Department of HUMAN SERVICES

February 28, 2020

GENERAL LETTER NO. 1-E-22

ISSUED BY: Appeals Section
Bureau of Policy Coordination

SUBJECT: Employees' Manual, Title 1, Chapter E, ***Appeals and Hearings***, Title page, revised; Contents (pages 1 and 2), revised; Contents (page 3), new; pages 1 through 44, revised; and pages 45 through 78, new.

Summary

Chapter 1-E is revised to:

- Update policies and procedures related to the appeals process for all programs to reflect current practices.
- Update legal references throughout the chapter.
- Add policies and procedures related to the state fair hearing process for managed care organization appeals.
- Add policies and procedures related to third-party liability appeals.
- Remove "aggrieved person" from the Definition Section and move the criteria to its own section to clarify who is eligible for a contested case hearing as an aggrieved party.
- Add information about accommodating written translation, verbal interpretation or other special accommodation requests for appeals.
- Update the section on Time Limit for Granting an Appeal Hearing to add the time standard for:
  - Dependent adult abuse
  - Medicaid eligibility determinations
  - Health care decision made by the Iowa Medicaid Enterprise when the appellant is covered by fee-for-service Medicaid
  - Health care decision made by a managed care organization
  - Family Planning Program
  - Autism Support Program
  - Iowa Individual Disaster Assistance Program
  - Iowa Disaster Case Management Program

  - Sex Offender Risk Assessment
  - PROMISE JOBS displacement grievance
  - PROMISE JOBS discrimination complaint
  - Offsets of county debts owed to the Department
- Add information relating to Child Care Assistance benefit and Family Planning Program overpayments. In addition, revise information relating to FIP, RCA, and PROMISE JOBS; Food Assistance; and Medicaid, State Supplementary Assistance, and Hawki Program overpayments.
- Clarify the difference between withdraw and dismissal request and which parties to the appeal can request either type.
- Add information regarding informal conferences.
- Update the criteria used to determine if benefits can continue pending the outcome of an appeal.
- Revise information regarding prehearing conferences.
- Update information regarding expedited hearings and add information specific to expedited appeal hearings for Medicaid eligibility, Medicaid managed care organization appeals, and Medicaid fee-for-service appeals.
- Clarify when a party fails to appear for an appeal hearing, the party may file a motion to vacate requesting good cause for failure to attend the appeal hearing.
- Clarify information regarding appeal hearings held in-person, hearings held by teleconference call, and administrative appeal hearings for attribution appeals.
- Revise information about who may represent an appellant during the appeals process and add information regarding an authorized representative for managed care appeals.
- Remove references to submitting a Department review to the Appeals Advisory Committee. Reviews are submitted directly to the DHS Appeals Section.

Effective Date

Immediately.

Material Superseded

This material replaces the entire Chapter E from Employees' Manual, Title 1, which includes the following pages:

Page	Date
Title page	April 12, 2013
Contents (page 1)	February 13, 2009
Contents (page 2)	May 1, 2015
1	October 28, 2005
2	January 26, 2007
3, 4, 4a	December 2, 2003

4b	April 12, 2013
4c, 4d	December 2, 2003
4e	January 26, 2007
4f	December 2, 2003
5	January 26, 2007
6	December 2, 2003
7, 8	January 26, 2007
9-11	February 13, 2009
12	April 12, 2013
13	October 28, 2005
14, 15	April 12, 2013
16	May 18, 1999
17	October 28, 2005
18	March 27, 2001
19-22	February 13, 2009
23	August 8, 2014
24, 25	February 13, 2009
26-29	April 12, 2013
30-32	May 18, 1999
33-41	April 12, 2013
42-44	May 1, 2015

Additional Information

Refer questions about this general letter to your income maintenance administrator.

Department of HUMAN SERVICES

Employees' Manual
Title 1, Chapter E

Revised February 28, 2020

Appeals and Hearings

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Overview

The United States Constitution mandates that the Department guarantee due process of law to people whom we serve. "Due process of law" requires that people be allowed to:

- Present their complaints at a hearing,
- Be heard by testimony or otherwise, and
- Have an opportunity to cross-examine the Department's representative regarding actions taken on their case.

Iowa law also requires that certain procedures be followed when state or federal constitution or law requires the Department to provide the opportunity for a hearing.

The appeals process is divided into three areas of responsibility between the different state agencies:

- The Department of Human Services (DHS) Appeals Section is responsible for logging in the appeal, determining if it is timely, and identifying the issue being appealed.
- Once all of these steps are completed, the appeal is certified to the Department of Inspections and Appeals, Division of Administrative Hearings, for the appeal hearing to be scheduled.
- Upon issuance of a Proposed Decision, the DHS Appeals Section is responsible for issuance of all Final Decisions.

This chapter applies to all Department appeals and hearings as required by the Iowa Administrative Procedures Act, under the federal regulations and state laws that apply to the programs administered by the Department. Hearing procedures for Food Assistance intentional program violations are found in Employees' Manual 7-J.

Legal Basis

The Fourteenth Amendment to the United States Constitution provides for appeals and hearings. The provisions of the Fourteenth Amendment are interpreted in the Code of Federal Regulations (CFR). The portions of the Code specifically dealing with appeals and hearings for each program are:

- Food Assistance, 7 CFR 273.15
- Medicaid, 42 CFR Part 431 Subpart E
- Managed care organizations, 42 CFR Part 438, Subpart F

Iowa's authorizing legislation is found at Iowa Code Chapter 17A. The Department has promulgated rules on appeals and hearings at 441 Iowa Administrative Code Chapter 7.

Definitions

Legal reference: 441 IAC 7.1(17A)

"**Administrative hearing**" means a type of hearing that an appellant may elect in which the presiding officer reviews the written record only and makes a decision based on the facts available within the appeal file. An administrative hearing does not require an in-person or teleconference hearing. The Appeals Section or the presiding officer makes the final determination to establish whether an administrative hearing may be held.

"**Administrative law judge**" means an employee of the Department of Inspections and Appeals who conducts appeal hearings.

"**Agency**" means the Department of Human Services, including any of its local, institutional or central administrative offices.

"**Aggrieved person**" means a person against whom the Department has taken an adverse action. This includes a person who meets any of the following conditions listed in Aggrieved Person.

"**Appeal**" denotes a review and hearing request made by a person who is affected by a decision made by the Department or its designee. An appeal is considered a contested case within the meaning of Iowa Code Chapter 17A.

"**Appeals section**" means the unit within the Department of Human Services that receives appeal requests, certifies requests for hearing, and issues final appeal decisions.

"**Appellant**" denotes the person who claims or asserts a right or demand (files the appeal) or the party who takes an appeal from a hearing to an Iowa district court.

"**Attribution appeal**" means an appeal to determine if additional resources can be allocated for the community spouse when the other spouse has entered a medical institution or is applying for home- and community-based waiver services. The result of the attribution appeal may affect Medicaid eligibility. An appellant may elect to have an attribution appeal held by administrative hearing.

"**Authorized representative**" means a person or organization designated by an appellant to act on the appellant's behalf or who has legal authority to act on behalf of the appellant, such as a guardian or power of attorney.

"**Bidder**" means an individual or entity that submits a proposal in response to a competitive bid issued by the Department of Human Services.

"**Contested case**" means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a "no factual dispute" contested case under Iowa Code section 17A.10A.

"**Department**" means the Iowa Department of Human Services (DHS).

"**Department of Inspections and Appeals (DIA)**" means the state agency which contracts with the Department to conduct appeal hearings.

