO Review and State Fair Hearings

To challenge a Medicaid or PeachCare decision, an applicant or beneficiary will proceed through one or both of the following appeals processes:

- ***CMO Review*** (see Section III). CMOs are responsible for making many types of benefit determinations (but not eligibility/enrollment decisions, which are handled by the state). If a managed care enrollee wishes to challenge an adverse benefit determination, the first step is to file an appeal with the CMO itself, which triggers a round of internal review (meaning, the appeal is decided by the CMO). These procedures are largely (but not entirely) identical for managed care enrollees in both Medicaid and PeachCare for Kids. If the CMO upholds the adverse decision, the enrollee is entitled to seek external review through the State Fair Hearing process.
- ***State Fair Hearings*** (see Section IV). OSAH ALJs preside over these hearings, which are available for appeals that pertain to the following three subjects: (1) Medicaid and PeachCare eligibility/enrollment determinations; (2) benefit determinations regarding Medicaid FFS enrollees; and (3) managed care benefit determinations made by a CMO, but only after the enrollee has completed the CMO review process (described above). The ALJ's decision represents the state's final administrative decision. The losing party may seek judicial review.

B. Which Procedures Apply to Each Type of Appeal?

To determine which procedures apply to a given appeal, an advocate should ask the following questions, then consult the Figure 3 to identify the appropriate appeal pathway:

1. Which program is the client enrolled in or applying for—Medicaid FFS, Medicaid managed care, or CHIP managed care (PeachCare for Kids)?

See Figure 2 for a list of the eligibility categories that fall within each of these programs.

Figure 2

Medicaid Fee-for-Service
• Individuals in a nursing home • Individuals in hospice • Aged, blind, and disabled (with exceptions) • Children in the Georgia Pediatric Program (GAPP)
Medicaid Managed Care
• The following groups are automatically enrolled in the "Georgia Families" managed care program: o Children under 19 o Parent/caretaker with children Medicaid o Transitional Medicaid o Pregnant women o Newborns o Women eligible due to breast and cervical cancer o Refugees • Georgia Families 360 (for high-risk youth) • Planning for Healthy Babies (P4HB)
PeachCare for Kids Managed Care
PeachCare for Kids (CHIP) recipients are automatically enrolled in managed care through Georgia Families

Source: Georgia Families Frequently Asked Questions & Answers, available at https://www.caresource.com/documents/georgia-families-member-faqs-and-answers-508

2. Does this appeal challenge an adverse decision about eligibility/enrollment or about benefits?

The state makes eligibility/enrollment decisions about whether an individual should be admitted to, or terminated from, a given program. In reaching these decisions, the state considers whether the individual meets all program eligibility criteria, and whether the individual completed all the steps necessary to apply, enroll, renew coverage, etc.

Once an individual is enrolled in a program, the state or CMO makes benefits decisions about whether to allow and pay for particular services. Relevant decisions may include prior authorization determinations that deny, limit, or delay access to a service. In addition, disputes about out-of-pocket costs, such as premiums and co-pays, fall within the scope of benefits decisions for purposes of the appeals rules. (Section III.B provides additional detail on the meaning of "adverse benefit determination" for purposes of the CMO review process.)

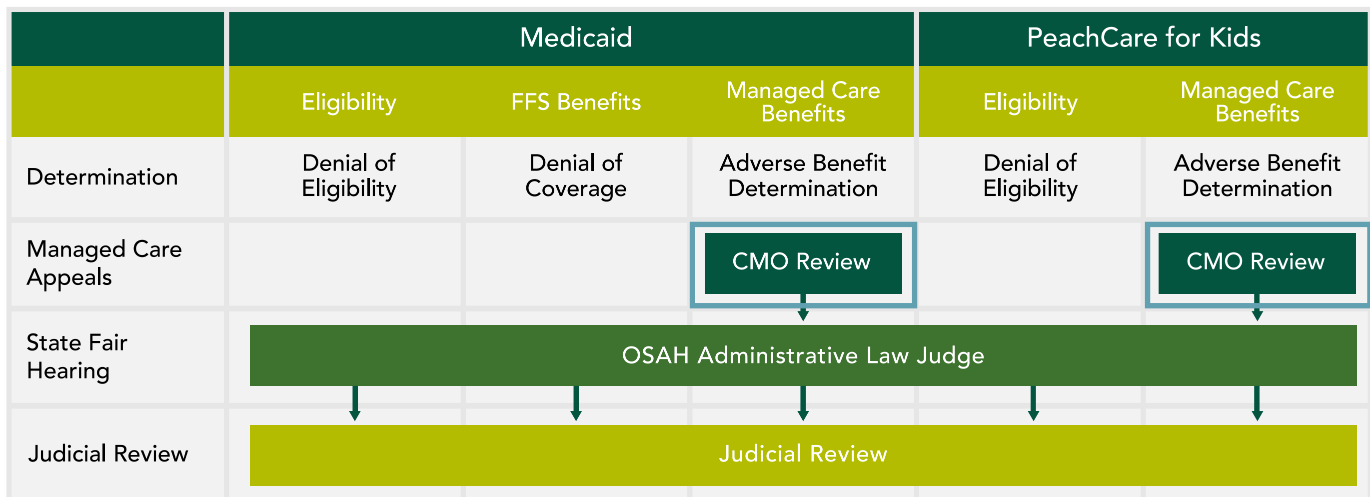
III. CMO REVIEW OF ADVERSE BENEFIT DETERMINATIONS IN MANAGED CARE

Individuals enrolled in managed care—whether under Medicaid or PeachCare for Kids—have the right to appeal an "adverse benefit determination" made by a CMO, such as a decision to deny access to a requested service, terminate a previously granted service authorization, or impose cost sharing. The first step is to ask the CMO itself to review the adverse benefit determination. *Eligibility* determinations, by contrast, are appealed directly to the state, as explained in Section IV.B.

This section describes the federal laws governing the CMO review process. As discussed in Section III.A, enrollees and advocates should also consult the member handbook and any other materials produced by the CMOs. These materials contain

Figure 3

Overview: Appeals Pathways in Medicaid and PeachCare for Kids



important details about where to send appeal requests and how to contact the CMO. Those details are subject to change. If the CMO upholds the adverse benefit determination, the enrollee may appeal the plan's decision to the state using the State Fair Hearing process, as described in Section IV. After the State Fair Hearing process is complete, the final administrative decision is reviewable by a judge.

A. Applicable Laws and Current Legal Inconsistencies

Federal regulations require each CMO to establish an internal appeals system that complies with a detailed set of procedural requirements.[10] These requirements are substantially identical across the Medicaid and PeachCare programs, with limited exceptions as described in this section.[11] Georgia's statutes, regulations, and Medicaid/CHIP state plans require compliance with those federal rules and generally do not add any details or requirements beyond the federal baseline.[12]

CMOs must distribute member handbooks and other materials that explain members' rights and benefits available under federal law, including instructions for filing appeals.[13] It is thus essential for enrollees and advocates to consult the current version of the CMO member handbook before initiating an appeal. Links are provided below to the current member materials *(as of October 1, 2020)*.

At the time of this writing, the regulatory landscape for CMO review of PeachCare benefits is in flux. After CMS overhauled the federal managed care rules in 2016, Georgia sought to standardize the appeals procedures for PeachCare and Medicaid, including by seeking CMS approval for amendments to the CHIP state plan. By the time CMS approved those changes in 2017,[14] DCH had already entered into contracts with the current set of CMOs. Those contracts incorporate the pre-amendment PeachCare appeals procedures, which fail to reflect current federal law and Georgia's current CHIP state plan. Notable inconsistencies pertain to maintenance of benefits (see Section III.D.2) and requesting a State Fair Hearing after CMO review (see Section III.F.3). As described below, the CMOs have responded to these inconsistencies in different ways, with the result that each CMO's member handbook uses a slightly different set of timelines and terminology. In addition to creating confusion, these inconsistencies may risk depriving enrollees of their rights under current law.

