Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The member is given an oral explanation of the appeals (fair hearing) process during the application process by the Income Maintenance worker. The Department also gives members an oral explanation at the time of any contemplated action. Depending on the adverse action, this could be done by the Income Maintenance Worker, the Case Manager and/or Medical Services who perform the level of care determination. The member is also given written notification (by the Income Maintenance Worker, the Case Manager, and/or Medical Services) of the following at the time of application and at the time of any department actions affecting the claim for assistance, including choice of provider of service; denial, reduction, suspension or termination of service:

Ø The right to request a hearing
Ø The procedure for requesting a hearing
Ø The right to be represented by others at the hearing, unless otherwise specified by the stature or federal regulation
Ø Provisions for payment of legal fees by the Department
Ø How to have assistance including to right to continue services while the appeal is pending.

The choice of HCBS vs. institutional services is discussed with the applicant at the time of the completion of the application by the income maintenance worker and again at the time of the service plan development by the case manager.

All Department of Human Services application forms, notices, pamphlets and brochures must contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices and on the Department Website. The process for filing an appeal can be found on all Notices of Decision issued by the Department and is included on the NOD issued by the Case Manager. Procedures regarding the appeal hearing can be found on the Notice of Hearing. As stated in Iowa Administrative code, any person or group of persons may file an appeal with the department concerning any decision, made.

The member shall be encouraged, but not required to make a written appeal on a standard form Appeal and Request a Hearing. Appeals may also be filed via the DHS website. If the member is unwilling to complete the form, the member would need to request the appeal in writing. The Iowa Department of Human Services or his or her Case Manager shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

All notices are kept at all local Department of Human Services Offices or the Case Managers file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   No. This Appendix does not apply

   Yes. The State operates an additional dispute resolution process

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair

Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

No. This Appendix does not apply

Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Iowa Department of Human Services Iowa Medicaid Enterprise is responsible for the operation of the complaint and grievance reporting process. In addition, the Department has a contract with Iowa State University that is responsible for the handling of complaints and grievances in regards to provision of services under this waiver.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any waiver member, member's family member/guardian, agency staff, concerned citizen or other public agency staff may report a complaint regarding the care, treatment, and services provided to a member of services. A member also has the right to appeal any decision through a fair hearing process at anytime. A member is not required to file a grievance or complaint before requesting an appeal. They are notified of the right to a fair hearing at the time of waiver application and at the time they are given any notice of decision. The complaint/grievance reporting process is afforded to all members and their legal representatives and is in addition to the fair hearing process. During the complaint intake process, complainants are informed that they have the right to a fair hearing if the complaint or grievance meets the fair hearing criteria identified in Appendix F-1.

Policy and Procedure Reporting
· A complaint may come from the following sources or formats:

o Incident reports of abuse or death. Provider organizations are required to report all major incidents within 24 hours to the Medicaid Case Manager, DHS worker, the Department's Bureau of Long Term Care (BLTC), and the member's legal guardian, if applicable.
o Medicaid Case Managers/DHS Workers/Area Agency on Aging Case Managers/Interdisciplinary Team members who have indicated concern with the provider's action or inaction regarding major incidents or trends in minor incidents.
o Reports of significant incident trends within an agency as indicated by the HCBS Quality Assurance Specialist or HCBS Regional Specialist.
o Complaints directly from waiver members, member's family or guardians, provider staff, concerned citizens, or other public agency staff regarding the care, treatment, and services provided to a member of services.

· A complaint may be submitted in writing, in person, by e-mail or by telephone. Verbal reports may require submission of a detailed written report.
· The complaint may be submitted to an HCBS Specialist, HCBS Program Manager, or Bureau Chief of Long Term Care.
· Written reports shall be sent to the Department of Human Services/Home and Community Based Waiver, Hoover State Office Building, 5th floor, 1305 E Walnut, Des Moines IA 50319-0114 or to the regional HCBS specialist at their local address.
· Complaints by phone can be made to the regional HCBS Specialist at their local number or by calling 515-725-1133. Phone calls to this number will be referred on to the appropriate regional HCBS Specialist or, in emergency situations, to the HCBS Program Manager or the Bureau Chief of Long Term Care.

· The complaint will be forwarded to the HCBS Specialist assigned to the region where the provider's home base is located
. Policy and Procedure Intake:
· The individual taking the initial complaint will complete the electronic HCBS Complaint Intake Form for reports that are e-mailed, phoned in or reported in person. The hard copy written reports from complainants are sufficient if they include all of the necessary information.
· Information necessary to include in every complaint intake

o Date complaint is received
o Provider information: Name, address, staff contacts
o Member information: names of members involved
o Summary of complaint: date/time, location, frequency of concern, details of concern
o Witness or other contact information
o Actions taken by complainant
o Other parties that have been reported to or whom are involved
o Actions taken by other parties, if applicable
o Name and contact information of complainant