"**Due process**" denotes the right of a person affected by a Department decision to receive a *Notice of Decision* and an opportunity to be heard at an appeal hearing and to present an effective defense.

"**Electronic account**" means a web-based account established by the Department for an applicant or member for communication between the Department and the applicant or member.

"**Electronic case record**" means an electronic file that includes all information collected and generated by the Department regarding each individual's Medicaid or Hawki eligibility and enrollment, including all documentation required for eligibility and any information collected or generated as part of a fair hearing process conducted by the Department or through the exchange appeals process.

"**Ex parte communication**" means written, oral, or other forms of communication between a party to the appeal and the presiding officer while an appeal is pending when not all parties were given the opportunity to participate.

"**Exchange**" means an American health benefit exchange established pursuant to Section 1311 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148). This entity makes qualified health plans available to qualified individuals and qualified employers.

"**First-level review**" means a review process that must be exhausted through a managed care organization before an appeal hearing is granted. Once the first-level review process is complete, a *Notice of Decision* will be issued by the managed care organization and will identify further appeal rights, if applicable.

"**FMAP-related**" describes coverage groups whose eligibility criteria are derived in relation to the family medical assistance program, directed toward children and their parents or caretakers.

"**Food Assistance administrative disqualification hearing**" means a type of hearing used to determine if an individual fraudulently received benefits for which the individual was not eligible. A presiding officer shall determine if the individual will be banned from participating in the Food Assistance program for a period of time.

"**Group hearings**" denotes an opportunity for two or more people to present their case jointly when all have the same complaint against agency policy.

"**Informal conference**" means a type of meeting between the appellant and the appellant's representative, unless precluded by federal law or state statute, and a representative of the Department. The purpose of the informal conference is to:

- Provide information as to the reasons for the intended adverse action,
- Answer questions,
- Explain the basis for the adverse action,
- Provide an opportunity for the appellant to explain the appellant's action or position, and
- Provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the Department at the hearing.

"**In-person or face-to-face-hearing**" means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.

"**Intentional program violation**" means deliberately making a false or misleading statement; misrepresenting, concealing, or withholding facts; or committing an act that is a violation of the Food and Nutrition Act of 2008, food assistance program regulations, or any state rule relating to the use, presentation, transfer, acquisition, receipt, possession or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a Food Assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

"**Local office**" means the county, institution or district office of the Department.

"**Managed care organization**" or "**MCO**" means an entity that is under contract with the Department to provide services to Medicaid recipients and meets the definition of "health maintenance organization" in Iowa Code section 514B.1.

"**Party**" means a party as defined in Iowa Code subsection 17A.2(8).

"**Prehearing conference**" means a type of meeting between the appellant and the appellant's representative, unless precluded by federal law or state statute, a representative of the Department and a presiding officer. The purpose of the prehearing conference is to:

- Discuss the appealed issue,
- Inquire as to the potential for voluntary settlement,
- Establish the hearing date,
- Establish the location of the hearing including whether the hearing will be by telephone or in person, and
- Discuss procedural matters relevant to the case.

"**Presiding officer**" means an administrative law judge employed by DIA. The presiding officer may also be the Department's director or the director's designee. The presiding officer has the authority to conduct appeal hearings and render proposed and final decisions.

"**Presumption**" denotes an inference as to the existence of a fact not known or drawn from facts that are known.

"**PROMISE JOBS discrimination complaint**" means any written complaint by a PROMISE JOBS participant or the participant's representative, which alleges that an adverse action was taken against the participant on the basis of race, creed, color, sex, national origin, religion, age, physical or mental disability, or political belief.

"**PROMISE JOBS displacement grievance**" means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives, which alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers.

"**Proposed decision**" means the presiding officer's recommended findings of fact, conclusions of law, and decision and order in contested cases where the Department did not reside.

"**Reconsideration**" means a review process that must be exhausted before an appeal hearing is granted. This includes, but is not limited to, a reconsideration request through:

- The Iowa Medicaid Enterprise (IME).
- A division or bureau within the Department.
- The Mental Health and Disability Services Commission.
- A licensed health professional as specified in 1-C, Review Process for a Denial of Access Due to Probable Harm.
- Any division or bureau within the Department from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a *Notice of Decision* or *Notice of Action* will be issued with appeal rights.

"**Sent**" means deposited in the mail with first-class postage or posted to an individual's electronic account.

"**SSI-related**" describes medical assistance coverage groups whose eligibility criteria, except for income and resource limits, are derived from the supplemental security income (SSI) program for people who are aged, blind, or disabled.

"**Teleconference hearing**" means an appeal hearing conducted by an administrative law judge over the phone.

"**Timely notice period**" is the time from the date a notice is mailed to the effective date of action. That period shall be at least ten calendar days, except in the case of probable fraud of the appellant. When probable fraud of the appellant exists, "timely notice period" shall be at least five calendar days from the date a notice is sent.

"**Vendor**" means a provider of health care under the Medicaid program or a provider of services under the service program.

The Right to Appeal

Legal reference: 441 IAC 7.5(17A), 7 CFR 273.15(a), 42 CFR 431.206

Any person or group of persons has the right to appeal any Departmental decision and to request an appeal hearing. No one may limit or interfere with this right. A person or group must never be denied the right to appeal. However, the right to appeal does not guarantee that an appeal hearing will be granted.

The Department determines whether a hearing will be granted. The Department will grant a hearing to any appellant when state or federal law or constitution grants the right to a hearing, except as provided at Right of the Department to Deny or Dismiss an Appeal.

The Department must advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status. Examples of adverse action include:

- Failure to act on the client's application with reasonable promptness.
- Denial of Food Assistance, financial assistance, Medicaid or services.
- Denial of correction of Child Abuse or Dependent Adult Abuse Registry information.
- Denial or revocation of a license, certification, approval or accreditation.
- Determination due to record check evaluation that a person may not be employed or is restricted from participating in an educational training program.
- Determination that a person must participate in a service program.
- Determination that an overpayment of benefits or services has occurred and repayment is requested.
- Determination that level of care requirements have not been met.
- Denial of a claim for payment or prior authorization for Medicaid fee-for-service members.
- Denial of a prior authorization for Medicaid managed care organization members.
- Retention of state or federal income tax refund monies or other state or federal warrants.
- Reduction or termination of Food Assistance, financial assistance, Medicaid or services.

The following sections give more information on:

- Informing persons about their appeal rights
- Publicizing hearing procedures

Informing Persons of Their Rights

Legal reference: 441 IAC 7.6(1), 7 CFR 273.15(f) and (i), 42 CFR 431.206

All Department application forms, notices, pamphlets, and brochures must contain information on the appeals process.

Give written notification regarding the appeal process on application forms, *Notices of Decision*, *Notices of Action*, and pamphlets prepared by the Department for applicants and recipients. Give an oral explanation of the appeals policy during the application process and at the time of any contemplated action by the Department when a need for an explanation is indicated.

Give written notification of the following at the time of application and at the time of any Department action affecting the claim for assistance:

- 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 statute or federal regulation.
- Provisions for payment of legal fees by the Department, if any.
- How to have assistance continued while the appeal is pending.

Provide a translation for persons not familiar with English into the language they understand. This can be in the form of a written pamphlet or orally. Arrange for an interpreter to be present during an appeal hearing, when one is requested. These services are provided at no cost to the individual.

Advise an appellant who is illiterate or semiliterate of their rights in a manner that satisfies their needs.