B. What Types of CMO Actions May Be Appealed Through the CMO Review Process?

The CMO review process is available for enrollees to challenge "adverse benefit determinations," as defined below. Note that federal regulations also require CMOs to have a process by which beneficiaries may file a grievance, which is "an expression of dissatisfaction" about any matter other than

Figure 4

CMO	Member Handbooks for Georgia's Medicaid/CHIP Managed Care Programs		
Amerigroup	Georgia Families	Planning for Healthy Babies	Georgia Families 360°
CareSource	Georgia Families	Planning for Healthy Babies	N/A
Peach State Health Plan	Georgia Families	Planning for Healthy Babies	N/A
WellCare	Georgia Families	Planning for Healthy Babies	N/A

an adverse benefit determination (such as the quality of services provided or a CMO's proposed extension of time to make an authorization decision).[15]

Under federal law, an "adverse benefit determination" includes any of the following actions:[16]

- A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- A reduction, suspension, or termination of a previously authorized service;
- A denial of payment for a service, in whole or in part;
- Failure to provide services in a timely manner, as described in the CMO member handbook (which must contain a description of the "amount, duration, and scope" of benefits);[17]
- A denial of a request to dispute a financial liability (e.g., cost sharing, co-payments, premiums, deductibles, coinsurance, and other liabilities);
- Failure to act within required time frames regarding:
    - o Service authorization decisions (required time frames are described in Section III.C.2);[18]
    - o The resolution of non-expedited appeals (typically 30 days) or of grievances (typically 90 days);[19] and
- For a resident of a rural area that is served by a single CMO, a denial of the enrollee's request to obtain services outside the CMO's network.[20] (As of the time of writing, this is likely inapplicable because of the overlap in CMO service areas.)

CMO DELAY MAY ENTITLE AN ENROLLEE TO A FAIR HEARING

A CMO's failure to comply with federal timelines for a standard (non-expedited) appeal qualifies as an adverse benefit determination, which may itself be appealed. In addition, if a CMO fails to comply with federal timelines for either a standard or expedited appeal, the enrollee is considered to have "exhausted" the CMO review process; the enrollee can, at that point, bypass any remaining CMO review procedures and proceed directly to a Fair Hearing (as described in Section III.F.2).

C. How Will the Enrollee Be Notified of an Adverse Benefit Determination?

A CMO must give a plan member timely and adequate written notice of an adverse benefit determination.[21]

1. Content

The notice must explain all of the following:[22]

- The adverse benefit determination the plan has made or intends to make;
- The reasons for the action;
- The enrollee's right to request, free of charge, access to and copies of all documents and other information relevant to the adverse benefit determination;
- The right to request an appeal through CMO review and/or a State Fair Hearing, as applicable, and how to do so;
- The right to request expedited review;
- The right to request the maintenance of benefits pending resolution of the appeal (if applicable); and

- The standards and processes for requesting expedited review.

2. Timing

The CMO must mail the notice within the following time frames:[23]

- Termination, suspension, or reduction of previously authorized service: At least 10 days before the date of action, subject to certain exceptions; [24]
- Service authorization requests:[25]
  - For standard requests, 14 days or as otherwise provided in the member handbook [26] (although the CMO may, in some circumstances, extend the timeline for up to 14 additional days, and must inform the enrollee of the delay and of the right to file a grievance challenging the delay);
  - For expedited requests, 72 hours; and
  - For requests concerning outpatient prescription drugs, 24 hours.

CMOS HAVE NOT RELIABLY PROVIDED TIMELY NOTICES

Georgia advocates report that managed care enrollees do not consistently receive timely notice of CMO adverse benefit determinations. In such situations, it is important to document key dates—such as the date written on the notice, the date the notice was actually received, and the effective date of the adverse action—and to respond immediately by filing a complaint with DFCS and/or a request for CMO review. Depending on the circumstances, the enrollee may be excused from compliance with certain deadlines, or may perhaps be permitted to bypass the CMO review process entirely.

D. What Are the Procedures for Requesting CMO Review?

Managed care enrollees in Medicaid and PeachCare have **60 days** from the date on the adverse benefit determination notice to request CMO review.[27] This request may be oral or in writing, in accordance with the instructions on the notice of adverse benefit determination; however, an oral request must be followed by a written and signed appeal unless the enrollee requests an expedited resolution (see Section III.D.1).[28] A provider or other authorized representative may request an appeal on the enrollee's behalf and represent the enrollee during the appeal process, as long as the enrollee provides written consent.[29]

THE "MAINTENANCE OF BENEFITS" DEADLINE MAY COME BEFORE THE APPEAL FILING DEADLINE

Although the deadline for filing an appeal is 60 days from the date on the adverse benefit notice, the deadline for requesting maintenance of benefits will likely come much sooner, as early as *10 days* after the adverse benefit notice. This is a critical protection. If a CMO is ending a current service or benefit (e.g., home care), the enrollee can ask to keep receiving that service until the appeal is resolved, as long as the request complies with the time frames discussed in Section III.D.2.

The CMO must acknowledge receipt of the appeal.[30] Georgia's PeachCare plan specifically requires acknowledgement of receipt within 10 days;[31] the state has not defined a specific response timeline for appeals filed by Medicaid beneficiaries, but *as of the time of writing*, all four CMOs apply the 10-day limit across both programs.

1. Expedited Review

Enrollees have a right to request expedited review of their adverse benefit determination. The CMO *must* expedite the review if the CMO determines—or if a provider indicates in connection with the enrollee's request—that the standard CMO review timeline could seriously jeopardize the enrollee's life; physical or mental health; or ability to attain, maintain, or regain maximum function.[32] An expedited appeal will generally be decided within 72 hours, although resolution may be delayed for the reasons described in Section III.F.2. If the CMO denies a request for expedited review, the CMO must take the following steps:[33]

- Make reasonable efforts to give the enrollee prompt oral notice of the denial of expedited review;
- Within two calendar days, give written notice of the reason for denying expedited review; and
- Resolve the appeal as expeditiously as the enrollee's health condition requires, but in no event longer than the time allowed under the standard appeal resolution time frame.

2. Maintenance of Benefits

If a CMO authorizes a particular service for an enrollee, then later decides to limit or terminate that service, the enrollee may be entitled to request "maintenance of benefits" (also referred to as "continuation of benefits"). If the request is granted, then the benefits continue as previously authorized until the appeal reaches a final resolution. This section begins by describing the federal right for Medicaid beneficiaries to request maintenance of benefits,[34] then discusses the more uncertain landscape with respect to PeachCare for Kids.

Medicaid. To maintain or regain access to benefits during the appeals process, an enrollee must file a request for maintenance of benefits in conjunction with the request for CMO review. (Note that, although a provider may generally serve as an enrollee's authorized representative for the purpose of CMO review procedures, a provider is *not* permitted to file a "maintenance of benefits" request on the enrollee's behalf.[35]) The deadline for filing this request is the **later** of the following: (1) **10 calendar days** after the CMO's notice of adverse benefit determination; or (2) the intended effective date of the adverse benefit determination.[36]

The CMO *must* grant continuation of benefits if the following conditions are met: the member filed the request for an appeal on time; the appeal involves the termination, suspension, or reduction of previously authorized services; the services were ordered by an authorized provider; and the period covered by the original authorization has not expired.[37] Benefits will be continued or reinstated while the CMO appeal (and, if necessary, the subsequent Fair Hearing) is pending.[38]

If the enrollee's appeal is ultimately unsuccessful, the CMO may—but is not required to—seek to recover from the enrollee the cost of any services furnished during the appeal due to a "maintenance of benefits" request.[39]

PeachCare for Kids. Unlike Medicaid, the federal CHIP rules do not require that managed care plans offer maintenance of benefits. However, Georgia's 2017 CHIP state plan amendment provides that a PeachCare enrollee has "the right to provide documentation or explanation of the member's medical need for consideration during the Appeal."[40] The amendment does not describe specific procedures for requesting or granting continuation of benefits.

As of the time of writing, two of Georgia's four CMOs (Amerigroup and WellCare) appear to permit PeachCare enrollees to request maintenance pursuant to the same procedures as Medicaid enrollees. The other two CMOs (CareSource and Peach State) state in their member handbooks that PeachCare enrollees

are not entitled to request maintenance of benefits. Advocates may thus wish to request maintenance of benefits for *all* enrollees who need those benefits pending appeal, irrespective of CMO, citing the language in the 2017 plan amendment.

