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 Service Worker and/or Medical Services who perform the level of care determination. The member is also given written notification (by the Income Maintenance Worker, the Service Worker, 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 service worker.

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 Service Worker. 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 service worker 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 service worker's file.

The member is given their appeal rights in writing, which explains their right to continue with their current services while the appeal is under consideration. Copies of all notices for a change in service are maintained in the service file. IME reviews this information during case reviews.

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 maintains an HCBS Quality Assurance/Provider Oversight contract 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 relative/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.

Policy and Procedure Reporting – A complaint may come from the following sources or formats:
•Incident reports. Provider organizations are required to report all major incidents within 72 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.
•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.
•Reports of significant incident trends within an agency as indicated by the HCBS Provider Quality Assurance Oversight Specialist.
•Complaints directly from waiver members, member's relatives/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 Provider Quality Oversight Specialist, HCBS Program Manager, any IME Unit, or Bureau Chief of Long Term Care. Complaints by phone can be made to a regional HCBS Provider Quality Assurance Oversight Specialist at their local number or by calling the IME. The Bureau of Long Term Care has established a committee to review complaints. The committee will meet biweekly to review current complaints.

Once received, the HCBS Quality Oversight Unit shall initiate investigation within one business day of receipt and shall submit a findings report to the Quality Assurance Manager within 15 days of finalizing the investigation. Once approved by the Quality Assurance Manager, the findings report is provided to the complainant and the provider in question. If the complainant is a participant, they are informed by the HCBS Quality Oversight Incident and Complaint Specialist that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.