Assist people living with disabilities using auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

Publication of Hearing Procedures

Legal reference: 441 IAC 7.4(17A); 7 CFR 273.15(f) and (i); 42 CFR 431.205, 431.206, and 438.406(a)

The Department publishes and widely distributes hearing procedures. Make this information available to all applicants, recipients, appellants, and other interested groups and individuals. The process for filing an appeal can be found on all *Notices of Decision* or *Notices of Action* issued by the Department. Procedures regarding the appeal hearing can be found on the *Notice of Hearing*.

Procedures must be written in a plain language and in a manner that is accessible to individuals who are limited English proficient and individuals living with disabilities.

Written Translations, Verbal Interpretation or Other Special Accommodations

Legal reference: 441 IAC 7.4(1)(a), 7 CFR 273.15(i)

The Department must accommodate a request for written translation of appeal correspondence or arrange for an interpreter to appear and interpret the appeal testimony during an appeal hearing. However, the Department is only required to provide translation and interpreter services to the appellant. No services will be provided for the appellant's attorney, witness, representative, etc.

Verbal Interpretation

The Department contracts with a provider to provide interpretation services. No employee, family member, or other person acting on the appellant's behalf can provide interpretation during an appeal hearing. As an appeal hearing is a legal proceeding, only court-certified interpreters will be allowed to participate. This guarantees the individual providing the interpretation service is an unbiased third party.

The office responsible for the action being appealed is responsible for setting up an interpreter for the appeal hearing. If the appellant speaks an obscure language, contact the contractor before the start of the appeal hearing to ensure there is an interpreter available on the date and time of the appeal hearing. If the contractor does not have an interpreter on staff for a specific language, the contractor will attempt to find someone who can do the interpretation.

The Appeals Section will provide an *Interpreter Contact Information* form when an interpreter is requested. Complete and upload the form into the Appeals Information System (AIS) within five calendar days of receipt of the form. The administrative law judge will connect the interpreter to the appeal hearing.

If the appeal is based on an Iowa Medicaid Enterprise or a managed care organization action, the income maintenance worker will provide the call in information for the interpreter, but will not need to attend the appeal hearing. Otherwise, the worker who took the action that is being appealed is responsible for providing the call in information and attending the appeal hearing.

Written Translations

The Department contracts with a provider to provide translation services. The worker responsible for the action that is being appealed is responsible for requesting translation of the appeal summary and any other supporting documentation that will be used at the hearing. However, a general rule for translations is if the appellant already received the document in English or if it was provided by the household, the document will not be translated into another language.

Email translation requests to the DHS, Translations mailbox. The mailbox is monitored by Central Office staff who work directly with the contractor to obtain the translation. Once complete, the translated version will be sent back to the requestor.

Special Needs Accomodations

Arrangements may also be made for the following special needs accommodations:

- Sign-language interpretation
- Relay Iowa for hearing impaired individuals
- Sorenson video conferencing
- Large-font documents for those who are blind
- Read items on a cassette tape
- Braille

Notify the Appeals Section as soon as the appellant requests special accommodations.

Notice of Decision or Action

Legal reference: 441 IAC 7.7(1), 7 CFR 273.13, 42 CFR 431.210 and 42 CFR 438.404

The Department is required to give **adequate** notice of an action when the Department:

- Approves or denies an application for assistance or services.
- Approves or denies a license, certification, approval, registration or accreditation.
- Proposes action for a state or federal tax or debtor offset. (See Adequate Notice for specific requirements.)

Whenever the Department proposes to terminate or reduce ongoing assistance or services or revoke a license, certification, approval, registration or accreditation, give **timely and adequate** notice of the pending action, except as listed under Dispensing With Timely Notice.

"Assistance" includes:

- Food assistance,
- Medical assistance,
- The Family Investment Program,
- Refugee Cash Assistance,
- Child Care Assistance,
- Emergency assistance,
- The Family Planning Program,
- Family or Community Self-Sufficiency Grant,
- PROMISE JOBS,
- State Supplementary Assistance,
- Healthy and Well Kids in Iowa (Hawki) Program,
- Foster care,
- Adoption,
- Aftercare services, or
- Other programs or services provided by the Department.

"Timely" means that the notice is mailed at least ten calendar days before the date the action becomes effective. The timely notice period begins on the day after the notice is mailed.

Emergency services for Food Assistance benefits may be issued without a *Notice of Decision*. However, once action is completed on the application, timely and adequate notice must be issued.

The following sections explain:

- Requirements for an "adequate" notice
- Definition of a timely notice and exceptions to when it is required
- Actions that do not require a notice of decision
- Actions due to probable fraud
- Reinstatement requirements

Adequate Notice

Legal reference: 441 IAC 7.7(1)"c," 7 CFR 273.13(a)(2)

"Adequate" means a written notice that includes:

- A statement of what action is being taken and the reasons for it.
- The administrative rule reference.
- The client's right to request a fair hearing.
- When assistance is continued if an appeal is filed, if applicable.
- The effective date of the intended action, if applicable.

Every notice the Department issues must be adequate. Failure to issue an adequate notice may invalidate the action appealed. The appeal rights statement is required on all notices of adverse action and must consist of the elements listed above.

Notice is issued to clients to offer them an opportunity to correct the reason for the intended adverse action and to allow sufficient notice to properly prepare a defense for an administrative hearing. Failing to state the reason for the action and the specific administrative rule reference denies the client the information necessary to cure the reason for the intended action or to know about what or how to prepare a defense for an administrative hearing.

Manually prepared *Notices of Decision*, *Notices of Action* or notices in letter format must meet all of these criteria. Tailor manually prepared notices to match computer-generated notices as closely as possible. A reference to the Employees' Manual or other technical guidance is not sufficient. As the manual has not been adopted as a formal agency rule, it does not have the same force and effect as law and cannot serve as the legal basis for the Department's position.

The notice should include the federal or state law or administrative rule reference regarding the action taken.

Dispensing With Timely Notice

Legal reference: 441 IAC 7.7(2), 7 CFR 273.13(b), 42 CFR 431.213

You may dispense with timely notice (but you must send adequate notice no later than the date benefits would have been issued) when:

- The Department approves or denies an application for assistance.
- There is evidence confirming that a recipient or family investment program payee has died, when there is no relative available to serve as a new payee.
- The Department determines that a household has moved out of Iowa.
- The person has been admitted or committed to an institution that does not qualify for payment under an assistance program.
- The person has been placed in a skilled nursing or intermediate care facility or long-term hospitalization.
- The person's physician prescribes a change in the level of medical care.
- Cash assistance or Food Assistance changes because a child is removed from the home through a judicial determination or is voluntarily placed in foster care.
- The person's whereabouts are unknown and the post office returned mail directed to the person indicating no known forwarding address. If the person is located within the payment month, reissue any undelivered warrant.
- The notice involves an adverse determination made with regard to the preadmission screening requirements.
- The person has been accepted for assistance in another state.
- The person provides a clear, written, signed statement that the person no longer wants assistance, or has given information that requires termination or reduction of assistance, and has indicated, in writing, that the person understands the consequence of supplying the information.
- The Department terminates or reduces benefits or makes changes based on a completed *Review/Recertification Eligibility Document* (RRED), form 470-2881, 470-2881(S), 470-2881(M) or 470-2881(MS).
- The Department terminated benefits for failure to return a completed report form (RRED).

- The Department terminates a special allowance or service granted for a specific predetermined period, and the person was informed in writing at the time of initiation that the allowance or service will terminate at the end of the specified period.
- The Department implements a mass change based on law or rule changes that affect a group of recipients.
- A service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year.