E. What Happens During the CMO Review Process?

Enrollees (and their authorized representatives) are entitled to a reasonable opportunity to present their case in person and in writing, including the right to present evidence and testimony and to make legal and factual arguments.[41] As part of the enrollee's preparation, the enrollee has a right to request, free of charge, reasonable access to and copies of the CMO's records and other information, including:[42]

- The enrollee's own case file and medical records;
- Information pertaining to the CMO's medical necessity criteria, as well as any processes, strategies, or evidentiary standards used in setting coverage limits; and
- Any other evidence considered or generated in connection with the original adverse benefit determination or the appeal.

The individual(s) assigned by the CMO to review the appeal must not have been involved in a previous level of review, nor may they be subordinates of anyone involved in prior review. In addition, reviewers must have appropriate clinical expertise in treating the enrollee's condition or disease if the appeal concerns clinical issues, such as a denial of services based on lack of medical necessity.[43]

Reviewers must consider all comments, documents, records, and other information submitted by the enrollee, including information that may not have been considered or submitted in connection with the initial adverse benefit determination.[44]

F. What Happens When the CMO Review Process is Complete?

The CMO must provide written notice of the reviewer's decision. For expedited reviews, the CMO must also make reasonable efforts to provide oral notice.[45] Federal law specifies that CMOs may have only one level of internal appeal,[46] and so, an enrollee who receives an unfavorable outcome after CMO review may then appeal to the State Fair Hearing process.

1. Content

The notice must describe the results of the CMO review and the date it was completed. If the reviewer decided in favor of the CMO, the notice must also describe:[47]

- The enrollee's right to request a State Fair Hearing, and how to do so;
- The right to request a continuation of benefits while the State Fair Hearing is pending and how to make such a request.

2. Timing

Standard Review. The CMO reviewer must reach a decision "as expeditiously as the enrollee's health condition requires," but generally no later than 30 days from the date the CMO received the appeal request.[48]

Expedited Review. For expedited claims, CMOs will generally provide a response no later than 72 hours after the CMO receives the appeal.[49] The CMO must make reasonable efforts to provide oral notice to the member.[50]

Extending the CMO Review Timeline. The timeline for a standard or expedited appeal may be extended by up to 14 calendar days if either: (1) the enrollee requests the extension; or (2) the CMO demonstrates that additional information is needed and that the delay is in the enrollee's interest.[51] If the CMO unilaterally extends the time frame under this second option, it must take the following steps:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay;

- Within two calendar days, give written notice of the reason for the extension and inform the enrollee of the right to file a grievance to contest that decision; and
- Resolve the appeal as expeditiously as the enrollee's health condition requires before the expiration of the extension.[52]

CMO's Failure to Act. If a CMO fails to adhere to these notice and timing requirements, the enrollee is deemed to have exhausted the CMO review process and may proceed directly to a State Fair Hearing.[53]

3. Outcome and Next Steps

If the CMO reviewer overturns the adverse benefit determination, the CMO must authorize or provide the disputed services within 72 hours of receiving notice of the decision, or sooner if the enrollee's health condition so requires.[54] If the enrollee received continued benefits while the appeal was pending, the CMO must pay for those services.[55]

If, however, the CMO reviewer upholds the adverse benefit determination (or fails to act within required time frames), the enrollee may appeal to the state through the appropriate State Fair Hearing process, as described in Section IV.[56] The enrollee must request a State Fair Hearing within 120 calendar days of the date of the CMO's notice of resolution.[57] (Note, however, that enrollees have only 10 days to request that benefits be maintained for the duration of the State Fair Hearing process, as described below in Section IV.D.2.) The notice of appeal resolution and the CMO member handbook will provide additional instructions on how to request a State Fair Hearing.[58]

G. Accessibility Measures

The CMO must provide enrollees with reasonable assistance in completing forms and taking the procedural steps involved in an appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.[59]

The CMO's written notices (including the notices of adverse benefit determination and resolution) must comply with federal format and language standards for managed care entities.[60] These standards[61] require that written materials be made available in all non-English languages that are prevalent in a CMO's service area, in addition to requirements such as using "easily understood language" and large font. CMOs must notify enrollees that oral interpretation is available for any language and that written translation is available in prevalent languages; that auxiliary aids and services are available upon request for enrollees with disabilities; that these services come at no cost to the enrollee; and how to access those services.

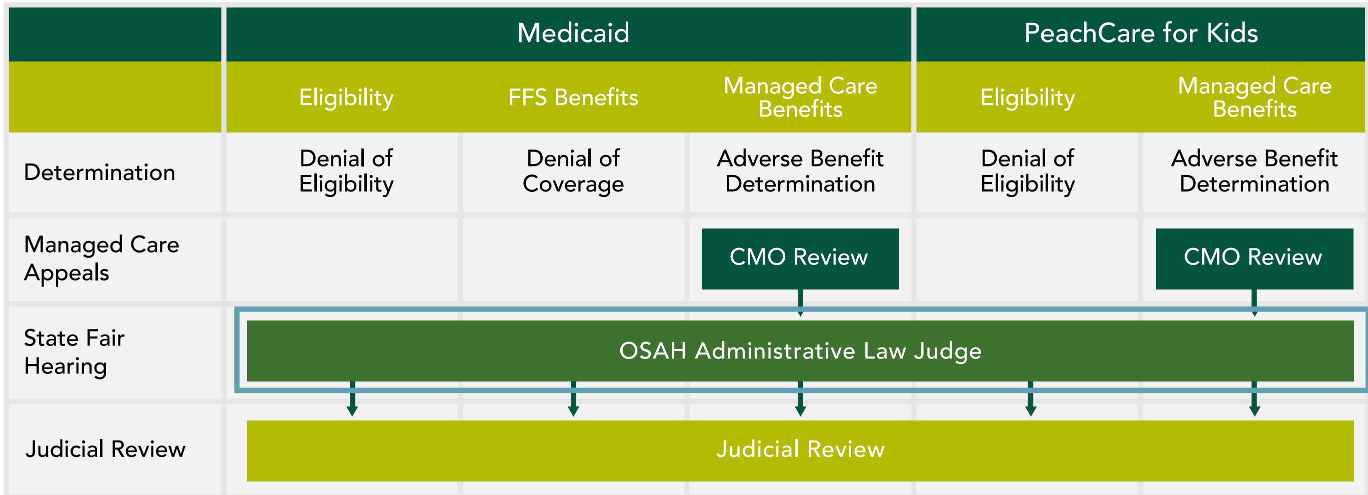
PRACTICE NOTES FOR CMO REVIEWS

Under state and federal law, the transition from CMO review to State Fair Hearing should operate much the same in both Medicaid and PeachCare for Kids. With respect to PeachCare, however, CMOs have not yet caught up with recent changes in federal law and Georgia's CMS-approved CHIP state plan. As of the time of writing, three of the four CMOs (Amerigroup, CareSource, and WellCare) still use the outdated terminology of "Formal Grievance Committee" review (rather than "State Fair Hearings"). In addition, one CMO (CareSource) informs its members that an appeal must be filed within 30 days of the CMO reviewer's decision, whereas federal law now provides a filing period of 120 days. Advocates may wish to err on the side of caution by adhering to the procedures described in a particular CMO's member materials, but should also be mindful of the federal law provision in the event a client seeks an appeal after 30 days but before the 120-day limit.

IV. STATE FAIR HEARINGS

Figure 5

Overview: Appeals Pathways in Medicaid and PeachCare for Kids



Through the State Fair Hearing process, individuals may seek administrative review of adverse decisions regarding eligibility, enrollment, or benefits in either Medicaid or PeachCare for Kids. (Managed care enrollees may first need to exhaust the CMO review process for any appeal that concerns benefits, as described above in Section III.) State Fair Hearings are conducted by OSAH ALJs. If the client receives an unfavorable determination from the ALJ, the client may then seek judicial review.

A. Applicable Laws and Current Ambiguities

Federal law defines the minimum requirements for State Fair Hearing processes in the Medicaid and CHIP programs.[62] Georgia has designated OSAH to conduct State Fair Hearings, thereby importing the default hearing procedures defined in the state's Administrative Procedure Act (APA) and OSAH's implementing regulations.[63] The Georgia Medicaid Manual provides additional detail regarding the State Fair Hearing procedures that apply to appeals concerning actions taken by the state, such as a denial or termination of eligibility.[64] The state has not, however, issued guidance to clarify the procedures that apply to appeals of adverse benefit decisions arising out of *CMO review*, even though these appeals are subject to certain special considerations under federal law, as described in this section. In addition, the state's guidance does not address the federal requirement to make expedited hearing procedures available in certain circumstances.

