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.

HCBS applicants and members have the right to appeal any adverse decision made by the Department. The information on how to file an appeal is posted on the HHS Appeals webpage: https://hhs.iowa.gov/programs/appeals.

Policies and procedures for State Fair hearings can be found in 441 IAC Chapter 7

All HHS member application forms, notices, pamphlets and brochures contain information on the appeals process and the opportunity to request an appeal. This information is available at all of the local offices. The process for filing an appeal can be found on all Notices of Decision (NOD) and Notices of Action (NOA). NODs and NOAs are issued anytime benefits or services are approved, denied, changed, or cancelled. An adverse benefit determination notice, that results in members' right to appeal, includes the following elements: the right to request a hearing, the procedure for requesting a hearing, the right to be represented by others at the hearing, unless otherwise specified by the statute or federal regulation, and how to obtain assistance, including the right to continue services while an appeal is pending. The member is encouraged, but not required, to make a written appeal on a standard Appeal and Request a Hearing form. Appeals may also be filed via the HHS website. Appeals may be made in person, by telephone, or in writing.

All notices are kept in the HHS member case file system, and the case manager'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. Iowa Medicaid reviews this information during case reviews.

When an HCBS member is assigned to a specific MCO, the assigned MCO community-based case manager explains the member's appeal rights through the Stat Fair Hearing process during the initial intake process. Members enrolled in an MCO must exhaust the entity's internal grievance processes before pursuing a State Fair Hearing.

MCO's give their members written notice of all adverse benefit determinations, not only service authorization adverse benefit determinations, in accordance with state and federal rules, regulations and policies, including but not limited to 42 CFR 438.402

MCO's shall mail the Notice of Adverse Benefit Determination at least ten (10) Days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. Members have 120 days from the date on the letter indicating the first-level review process has been exhausted. This requirement is outlined in the concurrent §1915(b) waiver, Part IV, Section E

MCO's Notice of Adverse Benefit Determination shall explain the reasons for the Adverse Benefit Determination, including the right of the Enrolled Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrolled Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. MCO's Notice of Adverse Benefit Determination shall explain the Enrolled Member's right to request an Appeal of the MCO's Adverse Benefit Determination, including information on exhausting the MCO's one (1) level of appeal and the right to request a State Fair Hearing after receiving Notice that the Adverse Benefit Determination is upheld.

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**

• **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.

The MCO grievance and appeals process operates in accordance with 42 CFR Part 438 Subpart F and is described in the concurrent 1915(b) waiver.

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**

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

FFS
Iowa Medicaid is responsible for operation of the complaint and grievance reporting process for all fee-for-service members. In addition, the Department maintains an HCBS QIO contract that is responsible for the handling of fee-for service member complaints and grievances in regard to provision of services under this waiver.

• **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).

Fee for Service grievances/complaints follow the parameters and timelines in accordance with 42 CFR 441.301(c)(7)(viii). Any fee-for-service waiver member, member's relative/guardian, agency staff, concerned citizen or other public agency staff may report a grievance/complaint regarding the care, treatment, and services provided to a member. A grievance/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 grievance/complaint may be submitted to an HCBS QIO Specialist, HCBS Program Manager, any Iowa Medicaid Unit, or its leadership. Grievance/Complaints by phone can be made to a regional HCBS QIO Specialist at their local number or by calling Iowa Medicaid. Iowa Medicaid has established a HCBS quality committee to review HCBS performance which includes review of grievances and complaints.

Once received, the HCBS QIO 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 member, they are informed by the HCBS QIO Incident and Complaint Specialist that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

MCO grievances/complaints follow the parameters and timelines in accordance with 42 CFR 438.408 and 438.410.

A complaint means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested.

A grievance is a formal complaint by a HCBS member about the way that a service provider is furnishing a Medicaid service or about the conduct of a waiver administrative process.

A complaint is the formal expression of dissatisfaction by a HCBS member with the provision of a waiver service or the performance of an entity in conducting other activities associated with the operation of a waiver.