Notice Not Required

Legal reference: 441 IAC 7.7(5), 7 CFR 273.13(b)

Notification is not required when:

- Services in the Social Service Block Grant Pre-Expenditure Report are changed from one plan year to the next, or the plan is amended because funds are no longer available.
- Service has been time-limited in the Social Service Block Grant Pre-Expenditure Report, and as a result, the service is no longer available.
- The Department changes the placement of a person in foster care.
- Payment has been in accordance with the Medicaid payment schedule for the service billed (because there is no adverse action).
- It has been determined, based on reliable information, that the Food Assistance household has moved from the project area.

Action Due to Probable Fraud

Legal reference: 441 IAC 7.7(3), 42 CFR 431.214

When the Department obtains facts indicating assistance should be canceled, suspended or reduced because of probable fraud and the facts have been verified through collateral sources, a notice of action will be timely when sent at least five calendar days before the action would become effective. Send the notice by certified mail, return receipt requested.

Reinstatement

Legal reference: 441 IAC 7.7(6)

Whenever a previously canceled case must remain canceled for a reason other than that covered by the original notice, send timely and adequate notice of the new cancellation, except as specified under Dispensing With Timely Notice.

Whenever a previously canceled case is eligible for reinstatement at a lower level of benefits for a reason other than that covered by the original notice, send timely and adequate notice of reinstatement, except as listed under Dispensing With Timely Notice.

Aggrieved Person

Legal reference: 441 IAC 7.2(17A), 7 CFR 273.15(a), 42 CFR 438.400

To be eligible for an appeal hearing, a person must meet the definition of an "aggrieved person" and qualify on a program-specific basis.

Financial Assistance

Financial assistance includes, but is not limited to the:

- Family Investment Program;
- Refugee Cash Assistance;
- Child Care Assistance;
- Emergency or Disaster Assistance;
- Family or Community Self-Sufficiency Grants;
- Family Investment Program hardship exemptions; and
- State Supplementary Assistance dependent person, in-home health related care, and residential care facility benefits.

Appealable issues may include:

- A request to be given an application was denied.
- An application for assistance has been denied or has not been acted on in a timely manner.
- The effective date of assistance is contested.
- The amount of benefits granted is contested.
- The assistance will be reduced or canceled.
- An overpayment of benefits has been established and repayment is requested.

Food Assistance

Appealable issues may include:

- A request to be given an application was denied.
- An application for assistance has been denied or has not been acted on in a timely manner.
- The effective date of assistance is contested.
- The amount of benefits granted is contested.
- The assistance will be reduced or canceled.
- A request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.
- An overpayment of benefits has been established and repayment is requested.

Medical Assistance Eligibility

Medical assistance eligibility includes, but is not limited to:

- FMAP-related coverage groups,
- SSI-related coverage groups,
- The Breast and Cervical Cancer Treatment Program,
- The Health Insurance Premium Payment Program,
- Healthy and Well Kids in Iowa (Hawki),
- The Iowa Health and Wellness Plan, and
- Waiver services.

Appealable issues may include:

- A request to be given an application was denied.
- An application has been denied or has not been acted on in a timely manner.
- The person's eligibility has been terminated, suspended or reduced.
- The level of benefits the person is eligible to receive has been reduced.
- A determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing is contested.

- The level of care requirements have not been met.
- The failure to take into account the appellant's choice in assignment to a coverage group.
- The effective date of assistance is contested.
- The amount or effective date of one of the following is contested:
  - Health insurance premiums,
  - Healthy and Well Kids in Iowa premiums,
  - Medicaid for Employed People with Disabilities premiums,
  - Iowa Health and Wellness Plan contributions,
  - Client participation, or
  - Medically Needy program spenddown.
- An overpayment of benefits has been established and repayment is requested.

Fee-for-Service Medical Coverage

Issues may include:

- The level of services that the person is eligible to receive has been reduced.
- The level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.
- The effective date of services is contested.
- A claim for payment or prior authorization has been denied.
- The medical assistance hotline has issued notification that services not received or services for which an individual is billed are not payable by medical assistance.
- Nonemergency medical transportation services by the broker designated by the Department have been denied.

Managed Care Organization Medical Coverage

A Medicaid member, an authorized representative or a provider who is acting on behalf of a member may file a state fair hearing request after receiving notification that the first-level review process through a managed care organization has been exhausted.

If a provider or authorized representative is filing an appeal on behalf of a member, the member's written consent must be submitted on form 470-5526, *Authorized Representative for Managed Care Appeals*. The managed care organization or the Appeals Section will obtain the member's written consent, if the appeal is filed verbally.

The Medicaid member, authorized representative or provider who is acting on behalf of the member may be deemed to have exhausted the managed care organization's appeals process when the managed care organization fails to adhere to the notice and timing requirements in 42 CFR 438.408.

Providers

Providers can be an individual or an entity. Issues may include:

- A license, certification, registration, approval or accreditation has been denied or revoked or has not been acted on in a timely manner.
- A fee-for-service claim for payment or request for prior authorization of payment has been denied in whole or in part and the provider states that the denial was not made according to Department policy.
- A medical assistance patient manager contract has been terminated.
- A payment has been withheld to recover a previous overpayment or an order to repay an overpayment has been received.
- An application for child care quality rating has not been acted upon in a timely fashion.
- A child care quality rating decision is contested.
- A certificate of child care quality rating has been revoked.

- An adverse action has been taken relating to the Iowa electronic health record incentive program, including:
  - Provider eligibility determination;
  - Incentive payment; or
  - Demonstration of adopting, implementing, upgrading, and meaningful use of technology.
- An application or reapplication for licensure was issued as a provisional license.
- A license has been issued for a limited time.

Social Services

Social services include, but are not limited to, adoption, foster care, and family-centered services. Issues may include:

- A request to be given an application was denied.
- An application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.
- An application or license has been denied based on a record check evaluation.
- A determination that a person must participate in a service program is contested.
- A claim for payment of services has been denied.
- A protective or vendor payment has been established.
- The services have been reduced or canceled.
- An overpayment of services has been established and repayment is requested.
- An adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.
- A referral to community care was not made as provided in 441 IAC 186.2(234).
- A referral to community care was made as provided in 441 IAC 186.2(234) and the community care provider's dispute resolution process has been exhausted.

Child Support

Issues may include:

- A person is not entitled to a support payment in full or in part because of the date of collection as provided in 441 IAC 95.13(17A) or a dispute based on the date of collection has not been acted on in a timely manner.
- A claim or offset is contested by a person's alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or in whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.
- A name has been certified for passport sanction.
- A termination in services has occurred.

PROMISE JOBS

Issues may include:

- A claim for participation allowances has been denied, reduced or canceled.
- The contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.
- The results of informal grievance resolution procedures are contested, an opportunity for an informal grievance resolution has been declined or a decision was not made within the 14-day period.
- PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
- An overpayment of benefits has been established and repayment is requested.
- Acts of discrimination are alleged on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin or political belief.

Child Abuse Registry, Dependent Adult Abuse Registry or Record Check Evaluation

Issues may include:

- A person is alleged responsible for child abuse.
- A correction of dependent adult abuse information has been requested.
- A record check evaluation restricted or denied employment in a health care facility, state institution or other facility. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider or a contractor. "Facility" includes, but is not limited to:
  - County or multicounty juvenile detention homes and juvenile shelter care homes,
  - Child-placing agencies,
  - Substance abuse treatment programs,
  - Group living foster care facilities,
  - Child development homes,
  - Child care centers,
  - State resource center,
  - Mental health institutes, and
  - State training schools.
- A record check evaluation results in the restriction of participation in an educational training program.

Mental Health and Disability Services

Issues may include:

- An application for state payment has been denied or has not been acted upon in a timely manner.
- Services under the state payment program have been reduced or canceled.
- A request to be given an application was denied.
- The person's eligibility has been terminated, suspended or reduced.