B. Which Adverse Actions May Be Appealed Through the State Fair Hearing Process?

The State Fair Hearing process is available for the following types of appeals:[69]

- An appeal concerning Medicaid or PeachCare *eligibility or enrollment*. An *applicant or beneficiary* (FFS or managed care) may seek to challenge:
    - o The state's decision to deny, terminate, suspend, or reduce Medicaid eligibility; or
    - o The state's failure to make a timely determination of eligibility (generally, within 90 days for an individual applying on the basis of disability, and 45 days for other applicants).[70]
- An appeal by a Medicaid *FFS beneficiary* concerning:

- o A determination made by the state regarding *benefits*, such as a decision to terminate, suspend, or reduce covered benefits or services;
- o An increase in *premiums or cost sharing*; or
- o The state's failure to act with reasonable promptness on a claim regarding these issues.

- An appeal by a Medicaid or PeachCare *managed care enrollee* who challenged a CMO's adverse benefit determination using the CMO review process (discussed in Section III) and received an unfavorable result, and now seeks state review.

The state need not grant a hearing if the sole issue raised in the appeal is a federal or state law that required an "automatic change" adversely affecting some or all beneficiaries.[71]

GEORGIA HAS SUBSTANTIALLY REVISED ITS STATE FAIR HEARING PROCEDURES

This manual describes Georgia's State Fair Hearing procedures as of October 2020. These procedures are fairly new, however. Advocates who have previous experience with State Fair Hearings in either Medicaid or PeachCare for Kids should be sure to review the updated procedures in the Georgia Medicaid Manual. Relevant changes include the following:

- ***The OSAH ALJ's Decision is Final.*** Previously, Georgia used a two-level State Fair Hearing system for the Medicaid program. The OSAH ALJ made a preliminary decision, which was subject to review by either DCH or DHS, depending on the type of appeal. However, these procedures failed to align fully with recent amendments to Georgia's APA, and also with the federal rules that govern Medicaid appeals. To rectify these inconsistencies, the state has implemented a one-level State Fair Hearing system in which the OSAH ALJ's decision represents the state's final administrative determination.[65] The losing party before the ALJ may proceed directly to judicial review, as described in Section III.F.3.
- ***Aligning Medicaid and PeachCare Appeal Procedures.*** Until recently, Georgia's PeachCare hearing procedures were quite different from the procedures applicable to Medicaid decisions.[66] In 2017 and 2018, however, Georgia revamped its PeachCare appeals procedures to more closely align them with the Medicaid's State Fair Hearing procedures.[67]

These changes are reflected in the current version of the Georgia Medicaid Manual, although certain references in preexisting rules have not been updated to reflect this new structure. In particular, Georgia's regulations on Medicaid appeals do not reflect the current practice of delegating State Fair Hearings to OSAH, instead describing procedures involving agencies that no longer exist, such as the Department of Medical Assistance (which was reorganized as part of DCH) and the Department of Human Resources (reorganized as DHS).[68]

C. How Will the Applicant or Beneficiary Be Notified of the Adverse Action?

Medicaid and PeachCare applicants and beneficiaries are entitled to written notice of an adverse action, as described in this section.[72] (Note: This section describes notifications regarding Medicaid and PeachCare eligibility, as well as adverse decisions about benefits in Medicaid FFS; for information on adverse benefit determinations for managed care enrollees, see Section III.)

1. Content

The notice must explain all of the following:[73]

- The proposed action, including the effective date;
- The reason for the action (for adverse actions concerning Medicaid, the state must provide a citation to "the specific Medicaid regulation" that justifies the adverse action);[74]
- The right to request an appeal and how to do so;
- The standard and expedited time frames for review;
- The right to request the maintenance of benefits pending resolution of the appeal (if applicable);
- The right to be represented in the hearing process;
- The availability of free legal representation, including telephone number; and
- A telephone number to contact for additional information.

2. Timing

Medicaid. The state must generally provide at least 14 days' advance notice of an adverse action. In some cases, however, the state need only provide notice as of the date the action is taken, including the following scenarios:[75]

- The state is denying an application for enrollment or benefits;
- The state is effectuating a change in eligibility or benefits that is mandated under state or federal law;
- The state is terminating or limiting benefits in accordance with a schedule that was established at the time the benefits were initially approved.

PeachCare for Kids. When the state suspends or terminates PeachCare eligibility, federal law requires the state to provide "sufficient notice" to enable the child's parent or caregiver to "take any appropriate actions that may be required to allow coverage to continue without interruption."[76] As of the time of writing, Georgia has not specified how many days' notice are required under this standard.

GEORGIA HAS AN UNEVEN TRACK RECORD WITH RESPECT TO TIMELY NOTICES OF ELIGIBILITY & TERMINATION DECISIONS

In 2018, 30,000 Medicaid beneficiaries were terminated without proper notice as the state transitioned its enrollment procedures to a new computer system.[77] Advocates report that, since that time, the state has continued to terminate beneficiaries without sending timely notice and, in some cases, without sending notice at all. Once the beneficiary becomes aware of the termination—perhaps because their healthcare provider was unable to bill Medicaid for their care—the beneficiary is often able to reestablish eligibility by notifying DFCS, assuming the beneficiary continues to meet all eligibility criteria. Advocates should be mindful of these issues in the state's program operations and should be prepared to raise the lack of timely notice as a "good cause" explanation where necessary to explain a missed appeal deadline.

D. What Are the Procedures for Requesting a State Fair Hearing?

To appeal an adverse action, the client must submit a hearing request within **30 days** of notification of the decision.[78] Although Georgia's guidance is not entirely clear, this timeline likely runs from the date *written on the notice*, as opposed to the date the client *receives the notice*. Advocates are advised to consult the language on the notice itself to clarify this point. An untimely request may be considered if the ALJ determines that the client has shown "good cause" for the delay.[79] The request for an appeal may be oral or in writing; an oral request must, however, be followed by a written request within 15 days.[80] With the client's written consent, a provider or other authorized representative may request a hearing on the client's behalf and represent the client during the hearing process.[81]

THE "MAINTENANCE OF BENEFITS" DEADLINE MAY COME MUCH SOONER THAN THE APPEAL FILING DEADLINE

Practitioners should be mindful that the deadline for filing a request for maintained/reinstated benefits comes much earlier than the deadline for filing an appeal, as described in Section IV.D.2.

Clients may submit their hearing requests to any DFCS office (for Medicaid appeals) or RSM (for appeals concerning PeachCare for Kids).[82] These agencies will review the request and may reach out to the client to determine whether a hearing can be avoided by, for example, identifying and correcting an error made by the state or helping the beneficiary to understand the legitimate basis for the adverse action.[83] If the state is unable to achieve an informal resolution, the state will forward timely requests to OSAH, the agency responsible for conducting the initial hearing.

PRACTICE TIP

Georgia advocates recommend sending hearing requests to DFCS/RSM and copying OSAH, the agency that will assign an ALJ to the case. That way, if DFCS neglects to process the hearing request in time, the advocate may request a hearing date directly from OSAH based on the originally filed notice of appeal.[84]

For more information on Georgia's ALJs, including details on how to request accommodations or a different hearing date, see https://osah.ga.gov.

(Note: The discussion in this section (Section IV.D) does *not* apply to managed care enrollees appealing from the CMO review process. See Section III.F for details about initiating a State Fair Hearing following CMO review. By contrast, the following sections (Section IV.D.1 and Section IV.D.2) on expedited review and maintenance of benefits do apply to clients appealing from CMO review.)

1. Expedited Review

Clients have a federal right to request expedited review under certain circumstances, as described in this section.[85] The state must, as expeditiously as possible, notify the client whether the request has been granted (beginning with oral or electronic notice, followed by written notice).[86] Even if an appeal has been designated for expedited review, the timeline may be delayed for the reasons described in Section IV.F.2.

GEORGIA'S LAW AND GUIDANCE FAIL TO DISCUSS MANDATORY PROCEDURES FOR EXPEDITED REVIEW

Although expedited procedures are required under federal law, Georgia's Medicaid Manual does not mention any expedited procedures. The OSAH regulations, meanwhile, direct ALJs to "conduct the hearing in such manner as justice requires" whenever expedited procedures are "required by law" or are deemed "necessary to protect the interests of the parties."[87] Given the absence of state guidance, this manual describes the federal requirements for expedited review.