· Upon receipt of the complaint intake, the HCBS specialist will review the information received to be sure all necessary information is included. The HCBS specialist may request additional information from the complainant when necessary.
· If the complainant requests to remain anonymous, the HCBS program will make every attempt to uphold confidentiality of the complainant.
· All receipts of complaint will be documented in the provider case file record maintained by the regional HCBS specialist.
· The complainant will be notified the report has been received and will be processed accordingly.
· The HCBS specialist will forward the electronic complaint intake form or written complaint within five working days of receipt to the quality assurance (QA) staff assigned to enter the information into the central office database. Once the information is received in central office, it will be printed, coded and entered into the database. The hard copy will be filed in a confidential location.
· The Bureau of Long Term Care has established a committee to review complaints received by the HCBS program and to provide feedback to the HCBS specialist. The committee will meet monthly to review all current complaints. The HCBS specialist will notify the committee if immediate feedback is needed.
· The HCBS quality assurance specialist will review the information for the following:
o Number of complaints by provider
o Nature of complaints

· The QA specialist will complete an analysis of the data and compile a report semi-annually. The analysis will contain information to assist in monitoring the quality and safety of provider agencies, to identify agency trends, and identify type of complaints prevalent. Significant trends will be reported to the HCBS specialist and HCBS quality assurance committee for follow-up.

Policy and Procedure Assessment
· The HCBS specialist will evaluate the nature of the complaint based upon the current HCBS standards within the Iowa Administrative Code and Federal requirements.
· A complaint will be determined to fall in the jurisdiction of HCBS when:

o The health, safety, welfare of an individual receiving service has/is being compromised or jeopardized. All such complaints will also be referred to the appropriate protective service agency. The HCBS specialist will coordinate with the other agency to determine if a deficient practice is/was present by the provider warranting HCBS follow-through with the agency.
o Pertains to a provider's lack of compliance with the IAC standards.
o Failed efforts by the Member/member's legal guardian/Interdisciplinary team to resolve the complaint/concern via the provider's grievance and appeal process.

· During the above process, if it is determined that an occurrence does not fall in the jurisdiction of HCBS, the specialist will notify the complainant of the decision and provide feedback. E.g.: Work with the Medicaid case manager/DHS worker assigned to assist the member to advocate with the provider and/or file a grievance/appeal with the agency and notify HCBS if the IDT or Grievance/Appeal process fails to resolve the concern.
· The HCBS specialist will enter information in the database regarding all follow-up action.
· The HCBS specialist will prioritize all complaints determined to fall within HCBS jurisdiction. Three levels of

priority will determine the severity and urgency of the complaint and the follow-up procedure.
1. Immediate jeopardy/Actual harm: A situation that has caused or is likely to cause a serious injury, harm, impairment, death, or abuse to a member.
o If the protective service agency has completed or is in the process of conducting an investigation, the HCBS specialist will coordinate with the other agency.
o If the protective service agency is not investigating, the HCBS specialist will begin an on-site review within two working days of receipt of the report.
o If it is determined that immediate jeopardy has been removed or actual harm is not present, the review will be initiated within twenty working days of receipt of the report.

2. Other complaints: Lack of compliance with the IAC, Failure to resolve through the IDT or grievance/appeal process, or QA specialist report of significant trends within an agency. A review will be initiated within twenty working days of receipt of the report.

3. Self-reports by providers: Self-reports by providers would not automatically be considered a complaint against the provider. Self-reports shall be prioritized by applying the same criteria as "1" and "2" above. The HCBS specialist may determine that the provider has fully investigated the self-reported incident. If the provider's report identifies a response and corrective action has been taken by the agency the HCBS specialist may determine additional investigation is not necessary. The HCBS specialist may request written information be submitted by the provider. Policy and Procedure Complaint Review Process· The review may be conducted on-site or by requesting information be submitted to the HCBS specialist. Information that can be viewed on-site or submitted includes, but is not limited to the following: Member case records, review of administrative policies and procedures, clinical practices, personnel records, performance improvement system, and documentation. The review process may also include interviews with members, staff, board of director members, case managers, guardians or others deemed necessary. All interviews and information obtained will be safeguarded for confidentiality.
· Complaints that are received, but not investigated per the criteria in this policy, do not require a written report.
· Upon completion of the investigation, a review report shall be written by the lead HCBS specialist within twenty-five working days. All reports will be considered public record. Information necessary to include in the report:

o Description of the complaint
o Action taken by the Specialist, including dates
o Findings in relation to IAC non-compliance
o Corrective action required, directions for submission and timelines
o Appeal guidelines
o Confidentiality of the member(s)
o Confidentiality of the complainant
· The HCBS specialist will place a copy of the report on the HCBS network share in a file located at "Hoovr3s1/complaints committee/complaint reports needing approval"
. The HCBS supervisor will be notified the report is in the above file for review and approval prior to it being sent to the provider. The HCBS supervisor will work with the BLTC Complaint Committee and HCBS specialist to finalize the report within five working days.
· The final report will be sent to the provider within thirty working days of completion of the investigation. A copy of the report will be saved on the HCBS network share in a file located at "Hoovr3s1/complaints committee/approved complaint reports"
· If the complainant requests a copy of the report it will be sent under separate cover.

Policy and Procedure Compliance
·The lead HCBS specialist may conduct follow-up compliance reviews to insure the provider is complying with corrective actions imposed in the complaint report. The compliance reviews may include an on-site visit or require the provider submit information to the specialist.
· Some complaints may rise to a level of imposing sanctions against a provider. The decision to impose sanctions shall be made by the BLTC complaint committee. When imposing sanctions, the Department shall follow IAC 441-79.2(249A) "Sanctions against provider of care". Providers have the right to appeal the sanctions under 441-Chapter 7.