- The level of benefits or services the person is eligible to receive has been reduced.
- The effective date of assistance or services is contested.
- The reconsideration process has been exhausted and a person remains dissatisfied with the outcome.
- The amount or effective date of cost-sharing requirements for the autism support program is contested.
- A service authorization request for applied behavioral analysis services has been denied or reduced.

Health Insurance Portability and Accountability Act (HIPAA)

A current or former applicant for or recipient of Medicaid or Hawki, or a person currently or previously in a Department facility whose request:

- To restrict use or disclosure of protected health information was denied.
- To change how protected health information is provided was denied.
- For access to protected health information was denied. When the denial is subject to reconsideration, persons denied access due to a licensed health care professional's opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.
- To amend protected health information was denied.
- For an accounting of disclosures was denied.

Drug Manufacturers

A manufacturer that has received a *Notice of Decision* regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement disagrees with the decision.

Competitive Procurement Bid Process Bidders

Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process and disagrees with the decision.

Family Planning Program

Issues may include:

- A request to be given an application was denied.
- An application has been denied or has not been acted on in a timely manner.
- The person's eligibility has been terminated or reduced.
- Who contests the effective date of assistance or services.
- Whose claim for payment or prior authorization has been denied.
- Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by the family planning program.
- Who has been notified that an overpayment of benefits has been established and repayment is requested.

Other Individuals or Providers

Individuals or providers that are not listed may meet the definition of an aggrieved person if the Department has taken an adverse action against that individual or provider.

Opportunity for Hearing

Legal reference: 441 IAC 7.8(1), 7 CFR 273.15(h), 42 CFR 431.221 and 42 CFR 438.402(c)

An appeal is an expression by the household or its representative that the household wishes to appeal a decision or desires an opportunity to present its case to a higher authority. No one shall limit or interfere with the freedom to request an appeal in any way.

When a person, the person's authorized representative or an individual or organization recognized by the Department as acting responsibly for the appellant expresses in writing dissatisfaction with any decision, action or failure to act with reference to the case, the Department must determine whether the person wishes to appeal and receive an appeal hearing before an administrative law judge.

The following sections give more information:

- Procedures for filing an appeal
- The Department's right to deny or dismiss an appeal
- Time limits for granting an appeal hearing
- Withdrawing an appeal request

Filing an Appeal

Legal reference: 441 IAC 7.8(2), 7 CFR 273.15(h), 42 CFR 431.221

An appeal request for Food Assistance, Medicaid, Hawki, Child Care Assistance, Family Planning Program or the Family Investment Program may be expressed verbally in person or by telephone or in writing. All other types of appeal requests must be in writing.

Instruct appellants to submit an appeal request via the Department's website or mail, email, fax or personally deliver the appeal request to the Appeals Section, the local office or to the Department office that took the adverse action. Appellants may call or stop by the Appeals Section or the Department office that took the adverse action to file a verbal appeal. Document the verbal appeal request on form 470-0487 or 470-0487(S), *Appeal and Request for Hearing.*

A Medicaid provider, or an authorized representative, requesting a hearing on behalf of a Medicaid member about an adverse benefit determination made by a managed care organization must have previous express written consent of the member or the member's lawfully appointed guardian on form 470-5526, *Authorized Representative for Managed Care Appeals*.

Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person. No hearing will be granted unless the provider submits a document providing the member's consent to the request for a hearing.

Encourage the appellant to make a written appeal on form 470-0487 or 470-0487(S), *Appeal and Request for Hearing*. Provide any instructions or assistance required in completing the form. However, use of this form is not required. If the appellant submits the written appeal on another paper, attach it to the appeal form.

The fact that an appellant is unwilling to complete or sign the appeal form does not preclude the right to file an appeal, as long as the appeal has been communicated to the Department by the appellant or appellant's representative and is in writing, when required.

The office where the appeal is received must document the receipt date of all appeals, including the date the appeal was orally requested, when applicable. Document the filing date by saving the envelope with the postmark and date stamping the date received at any Department office. Attach the envelope to the appeal form, scan all documents, and forward it electronically to the DHS Appeals Section **within 24 hours of receipt**.

A written appeal submitted by mail is considered filed on the date postmarked on the envelope that is sent to the Department. When the postmarked envelope is not available, a written appeal is filed on the date the appeal is date-stamped received by the Department.

An appeal submitted through an electronic delivery method, such as email, submission of the online form or FAX, is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method, the filing date is the date the appeal is stamped received by the Department.

Advise the person of any legal services that may be available and that the individual may be represented by counsel at the individual's own expense.

Registration and Acknowledgment of Appeal

Legal reference: 441 IAC 7.10(1) and (2)

Upon receipt of an appeal, the DHS Appeals Section registers the appeal and sends an acknowledgment of receipt of the appeal to the appellant, representative, and all parties to the appeal. Department staff are notified by electronic mail via the Appeals Information System (AIS).

For appeals regarding child abuse, all subjects other than the person alleged responsible (appellant) are notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

Right of the Department to Deny or Dismiss an Appeal

Legal reference: 441 IAC 7.5(2), 7.5(4), 7.8(6); 7 CFR 273.15(a), 273.15(j); 42 CFR 431.223

The DHS Appeals Section has the responsibility for determining whether a hearing will be granted. A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law. However, there are times when a hearing will not be granted, such as:

- Upon review, the Appeals Section determines that the appellant does not meet the criteria of an aggrieved person. (See Aggrieved Person.)
- State or federal law or regulation provides for a different forum for appeals.
- The appeal is filed prematurely, when there is no adverse action by the Department or the appellant has not exhausted the reconsideration process or the first level review process with a managed care organization.
- The appeal is not timely. (See Time Limit for Granting an Appeal Hearing.)
- Either state or federal law requires automatic grant adjustments for classes of recipients. The director will decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.
- Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.
- A person is appealing a notice received from the Federal Treasury Offset Program.
- Children have been removed from or placed in a specific foster care setting or preadoptive family.
- The service is no longer available from the Department.
- Repayment of Food Assistance benefits as a result of trafficking is requested on form 470-4179, *Notice of Food Assistance Debt*.
- A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid, but presumptive eligibility ends due to the person's failure to file an application.
- A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid.
- A review of a rate determination for foster group care services.

- The maximum provider rate ceiling for child care assistance.
- The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund.
- The appellant has a complaint about child support recovery matters other than those defined in the Aggrieved Person section. This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.
- The appellant has a complaint about a local office employee.
- A request for an exception to policy has been denied.
- A Final Decision from a previous appeal hearing with a presiding officer has been implemented.
- The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.
- The appeal involves patient treatment interventions outlined in the patient handbook of the Civil Commitment Unit for Sexual Offenders.
- A provider or authorized representative for a managed care appeal fails to submit form 470-5526, *Authorized Representative for Managed Care Appeals*, providing the member's approval of the request for appeal.
- Notice was issued by the Exchange regarding determination of eligibility for enrollment in a qualified health plan or for advance payment of the premium tax credit or cost-sharing reductions.
- Notice has been issued regarding the completion of a family assessment that indicates no determination of child abuse or neglect has been made and no information has been reported to the child abuse registry.
- Notice has been issued regarding a managed care organization grievance request.
- Notice has been issued by a managed care organization to a provider regarding a claims dispute issue.
- The sole basis for denying, terminating or limiting assistance for Diversion, Emergency Assistance or the Family Planning Program is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.
- The issue appealed is moot.
- The issue appealed has previously been determined in another appeal by the same appellant.