For **Medicaid appeals that originate within the State Fair Hearing process** (i.e., those pertaining to Medicaid eligibility/enrollment or FFS benefits), an appeal must be expedited if the standard time frame could jeopardize the client's "life, health or ability to attain, maintain, or regain maximum function."[88] Expedited appeals must be resolved "as expeditiously as possible," but no later than the following time frames:[89]

- For a claim related to eligibility, 7 working days after the agency receives a request for expedited fair hearing; and
- For a claim related to Medicaid FFS benefits, 3 working days after the agency receives the client's case file.

For **Medicaid appeals arising out of CMO review** of an adverse benefit determination, an expedited State Fair Hearing is available if either of the following applies: (1) the CMO designated the appeal as expedited but failed to resolve it within the expedited time frame; or (2) the appeal was resolved within the time frame for expedited resolution and the decision was adverse to the client. An appeal that meets either of these criteria must be decided by the state within 3 working days after the agency receives the case file and information from the CMO.[90]

For **PeachCare appeals concerning eligibility or enrollment**, "the State must consider the need for expedited review when there is an immediate need for health services."[91]

For **PeachCare appeals concerning benefits**, the state's review must be "completed in accordance with the medical needs of the patient," but no later than three days "if the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function."[92] Note, however, that these federal requirements concern benefits appeals that originate within the PeachCare Fair Hearing process; unlike the federal Medicaid rules, the CHIP rules do not define timelines specific to Fair Hearings that arise out of CMO review. Georgia's CHIP state plan mentions the possibility of expedited procedures, but does not elaborate on these procedures.[93]

2. Maintenance of Benefits

When clients file their appeals, they may request to maintain or reinstate eligibility or benefits that are affected by the adverse action.[94] The deadline for filing such a request is **10 days** after the date on the written notice of adverse action.[95] Managed care enrollees appealing from CMO review must, similarly, file their request for maintenance of benefits within **10 days** of receiving the notice of CMO resolution.[96] The notice of state action or CMO resolution will explain the specific circumstances under which benefits can be continued.[97] If a client loses the state hearing, the state has the right to ask the client to repay the continued benefits.

PRACTICE TIP

Georgia practitioners strongly recommend requesting to maintain or reinstate benefits whenever possible. Although the state has the right to recover the costs of any maintained services from clients who lose their appeal, the state has, historically, almost never sought to enforce that right.

THE CLOSURE OF DFCS OFFICES MAY CREATE BARRIERS FOR BENEFICIARIES

In response to the COVID 19 pandemic, DFCS reduced in-person operations at many of its locations. DFCS has since suggested that some offices may remain closed permanently, which could jeopardize access to in-person hearings for beneficiaries who live far away from the nearest open DFCS office. Advocates should bear in mind that OSAH regulations allow hearings to be conducted by alternate means—such as by telephone or two-way videoconferencing—if all parties have consented and the alternate means will not "jeopardize the rights" of any party.[102]

E. What Happens During the OSAH Hearing Process?

Clients are entitled to a hearing before an impartial adjudicator, which is consistent with Georgia's approach of delegating the initial hearing to an OSAH ALJ.[98] At least 10 days before the hearing, OSAH will notify the client of the date and time of the hearing, which could potentially be conducted at a government office in the client's county (such as the DFCS office), at the OSAH office in Atlanta, by telephone, or by audio-video telecommunications.[99] The client may request to change the time and/or location of the hearing for good cause.[100] The ALJ has the option of dismissing the appeal entirely if the client fails to attend the hearing without good cause.[101]

Hearing procedures are governed by federal Medicaid and CHIP law, and also by state OSAH rules on administrative proceedings. ALJs have the authority to relax OSAH regulations as necessary "to facilitate the resolution of a matter without prejudice to the parties and in a manner consistent with . . . applicable law."[103] ALJs may not disregard federal law, but do have the authority to "determine which law governs a hearing when [an OSAH rule] conflicts with or is supplemented by a state or federal statute or rule."[104]

Clients (and their authorized representatives) are entitled to present their case before the ALJ, including the right to provide evidence and offer testimony and to question or refute the state's (or CMO's) evidence, such as by cross-examining witnesses.[105] The ALJ's decision must be based exclusively on the evidence introduced at the hearing,[106] but the record is not limited to evidence that was considered by the state or CMO when it made the underlying adverse decision.[107] That said, there may be due process concerns if the state or CMO articulates new justifications for an adverse action without providing sufficient notice, thereby depriving the client of a meaningful opportunity to prepare a response.

When preparing for the hearing, the client has a right to examine the case record and all other pertinent documents and records, and also to subpoena witnesses.[108] DFCS represents the state Medicaid agency during appeals that concern actions taken by the state. In appeals arising out of CMO review, the CMO represents its own interests. If the hearing involves medical issues (such as a diagnosis or a physician's report), the ALJ may order a medical assessment at agency expense.[109]

COME PREPARED WITH YOUR OWN EVIDENCE

The Georgia Medicaid Manual provides that DFCS is responsible for ensuring that relevant witnesses and records are present at a State Fair Hearing.[110] Georgia practitioners suggest, however, that DFCS does not reliably perform that duty. Advocates are advised to independently confirm the presence of key witnesses and to bring their own copies of key records, relevant laws, and other important documents.

The state generally bears the burden of proof in OSAH hearings, including when "an applicant or recipient of a public assistance benefit" challenges "an agency action reducing, suspending, or terminating a benefit."[111] After the state has presented its evidence, the client may move for "involuntary dismissal" on the ground that the state failed to carry its burden; if the ALJ denies the motion, the client retains the right to present their own evidence.[112]

F. What Happens When the OSAH ALJ Reaches a Decision?

The ALJ must issue a written decision that meets the following requirements.[113]

1. Content

The decision must be based exclusively on evidence introduced at the hearing.[114] The written decision must describe the ALJ's reasoning, identify supporting evidence and policy, and make findings of fact and conclusions of law (including citations to regulations that support the decision).[115] If the ALJ's decision is adverse to the client, the notice must also describe the client's right to seek judicial review, as described in Section IV.F.3.[116]

2. Timing

Standard Review. According to the Georgia Medicaid Manual, the ALJ's decision must be issued within **90 days** from the date the written hearing request was received by the agency, except in the event of a postponement or continuance.[117] This timeline creates certain tensions with federal Medicaid law, however, as described in the text box.

Expedited Review. The timelines for expedited review are generally as follows (as described in Section IV.D.1):

- Appeals concerning *Medicaid eligibility/ enrollment*: 7 days.
- Appeals concerning *PeachCare eligibility/enrollment*: No expedited timeline specified.
- Appeals concerning *Medicaid and PeachCare benefits*: 3 days.

Extending the State Fair Hearing Timeline.

- *Medicaid appeals.* Federal law allows the state to extend the State Fair Hearings timeline only in the following "unusual circumstances": (1) the agency cannot reach a decision because the client requests a delay or fails to take a required action; or (2) there is an administrative or other emergency beyond the agency's control.[121] If one of these criteria is met, the hearing offer may grant an extension of up to 30 days.[122]
- *PeachCare benefits appeals.* Georgia's CHIP state plan permits the timeline for a standard or expedited benefits appeal to be extended by up to 14 days if either: (1) the enrollee requests the extension; or (2) the CMO demonstrates that additional information is "necessary" to adjudicate the appeal and has notified the client of its intent to seek an extension.[123]
- *PeachCare eligibility/enrollment appeals.* Neither federal law nor Georgia's CHIP state plan specifies extension procedures

GEORGIA'S TIMELINE FOR MEDICAID FAIR HEARINGS APPEARS TO EXCEED FEDERAL LIMITS

Georgia's timelines for Medicaid Fair Hearings may, in some circumstances, exceed the limits established in federal law. (The federal CHIP rules are more flexible. So, Georgia's procedures do not necessarily create parallel concerns with respect to PeachCare appeal timelines.) Advocates should be mindful of these federal requirements to ensure that Medicaid beneficiaries are not deprived of their right to swift resolution of Medicaid appeals. Points of potential conflict include the following:

- First, the Georgia Medicaid Manual measures the 90-day timeline for ALJ review starting from "the date the written request for a hearing is received by the agency."[118] Under the federal Medicaid rules, by contrast, the overall 90-day clock runs from the date of any hearing request, written or oral.[119] As described above, an oral request may precede a written request by up to 15 days.
- Second, for Medicaid Fair Hearing appeals that arise out of the CMO review process, federal law requires that a final administrative determination be made within 90 days *of the date the client originally filed an appeal with the CMO* (excluding any days between the CMO reviewer's decision and the date the client filed for State Fair Hearing review).[120]

in this type of appeal. Under the default OSAH procedures, however, the ALJ may grant a continuance "upon a showing of good cause."[124]

3. Outcome and Next Steps

The ALJ's decision "is a final decision that may only be appealed by filing a petition for judicial review."[125] If the ALJ's decision is favorable to the client, the state must continue any enrollment or benefits that were maintained during the hearing and must retroactively approve any benefits that were discontinued.[126]

A decision against the client results in withdrawal of any maintained eligibility or benefits. The state also has a right (but not an obligation) to collect from the client the costs of any benefits that were maintained, as noted in Section IV.D.2. Because the ALJ's decision represents the state's final administrative determination, a client who loses before the ALJ has no further administrative remedies available, and so may seek judicial review. A petition for judicial review must be filed within 30 days after service of the final decision or, if a rehearing is requested, **within 30 days** after the decision thereon.[127] The petition may be filed in the Superior Court of Fulton County or in the superior court of the client's county of residence.[128]

The petition must state the nature of the client's interest, facts showing that the client is aggrieved by the decision, and any grounds upon which the client contends that the decision should be reversed or modified.[129] In addition, either the agency or the court may order a stay of the adverse final decision "for good cause shown."[130] Either party may request to submit additional evidence as long as the evidence is "material" and there was "good cause" for not introducing it earlier.[131] The review "shall be conducted by the court without a jury," and the court shall not disturb the agency's judgment "as to the weight of the evidence on questions of fact."[132]

G. Accessibility Measures

Upon request, the state must provide clients with reasonable assistance in completing forms and taking the procedural steps involved in an appeal.[133] The State Fair Hearing process must be made accessible to individuals with limited English proficiency or disabilities, including through the provision of auxiliary aids and interpretation services at no cost to the client.[134] Enrollees may request assistance from the agency for transportation to and from the hearing.[135]

V. STRATEGIC RECOMMENDATIONS FOR ADVOCATES

(1) **Be aggressive in enforcing an enrollee's constitutional, federal, and state procedural rights.** CMOs and state agencies make mistakes, which can be addressed through the appeal process. A clear articulation of error may even be sufficient to achieve an early settlement without a hearing.[136]

(2) **Exercise your right to review the case file and other relevant documents.** In addition to assisting with hearing preparation, this step may allow you to avoid a hearing entirely. For example, you may discover that the adverse decision was issued due to a missing document that you are now able to provide.

(3) **Provide clear, concise briefing on the relevant legal principles and policy documents.** Consider including copies of relevant laws, regulations, or cases for easy reference by the adjudicator.

(4) **Prepare your witnesses.** Make sure that the client and any other witnesses know what to expect from the hearing so they are prepared to testify and so you know what they are likely to say on the stand.

RAISING AND PRESERVING CONSTITUTIONAL ARGUMENTS

OSAH ALJs do not have the authority to resolve challenges under the U.S. Constitution or the Georgia Constitution, but may, at the ALJ's discretion, "take evidence and make findings of fact relating to such challenges."[137] Georgia law provides that judicial review of an OSAH decision is generally limited to issues that were raised during the administrative proceedings;[138] thus, it may be strategically important to assert all possible arguments during the State Fair Hearing—thereby preserving them for later stages of the litigation—even if certain issues surpass the ALJ's jurisdiction.

(5) **Don't depend on DFCS to secure witnesses and other materials for the hearing.** Independently confirm the attendance of key witnesses. Bring your own copies of key documents, including the statutes or regulations that underpin your arguments.

(6) **Be mindful of deadlines.** In particular, keep in mind that the deadline for requesting maintenance of benefits may be much earlier than the deadline for requesting an appeal.

(7) **In general, request a continuation of benefits if the regulatory requirements are met.** Even when beneficiaries ultimately lose their appeals, it's extremely uncommon for the state to exercise its right to seek repayment for the continued benefits.

APPENDIX A: ACRONYMS

ALJ	Administrative Law Judge
CHIP	Children's Health Insurance Program
CMO	Care Management Organization
CMS	Centers for Medicaid and Medicare Services
DCH	Department of Community Health
DFCS	Division of Family and Children Services
DHS	Department of Human Services
FFS	Fee-for-service
GAPP	Georgia Pediatric Program
MCO	Managed Care Organization
OSAH	Office of State Administrative Hearings
SPA	State Plan Amendment

APPENDIX B: RELEVANT LAW, GUIDANCE, AND OTHER AUTHORITIES

Federal Law	• Federal statute: 42 U.S.C. §§ 1396a(a)(3), 1396u–2(b)(4) • Federal regulations o Medicaid FFS appeals: 42 C.F.R. §§ 431.200-431.250 o Medicaid Managed Care appeals: 42 C.F.R. §§ 438.400-438.424 o CHIP appeals: 42 CFR Part 457 Subpart K; 42 C.F.R. § 457.1260 • Federal Guidance: CMS State Medicaid Manual §§ 2900–2904.2 (Fair Hearings and Appeals), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927
Georgia State Law	• CMOs: O.C.G.A. § 33-20A-42 • Medicaid State Fair Hearings: O.C.G.A. § 49-4-153 • State Administrative Procedure Act (including OSAH procedures): o O.C.G.A. §§ 50-13-1 et seq. o G.A.C. §§ 616-1-2 et seq., available at https://osah.ga.gov/ • Georgia Medicaid Manual, available at https://odis.dhs.ga.gov/General/Home/DhsManuals?id=813 (Note: Medicaid and PeachCare State Fair Hearings are discussed in Appendix B. The manual uses the shorthand "A/R" to refer to "applicants and recipients.")
Georgia State Plans	• Medicaid State Plan § 4.2, available at https://dch.georgia.gov/medicaid-state-plan. • PeachCare State Plan: See CHIP State Plan Amendments 17 0023 (CMO adverse benefit determinations) & 18 0027 (eligibility and enrollment decisions), available at https://www.medicaid.gov/chip/state-program-information/index.html.

FOOTNOTES

1 For the eligibility criteria that govern these programs, see Ga. Medicaid, Basic Eligibility, https://medicaid.georgia.gov/how-apply/basic-eligibility.

2 Kaiser Family Foundation, Monthly Child Enrollment in Medicaid and CHIP (2019), https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment.

3 The Medicaid statutes appear in Title XIX of the Social Security Act. The CHIP statues appear in Title XXI.

4 KFF, Share of Medicaid Population Covered under Different Delivery Systems, https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems (updated Jul. 1, 2019).

5 If a plan imposes "prior authorization" requirements, it means that a beneficiary or provider must request permission in advance for a particular healthcare service, such as a non-emergency surgery or a prescription drug. If the beneficiary fails to secure prior authorization for a service—whether because the beneficiary failed to ask, or because the plan determined that the service did not qualify for coverage under plan guidelines—the plan will not reimburse the provider for the service.

6 Ga. Medicaid, Care Management Organizations (CMO), https://medicaid.georgia.gov/programs/all-programs/georgia-families/care-management-organizations-cmo.

7 Peach State Health Plan, News: All Together Now (Jan. 23, 2020), https://www.pshpgeorgia.com/newsroom/co-existing-market-merger-close.html.

8 42 C.F.R. §§ 431.205 (Medicaid FFS), 457.1120 (CHIP FFS), 438.228 (Medicaid managed care), 457.1260 (CHIP managed care).

9 *Goldberg v. Kelly*, 397 U.S. 254 (1970).

10 42 C.F.R. §§ 438.402, 457.1260.

11 The federal rules governing appeals for Medicaid managed care appear at 42 CFR Part 438, Subpart F. These rules also apply to CHIP managed care, with limited exceptions pertaining to the procedures for continuation of benefits during the pendency of an appeal. Id § 457.1260.