When the DHS Appeals Section receives a request for appeal and determines that there is no right to a hearing because of one of the above reasons, the DHS Appeals Section will issue a written denial.

The DHS Appeals Section or the Department of Inspections and Appeals also has the right to deny or dismiss the appeal when:

- The appellant has withdrawn the appeal. (See Withdrawal of Appeal Request.)
- The Department, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.
- The Department implements the action and issues a *Notice of Decision* or *Notice of Action* to correct an error made by the Department that resulted in the appeal.
- The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.
- The appeal has been abandoned. Abandonment may be deemed to have occurred when the appellant, the appellant's authorized representative or the Department's representative fails to appear at the prehearing or hearing without good cause.

Time Limit for Granting an Appeal Hearing

Legal reference: 441 IAC 7.5(4), 7 CFR 273.15(g), 42 CFR 431.221 and 42 CFR 438.408(f)(2)

The DHS Appeals Section has the responsibility for determining whether an appeal shall be considered timely. Subject to the provisions of Right of the Department to Deny or Dismiss an Appeal, the granting of a hearing is governed by these time standards:

- For child abuse: A hearing will be granted on appeals made by a person alleged responsible for the abuse within 90 days from the date of the notice of child abuse assessment. NOTE: Subjects of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the hearing if the motion is made within 10 calendar days after the appeal notification.
- For dependent adult abuse: A hearing will be granted on appeals made within six months from the date of the adult protective notification.

- For state or federal tax or debtor setoffs: A hearing will be granted on appeals made within 15 days of the date of the letter of notification for state or federal tax offset or offset of any other warrant. NOTE: Hearings are held for offset of federal tax warrants or other federal warrants only if the offset is due to a child support debt.
- For Food Assistance:
  - A hearing will be granted on appeals made within 90 days of the date on the *Notice of Decision* or *Notice of Action*. A request for restoration of any Food Assistance benefit loss more than 90 days, but less than a year before the request, is also eligible for an appeal hearing.
  - A household may request a hearing to dispute the current level of benefits at any time within a Food Assistance certification period.
- For Medicaid:
  - A hearing regarding an eligibility determination will be granted on appeals made within 90 days of the date on the *Notice of Decision* or *Notice of Action*.
  - A hearing regarding a health care decision made by the Iowa Medicaid Enterprise when the individual is covered by fee-for-service Medicaid will be granted on appeals made within 90 days of the date on the *Notice of Decision* or *Notice of Action*.
  - A hearing regarding a health care decision made by a managed care organization will be granted on appeals made within 120 days after the appeal is deemed to have exhausted the managed care organization's appeals process.
- For Family Planning Program or Autism Support Program: A hearing will be granted on appeals made within 90 days of the date on the *Notice of Decision* or *Notice of Action*.
- For the Iowa Individual Disaster Assistance Program: A hearing will be granted on appeals made within 15 days of the date on the Department's reconsideration decision.
- For the Iowa Disaster Case Management Program: A hearing will be granted on appeals made within 15 days of the date on the Department's reconsideration decision.
- For sex offender risk assessment: A hearing will be granted on a sex offender risk assessment made within 14 calendar days of the issuance of the notice.

- For PROMISE JOBS displacement grievance: A hearing will be granted on an appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance when made within 10 days of issuance of the resolution decision, or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause exists to grant a hearing.
- For PROMISE JOBS discrimination complaint: A hearing will be granted on appeals made within 30 days after official notification of the action alleged to have involved discrimination.
- For Offsets of County Debts Owed to Department: A hearing will be granted on appeals made within 30 days of the date of the notification indicating there is a potential offset. The county's request for appeal will suspend the offset action until a final appeal decision is issued.
- For all other cases:
  - A hearing will be held if the appeal is filed within 30 days after official notification of an action or before the effective date of the action.
  - For programs, other than county debt offsets, that have a 15- or 30-day appeal timeframe, an appeal may still be granted if the appeal is filed more than 30 days, but less than 90 days after notification. The director will determine whether a hearing will be held. (See Reasons to Grant a Hearing.)
  - If a county appeals a debt offset, the county waives any right to appeal if the county fails to respond within 30 calendar days of the date of the notification.
  - Appeals filed more than 90 days after notification will not be heard.

The first day of the period within which an appeal must be filed is the day after the date the official notice is issued. When the last day of the period falls on a holiday or weekend, the time is extended to the next working day. However, the time limit for submitting an appeal is not extended while attempts at an informal settlement are in progress.

> Ms. A receives a *Notice of Decision* dated May 10, canceling her Family Investment Program grant effective June 1. The first day of the period within which she can appeal is May 11. The last day she can file an appeal and still be considered timely would be June 9. Since June 9 falls on a Saturday, the time is extended to the following Monday, June 11.

The following sections explain:

- Circumstances when the director may grant a hearing on an appeal request filed more than 30 days after the action
- Special circumstances governing the timeliness of appeals of:
  - Imposition of a FIP limited benefit plan
  - Collection of FIP and Food Assistance overpayments
  - Collection of Medicaid and State Supplementary Assistance overpayments
  - Job discrimination or displacement through PROMISE JOBS

Reasons to Grant a Hearing

Legal reference: 441 IAC 7.5(4)"a" and "d" and 7.5(5)

When an appeal is made more than 15 or 30 days, but less than 90 days after the official notice is received, the director may grant a hearing if one of the following conditions existed during the 15-day or 30-day timely appeal period:

- There was a serious illness or death of the appellant or a member of the appellant's family.
- There was a family emergency or household disaster, such as fire, flood or tornado.
- The appellant offers a good cause that was beyond the appellant's control and can be substantiated.
- There was a failure to receive the Department's notification for a reason out of the appellant's control. Lack of a forwarding address is in the appellant's control. However, a hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness or other good cause.

The following are factors that will be considered in determining if good cause exists:

- Did the appellant have the intent to appeal the decision?
- Is the appellant claiming that the DHS action was wrong and does the appellant present a basis for claiming the Department's action was wrong?
- Did the appellant fail to file the appeal within the 15-day or 30-day timeframe because of a mistake (regardless of whether the mistake was made by the appellant or someone helping the appellant with the appeal), or did the appellant willfully ignore the time frames?

The time limit for filing an appeal is not extended while attempts at informal settlements are in progress. For further information on informal settlements, refer to Prehearing Conference later in this chapter.

Managed Care Appeals

Legal reference: 42 CFR 438 Subpart F

A Medicaid member, or someone acting on their behalf, may appeal a managed care organization's decision to deny a specific medical item, service or prescription drug. The member must exhaust the managed care organization's first-level review process before filing an appeal with the Department.

If the managed care organization fails to issue a decision on the first-level review process within 30 calendar days from the date the managed care organization received the first-level appeal or failed to properly request an extension, the Appeals Section may deem that the appellant has exhausted the first-level appeals process. When this happens, the appellant may initiate a state fair hearing request.

The Appeals Section will work with the managed care organization to determine if the first-level appeal process has been exhausted. Staff from the managed care organization will participate in the appeal hearing, if one is scheduled.

Write an appeal summary that identifies the period of medical assistance eligibility and the eligible group for the time period covered by the appeal. Upload the appeal summary and exhibits into the Appeals Information System (AIS) and mail a copy to the appellant and their representative.

Third Party Liability

Legal reference: 441 IAC 75.2(249A), 75.4(3); 42 CFR 433.145 and 146

Iowa Medicaid Enterprise and each managed care organization has a unit that handles third-party liability claims. The unit's primary purpose is to identify and collect monies from any available medical resource that can pay all or part of a member's medical expense. A member or a person acting on the member's behalf must cooperate by providing information and verification about any medical or third party resources.