12 See O.C.G.A. § 33-20A-42 (Medicaid and PeachCare beneficiaries who are enrolled in managed care "shall, after first exhausting the grievance procedure of the managed care plan . . . , be afforded the fair hearing rights provided pursuant to Code Section 49-4-153 or the [CHIP] state plan."); Ga. CHIP SPA 17 0023. Notably, CMOs are exempt from the requirements of Georgia's Patient's Right to Independent Review Act, which defines procedural requirements for certain managed care plans in the commercial market. See O.C.G.A. § 33-20A-31(2)(C) & (5) (defining "eligible enrollee" in a manner that excludes Medicaid and PeachCare beneficiaries).

13 42 C.F.R. § 438.10(g).

14 Ga. CHIP SPA 17 0023.

15 42 C.F.R. § 438.400(b).

16 42 C.F.R. § 438.400(b).

17 42 C.F.R. § 438.10(g)(2)(iii).

18 42 C.F.R. §§ 438.404(c)(5), (6).

19 See 42 C.F.R. §§ 438.408(b)(1) & (2).

20 See 42 C.F.R. § 438.52(b)(2)(ii).

21 42 C.F.R. § 438.404(a).

22 42 C.F.R. § 438.404(b).

23 42 C.F.R. § 438.404(c).

24 42 C.F.R. §§ 431.211-214 (describing exceptions pertaining to, among other things, a scenario in which the beneficiary requests to end services; the beneficiary has been admitted to an institution and is ineligible for Medicaid; the beneficiary's whereabouts are unknown; the beneficiary has been accepted for Medicaid services by another jurisdiction; the beneficiary's physician prescribed a change in the level of medical care; the adverse determination pertains to preadmission screening requirements for mentally ill residents for nursing facilities; or the agency suspects that the beneficiary has committed fraud).

25 42 C.F.R. §§ 438.404(c)(3)–(6) (incorporating the timelines in id. § 438.210(d)).

26 42 C.F.R. § 438.10(g)(2)(iv) (providing that the member handbook must describe the "requirements for service authorizations").

27 42 C.F.R. § 438.402(c)(2)(ii).

28 42 C.F.R. §§ 438.402(c)(3)(ii), 438.406(b)(3).

29 42 C.F.R. § 438.402(c)(1)(ii).

30 42 C.F.R. § 438.406(b)(1).

31 Ga. CHIP SPA 17-0023.

32 42 C.F.R. § 438.410(a).

33 42 C.F.R. §§ 438.410(c), 438.408(c).

34 42 C.F.R. §§ 438.420 (defining procedures on continuation of benefits for Medicaid managed care enrollees), 457.1260 (requiring CHIP managed care plans to comply with Medicaid manage care rules except the rules on continuation of benefits in § 438.420).

35 42 C.F.R. § 438.420(b)(5).

36 42 C.F.R. § 438.420(a).

37 42 C.F.R. § 438.420(c).

38 42 C.F.R. § 438.420(c).

39 Specifically, federal law provides that a managed care organization "may, consistent with the state's usual policy on recoveries . . . and as specified in the [managed care] contract, recover the cost of services furnished." 42 C.F.R. §§ 438.420(d). *As of the time of writing*, the Georgia Families model managed care contract states that a CMO "may recover from the Member the cost of the services furnished to the Member while the Appeal is pending, to the extent that they were furnished solely because of [maintenance of benefits] requirements." State of Georgia Contract Between the Georgia Department of Community Health and [Contractor] for Provision of Services to Georgia Families, Section 4.14.8.4, https://medicaid.georgia.gov/sites/medicaid.georgia.gov/files/related_files/site_page/GF%20Contract%20-%20Generic%20%28002%29.pdf.

40 Ga. CHIP SPA 17-0023.

41 42 C.F.R. § 438.406(b)(4).

42 42 C.F.R. §§ 438.404(b)(1), 438.406(b)(5).

43 42 C.F.R. § 438.406(b)(2).

44 42 C.F.R. § 438.406(b)(2).

45 42 C.F.R. § 438.408(d)(2).

46 42 C.F.R. § 438.402(b).

47 42 C.F.R. § 438.408(e).

48 42 C.F.R. § 438.408(b)(2).

49 42 C.F.R. § 438.408(b)(3). State regulations do not appear to require this 72-hour limit, but all plans follow this timeline. The Medicaid managed care contract has not yet been reviewed.

50 42 C.F.R. § 438.408(d)(2).

51 42 C.F.R. § 438.408(c).

52 42 C.F.R. § 438.408(c).

53 42 C.F.R. § 438.408(c)(3).

54 42 C.F.R. § 438.424(a).

55 42 C.F.R. § 438.424(b).

56 42 C.F.R. § 438.402(c)(1); 438.408(f)(1).

57 42 C.F.R. § 438.408(f)(2).

58 Federal law also permits the state to offer an optional "external medical review" in lieu of, or in addition to, a State Fair Hearing. 42 C.F.R. § 438.402(c)(1)(i)(B). It does not appear that Georgia offers this type of external review, however.

59 42 C.F.R. § 438.406(a).

60 42 C.F.R. §§ 438.10(d), 438.408(d)(2).

61 42 C.F.R. § 438.10(d).

62 The Medicaid State Fair Hearing requirements are described at 42 C.F.R. Part 431, Subpart E and the CMS State Medicaid Manual §§ 2900–2904.2. The CHIP regulations are codified at 42 C.F.R. Part 457, Subpart K. Although the federal CHIP rules refer to these procedures as "program specific review" procedures, this manual follows Georgia's current approach of using the term "State Fair Hearing" (the same term used for Medicaid hearings).

63 O.C.G.A. § 49-4-153(b)(1); Ga. CHIP SPA 18-0027. The Georgia APA is codified at O.C.G.A. §§ 50-13-1 et seq. OSAH's implementing regulations are codified at G.A.C. §§ 616-1-2 et seq. See also

64 Ga. Medicaid Manual, Appendix B ("Hearings").

65 The current version of the Georgia Medicaid Manual states that this change was effective May 8, 2018. This policy change did not appear in the Medicaid Manual until June 2020, however. Advocates report that, until that time, the state continued to enforce the two-level Medicaid Fair Hearing system.

66 In addition to having different timelines for filing and processing appeals, PeachCare beneficiaries had no access to the OSAH ALJ hearing process, and instead appealed to a separate body referred to variously as the "Formal Appeals Committee" or the "Formal Grievance Committee." These bodies are still referenced in certain CMOs' member handbooks, as noted above in Section III.F.3.

67 See Ga. CHIP SPAs 17-0023 (CMO and state review of adverse benefit determinations) & 18-0027 (state review of eligibility & enrollment decisions); Ga. Medicaid Manual at B-9 to 10 (providing that PeachCare State Fair Hearings follow the same procedures applicable under Medicaid).

68 G.A.C. §§ 350-4 et seq.

69 42 C.F.R. §§ 431.201, 431.220(a), 457.1130(a); O.C.G.A. §§ 49-4-153(b)(1).

70 42 C.F.R. §§ 435.912(c)(3), 457.340(d).

71 42 C.F.R. §§ 431.220(b), 457.1130(c).

72 Ga. Medicaid Manual § 2701 1; 42 C.F.R. §§ 431.206(c), 431.210.

73 Ga. Medicaid Manual § 2701 1; 42 C.F.R. §§ 431.206(b), 431.210, 457.340(e), 457.1180.

74 See Ga. Medicaid Manual § 2701; see also 42 C.F.R. §§ 431.211. Federal law requires a minimum of 10 days' notice, but Georgia has defined a minimum notice requirement of 14 days (unless an exception applies).

75 See Ga. Medicaid Manual § 2701; 42 C.F.R. §§ 431.212–431.213.

76 42 C.F.R. § 457.340(e)(2).

77 Ariel Hart, *State to Reinstate Medicaid Benefits to Georgians Who Lost Them*, Atlanta Journal-Constitution (June 25, 2019), https://www.ajc.com/news/state--regional-govt--politics/state-reinstate-medicaid-benefits-georgians-who-lost-them/UqMdKQHkroZMpKBBmXNeCO/.

78 Ga. Medicaid Manual, Appendix B 1; Ga. CHIP SPA 18-0027. With respect to Medicaid, federal law allows the state to establish a "reasonable time" period up to "90 days from the date that notice of action is mailed." 42 C.F.R. § 431.221(d). Georgia has defined a hearing request deadline of 30 days, and has opted to apply that same time period to PeachCare for Kids.

79 Ga. Medicaid Manual, Appendix B-1.

80 Ga. Medicaid Manual, Appendix B-1; Ga. CHIP SPA 18-0027.

81 Ga. Medicaid Manual, Appendix B 1 to 2; 42 C.F.R. §§ 431.221, 435.923; Ga. CHIP SPAs 17-0023, 18-0027.

82 Ga. Medicaid Manual, Appendix B-2, B-9.

83 Ga. Medicaid Manual, Appendix B-6 to 7, 9.

84 G.A.C. § 616-1-2-.03(2) ("If an agency fails to forward a hearing request to the Court within thirty (30) calendar days after receipt of the request, . . . the party requesting the hearing may file a petition for a direct appeal with [OSAH].").

85 42 C.F.R. §§ 431.242(f), 457.1160.

86 42 C.F.R. § 431.224. This rule applies to Medicaid appeals. There does not appear to be an equivalent federal requirement for CHIP appeals.

87 G.A.C. § 616-1-2-.31.

88 42 C.F.R. § 431.224(a)(1).

89 42 C.F.R. § 431.244(f)(3).

90 42 C.F.R. § 431.244(f)(2).

91 42 C.F.R. § 457.1160(a).

92 42 C.F.R. § 457.1160(b).

93 Ga. CHIP SPA 17-0023.

94 Georgia has chosen to provide identical "maintenance of benefits" procedures across all types of Medicaid and PeachCare appeals. Ga. Medicaid Manual, Appendix B-10. We note, however, that although petitioners have a federal right to maintenance of benefits during all types of Medicaid appeals, 42 C.F.R. § 431.231, the federal CHIP rules require maintenance only during appeals that concern a "suspension or termination of enrollment," 42 C.F.R. § 457.1170. There is no federal requirement for states to permit maintenance of specific CHIP benefits in appeals where the petitioner's CHIP enrollment is not at issue. Georgia's CHIP state plan provides that, during CMO review, petitioners have a "right to provide documentation or explanation of [their] medical need for consideration during the Appeal." Ga. CHIP SPA 17 0023.

95 Ga. Medicaid Manual, Appendix B-3. Allowances may be made if the petitioner claims that the notice of adverse action was not timely received, as described at id. B-3.and B-16 to 17.

96 42 C.F.R. § 438.420(c)(2).

97 42 C.F.R. §§ 431.210(e), 438.408(e), 457.1180.

98 42 CFR § 431.240(a), 457.1140(a), 457.1150(a); see also G.A.C. § 616-1-2-.32 (recusal of an ALJ).

99 CMS State Medicaid Manual § 2902.6 (noting that "special plans" should be made "for the convenience of the claimant," such as allowing a hearing to be conducted "by telephone when the claimant is unable to attend in person"); G.A.C. § 616-1-2-.22(4) (An OSAH "hearing may be conducted by alternate means"—including "remote telephonic communication" or "two-way videoconferencing"—if all parties have consented and the alternate means will not jeopardize any party's rights).

100 Ga. Medicaid Manual, Appendix B-14; G.A.C. § 616-1-2-.41.

101 42 C.F.R. § 431.223(b); G.A.C. § 616-1-2-.30.

102 G.A.C. § 616-1-2-.22(4).

103 G.A.C. § 616-1-2-.02(2).

104 G.A.C. § 616-1-2-.02(4) (emphasis added). Notably, certain default OSAH procedures may be in tension with federal Medicaid and CHIP law. For example, the OSAH rules on "summary determination" without a hearing (G.A.C. § 616-1-2-.15) are likely inconsistent with federal rules that vest Medicaid and CHIP petitioners with the right to make their case at a hearing (42 CFR §§ 431.240(a), 457.1140(a), 457.1150(a)).

105 Ga. Medicaid Manual, Appendix B-5; 42 C.F.R. §§ 431.242, 457.1140(d); O.C.G.A. § 50-13-13. ALJs may consolidate multiple petitioners' hearings where the sole issue involved is one of state and/or federal law, regulation or policy. 42 C.F.R. § 431.222; Ga. Medicaid Manual, Appendix B 14. Under the OSAH rules, ALJs are directed to apply the state's rules of evidence as a default, but also to "consider evidence not otherwise admissible . . . if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their affairs." G.A.C. § 616-1-2-.18(1)(a).

106 42 C.F.R. § 431.244(a); see also Ga. Medicaid Manual, Appendix B-4, 15.

107 457.1140(d)(3) (permitting "supplemental information"); G.A.C. § 616-1-2-.21(3).

108 Ga. Medicaid Manual, Appendix B-5; 42 C.F.R. §§ 431.242(a), 457.1140(d).

109 42 C.F.R. §§ 431.240(b), 457.1150; Ga. Medicaid Manual, Appendix B-15.

110 Ga. Medicaid Manual, Appendix B-5.

111 G.A.C. § 616-1-2-.07(1)(d). It is possible that the CMO similarly bears the burden of proof in appeals arising out of CMO review, although this point is not expressly addressed in Georgia's Medicaid law or guidance.

112 G.A.C. § 616-1-2-.35.

113 42 C.F.R. §§ 431.244(d), 457.1140(c); O.G.C.A. § 49-4-153(b)(1); G.A.C. § 616-1-2-.27.

114 42 C.F.R. § 431.244(a); Ga. Medicaid Manual, Appendix B-4, 15.

115 42 C.F.R. § 431.244(d); Ga. Medicaid Manual, Appendix B-4, 15; G.A.C. § 616-1-2-.27(1).

116 42 C.F.R. § 431.245(b); Ga. Medicaid Manual, Appendix B-15.

117 42 C.F.R. § 431.244(f); Ga. CHIP SPA 18-0027; Ga. Medicaid Manual, Appendix B-15.

118 Ga. Medicaid Manual, Appendix B-5.

119 42 C.F.R. § 431.244(f) (referencing id. § 431.221(a)(1)).

120 42 C.F.R. § 431.244(f)(1)(i).

121 42 C.F.R. § 431.244(f)(4). The state must document the reasons for any delay in the petitioner's record.

122 CMS State Medicaid Manual §§ 2902.10, 2903.3(B).

123 Ga. CHIP SPA 17-0023.

124 G.A.C. § 616-1-2-.41(1).

125 Ga. Medicaid Manual, Appendix B-11; 42 C.F.R. § 431.244; Ga. CHIP SPAs 17-0023, 18-0027.

126 42 C.F.R. § 431.245; Ga. Medicaid Manual, Appendix B 10. Georgia's CHIP plan specifically states that, if the petitioner succeeds on an appeal related to eligibility, the petitioner's enrollment will be "effective retroactive to the first day of the month in which the completed application" was received by the state. Ga. CHIP SPA 18-0027.

127 Ga. Medicaid Manual, Appendix B-11 to 13; O.C.G.A. §§ 49-4-153(c), § 50-13-19(b).

128 O.C.G.A. § 50-13-19(b).

129 O.C.G.A. § 49-4-153(c); O.C.G.A. § 50-13-19. Judicial review is generally limited to issues raised during the administrative proceedings. O.C.G.A. § 50-13-19(c).

130 O.C.G.A. § 50-13-19(d)(1).

131 O.C.G.A. § 50-13-19(f).

132 O.C.G.A. § §§ 50-13-19(g), (h).

133 42 C.F.R. § 431.221(c); Ga. Medicaid Manual, Appendix B-2.

134 42 C.F.R. §§ 431.205(e), 431.206(e), 435.905, 457.110 (incorporating id. § 435.905(b)); Ga. Medicaid Manual, Appendix B-2.

135 Ga. Medicaid Manual, Appendix B-5.

136 Eric Carlson, Legal Basics: Medicaid Appeals (June 2018), National Center on Law & Elder Rights, https://ncler.acl.gov/pdf/Legal%20Basics-%20Medicaid%20Appeals.pdf (explaining that "requesting a fair hearing can bear fruit immediately," perhaps because a state appeals worker "may find a mistake made by the eligibility worker," or because a state "appeals representative may have a greater interest in settling a case, rather than preparing for or participating in a hearing").

137 G.A.C. § 616-1-2-.22(3).

138 O.C.G.A. § 50-13-19(c).