Prepare an appeal summary, gather exhibits and participate in the appeal hearing. Be prepared to testify about the eligibility requirement to cooperate with the Third-Party Liability Unit and the consequences for failure to cooperate.

Staff from the Iowa Medicaid Enterprise or the managed care organization will attend the hearing to provide details on the medical claims filed, why a third party was potentially responsible for payment or why the failure to cooperate with the third-party liability notification was sent.

Coordination between the two entities may be necessary before the start of the appeal hearing.

Appeals of Limited Benefit Plans

Legal reference: 441 IAC 7.5(8), 93.15(4)

A person has the right to appeal the establishment of the limited benefit plan **only once**. However, there are two different times when the person can appeal a **first** limited benefit. A person may appeal the first limited benefit at **one** of the following times:

- When a *Notice of Decision* establishes the beginning date of the limited benefit.
- When a *Notice of Decision* establishes the six-month period of ineligibility.

A person may appeal a second or subsequent limited benefit **only** when a *Notice of Decision* establishes the beginning date of the limited benefit.

If another appeal is filed after the limited benefit appeal, a hearing may be granted only if the appeal involves worker error, such as an incorrect grant computation or an error in determining the eligible group.

Appeals of FIP, RCA, and PROMISE JOBS Overpayments

Legal reference: 441 IAC 7.5(6)

A person's right to appeal the existence, computation, and amount of a Family Investment Program, Refugee Cash Assistance or PROMISE JOBS overpayment begins when the Department sends the first notice informing the person of the overpayment, on:

- Form 470-4683, *Notice of FIP or RCA Overpayment*, or
- Form 470-4688, *Notice of PROMISE JOBS Overpayment*.

A hearing will not be held if an appeal is filed in response to a second or subsequent *Notice of Overpayment*. The right to appeal is subject to the 30-day time limit described under Time Limit for Granting an Appeal Hearing.

A person's right to appeal the recovery of an overpayment through benefit reduction, as described in 4-H, Methods of Recovery, begins when the person receives form 470-0485, 470-0485(S), 470-0486 or 470-0486(S), *Notice of Decision* or *Notice of Action*, informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

Appeals of Food Assistance Overpayments

Legal reference: 441 IAC 7.5(10); 7 CFR 273.15(g)

A person's right to appeal the existence, computation, and amount of a Food Assistance overpayment begins when the Department sends the first notice informing the person of the overpayment, on form 470-4668, *Notice of Food Assistance Overpayment*.

A hearing may be held if an appeal is filed in response to a second or subsequent *Notice of Overpayment* if the appeal is filed within the 90-day time limit described under Time Limit for Granting an Appeal Hearing.

A person's right to appeal the recovery of an overpayment through benefit reduction begins when the person receives form 470-0485, 470-0485(S), 470-0486 or 470-0486(S), *Notice of Decision* or *Notice of Action*, informing the person that benefits will be reduced to recover a Food Assistance overpayment.

Appeals of Child Care Assistance Benefit Overpayments

Legal reference: 441 IAC 7.5(9)

A person's right to appeal the existence, computation, and amount of a Child Care Assistance benefit overpayment begins when the Department sends the first notice informing the person of the overpayment, on form 470-4530, *Notice of Child Care Assistance Overpayment*.

A hearing will not be held if an appeal is filed in response to a second or subsequent *Notice of Overpayment*. The right to appeal is subject to the 30-day time limit described under Time Limit for Granting an Appeal Hearing.

A program overpayment means child care assistance was received by or on behalf of a person in excess of that allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Child Care Assistance recipients and child care providers may be responsible for repayment of the overpayment.

Appeals of Family Planning Program Overpayments

Legal reference: 441 IAC 7.5(11)

A person's right to appeal the existence, computation, and amount of a Family Planning Program overpayment begins when the Department sends the first notice informing the person of the overpayment, on form 470-5483, *Notice of Family Planning Program Assistance Overpayment*.

A hearing will not be held if an appeal is filed in response to a second or subsequent *Notice of Overpayment*. The right to appeal is subject to the 90-day time limit described under Time Limit for Granting an Appeal Hearing.

Appeals of Medicaid, State Supplementary Assistance, and Hawki Program Overpayments

Legal reference: 441 IAC 7.5(7)

A person's right to appeal the existence, computation, and amount of a Medicaid State Supplementary Assistance or Healthy and Well Kids in Iowa (Hawki) program overpayment begins when the Department sends the first notice informing the person of the overpayment on:

- Form 470-2891, *Notice of Medical Assistance Overpayment*, or
- Form 470-3984, *Notice of Healthy and Well Kids in Iowa (Hawki) Premium Overpayment*.

A hearing will not be held if the appeal is filed in response to a second or subsequent *Notice of Overpayment*. The right to appeal is subject to the 90-day time limit described under Time Limit for Granting an Appeal Hearing.

PROMISE JOBS Displacement and Discrimination Appeals

Legal reference: 441 IAC 7.5(4)"f"

PROMISE JOBS displacement and discrimination appeals will be granted hearing on the following basis:

- An appeal of an informal grievance resolution decision on a PROMISE JOBS displacement grievance must be made in writing within 24 days of the filing of the displacement grievance or within ten days of mailing date of the resolution decision, whichever is sooner.
- An appeal by a PROMISE JOBS participant alleging discrimination must be made within the timeframes described under Time Limit for Granting an Appeal Hearing, in relation to the action alleged to have involved discrimination. Good cause may be allowed as described in Reasons to Grant a Hearing.

Withdrawal of Appeal Request

Legal reference: 441 IAC 7.8(8)

When the appellant or their representative desires to voluntarily withdraw the appeal, accept the request to withdraw the appeal by telephone, in writing or in person. A written request may be submitted on form 470-0492 or 470-0492(S), *Request for Withdrawal of Appeal*, however, use of the form is not required. Document a verbal withdraw request on the *Request for Withdrawal of Appeal* form.

A request to withdraw an appeal for child or dependent adult abuse must be made on the record before an administrative law judge or in writing and signed by the appellant or the appellant's legal counsel.

If the appeal has been assigned an appeal number, upload the *Request for Withdrawal of Appeal* into the Appeals Information System (AIS) and use the send email feature to notify other DHS parties and the administrative law judge of the request.

If no appeal number has been assigned, forward a copy of the form to the DHS, Appeals mailbox. The Appeals Section will upload a copy of the withdraw request, once the appeal record has been established in AIS.

If the request is made directly to the DHS Appeals Section, the DHS Appeals Section will document the request, upload into AIS and notify the local office and the Department of Inspections and Appeals that the appeal is withdrawn.

Only the appellant or their representative can request to withdraw an appeal. No other party can withdraw the appeal. If the issue has been resolved, the other parties may request the appeal be dismissed. See Dismissal of Appeal Request for more information.

An appeal is not withdrawn until the judge issues a Withdrawal Order. Do not assume the judge is going to grant the request just because a withdraw request was uploaded into AIS. Until the order is issued, proceed accordingly by completing an appeal summary, gathering exhibits, and preparing for the appeal hearing.

Withdrawal at Informal or Prehearing Conference

An informal or prehearing conference may lead to a resolution of the dispute. However, the hearing process will continue unless the appellant or their representative makes a verbal or written request to withdraw.

Confirm the withdraw request with the appellant's representative, if applicable. If a withdraw request is made without the knowledge of an attorney on record, the request may still be valid. However, the request may be invalid if the attorney presents valid objection to the withdrawal.

When the Department discovers that it erred in the initial decision, immediately advise the appellant of the Department's willingness to rectify the error. When the appellant accepts the corrections of error and withdraws the appeal, make the correction immediately.

Dismissal of Appeal Request

Legal reference: 441 IAC 7.8(6)

During the appeals process, determine if the issue being appealed can be resolved. Complete and upload into AIS form 470-5597, *Dismissal Request*, along with documentation proving the issue is resolved.

Examples of documentation showing the issue has been resolved could include:

- A *Notice of Decision* or *Notice of Action* showing benefits have been approved or reinstated to the previous level,
- An overpayment claim has been zeroed out,
- A sanction has been lifted,
- Documentation showing the requested service is now approved, etc.

Use the send email feature in AIS to notify the judge of the dismissal request. Send a copy of the dismissal request to the appellant and their representative, if applicable.

An appeal is not dismissed until the judge issues a Dismissal Order. Do not assume the judge is going to grant the request just because a dismissal request was uploaded into AIS. Until the order is issued, proceed accordingly by completing an appeal summary, gathering exhibits, and preparing for the appeal hearing.

Responsibilities of Department's Representative

The worker or office that took the action being appealed or provided information on the client is responsible for representing the Department in the appeal process. This may include the PROMISE JOBS worker on a limited benefit plan, the child support recovery worker on a noncooperative FIP case, Iowa Medicaid Enterprise staff, the managed care organization, dental carrier or other contract staff.

Representing the Department involves:

- Submitting the appeal request and summary of action to the Appeals Section and appellant
- Coordinating with an attorney from the Attorney General's office when one is assigned
- Conducting an informal conference, if the appellant requests it
- Continuing assistance pending the final decision, if the appellant qualifies

The following sections explain these duties in more detail.

Submitting Information

Legal reference: 441 IAC 7.8(9), 7 CFR 273.15(i)(1)

Unless the appeal is voluntarily withdrawn, the Department worker or agent responsible for representing the Department at the hearing must forward the appeal request to the DHS Appeals mailbox within one working day of receipt of the appeal. If the appeal was mailed, include a copy of the postmarked envelope.

Within ten days of the receipt of the appeal, write an appeal summary and attach supporting documentation of the factual basis for the action being appealed. See Appeal Summary.

Provide copies of all the materials sent to the DHS Appeals Section to the appellant and the appellant's representative at the same time.

The Appeals Section is not responsible for providing copies of the appeal summary to the appellant, the appellant's representative or any other party to the appeal. The Department worker is responsible to ensure that all parties receive copies of the summary.

The administrative law judge will review the appeal summary and supporting documentation electronically through AIS. There is no need to send a separate paper copy to the judge.

Notify the DHS Appeals Section if other agencies or staff are parties to the appeal. Appeals staff will ensure that the other agencies are added to the appeal file to be notified of hearing dates and receive correspondence regarding the appeal. These may include:

- Department of Inspections and Appeals Investigations or Overpayment Recovery staff.
- Department of Iowa Workforce Development personnel.
- PROMISE JOBS workers.
- Quality Control staff.
- Disability Determination Service Bureau staff.

Also continue or reinstate benefits or services pending the appeal, if applicable. See General Standards for Continuation of Assistance Pending Final Appeal Decision.

Appeal Summary

An appeal summary is a statement of the facts about the situation that is being appealed and includes information on the household composition. It is the most important document written in preparation for the hearing and will always be an exhibit at the hearing.

Your appeal summary should contain the following:

- Name of the appellant.
- Appeal number.
- Date of the appeal.
- A brief description of the issue being appealed.
- Detailed explanation of what happened leading to the appeal.
- Facts and policies regarding the Department's action.
- Citations to the Iowa Administrative Code.

Attach copies of all supporting documents. The number of exhibits will vary according to the issue of the case.

Always include the application and authorization to represent if the appellant has authorized a representative. If the supporting documentation contains confidential information, such as the name of a child abuse reporter, de-identify this before providing the appellant a copy of the summary. Other types of supporting documents may include specific notices, requests for information, paystubs, review forms, caseworker notes, etc.

Reference the supporting documents in the appeal summary and label as Exhibit 1, 2, 3 or Exhibit A, B, C. This will assist the administrative law judge and other parties to know which exhibit is being referenced during the hearing.

Appeals regarding overpayments require **all** information on how you calculated the overpayment. The appeal summary should include:

- Why the overpayment occurred.
- How you determined the start and end dates of the overpayment.
- What verification you used to determine an overpayment (pay stubs, proof of child support received or paid, proof of social security income, bank account statements, etc.).

- Calculation of the overpayment for each month of the overpayment claim (scratchpad screen prints or other detail work).
- Verification of months of eligibility or benefits, such as a copy of SSNI (Medicaid eligibility file) or ISSV (Issuance Verification system) screens.
- The amount of benefits issued (e.g., a copy of the ISSV screen).
- Any email messages that may support or explain the overpayment decision.
- For medical overpayments, the client's medical claim history.
- For Medically Needy overpayments, the specific spenddown periods and the spenddown calculations.
- For child care assistance overpayments, the amount of assistance paid (e.g., a copy of the payment history or timesheets).
- For PROMISE JOBS allowance overpayments, the client's family investment agreement or other documents that authorize transportation, child care, etc. allowances.

The administrative law judge will review the exhibits and attempt to recreate the overpayment calculations to determine if the establishment and computation of the overpayment is correct. The judge does not have access to computer screens and cannot ask for additional information after the record is closed. The judge can only review the information that was submitted as part of the appeal summary.

If the judge is unable to recreate the overpayment calculations, the overpayment may be modified to a lower amount or zeroed out completely.

Coordination With Attorney General's Office

In some situations, primarily child abuse and service appeals, an assistant attorney general will be assigned to act as the Department's attorney. In these situations, the acknowledgment letter will indicate in the "cc" section that the Attorney General's Office is involved. The Department worker is responsible for contacting the attorney and coordinating information for the appeal summary.

A prehearing conference will be scheduled by the Department of Inspections and Appeals for these types of appeals. See Prehearing Conference.

Informal Conference

Legal reference: 441 IAC 7.8(3) and (5), 7 CFR 273.15(d)

When requested, an informal conference shall be held with the appellant. An appellant's representative may attend and participate in the informal conference, unless precluded by federal law or state statute.

An informal conference can be used to:

- Provide information or explanations about the reasons for the intended adverse action.
- Answer questions.
- Explain the basis for the intended adverse action.
- Provide an opportunity for the appellant to explain the appellant's action or position.
- Provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the Department at the hearing, in accordance with public laws and fair information practices.

The appellant does not need to request an informal conference to examine the contents of the case record, including any electronic case record.

Observe the following procedures regarding the informal conference:

- Offer an informal conference to every appellant. If the appeal form is used, the offer is considered to have been made.
- Advise the appellant that use of an informal conference is optional and it in no way delays or replaces the hearing process.
- Schedule the conference as soon as possible after the appeal is filed. For households contesting a denial of Food Assistance emergency service, schedule the conference within two working days, unless the household requests that it be scheduled later or states that it does not wish to have a conference.

An informal conference shall not be used to discourage an appellant from proceeding with their appeal. The right of appeal shall not be limited or interfered with in any way, even when the appeal complaint may be without basis in fact or because of an individual's misinterpretation of law, agency policy or methods of implementing policy.

General Standards for Continuation of Assistance Pending Final Appeal Decision

Legal reference: 441 IAC 7.9(1), 42 CFR 431.230

Assistance shall not be suspended, reduced, restricted, discontinued, or terminated, nor shall a license, registration, certification, approval or accreditation be revoked or other proposed adverse action taken pending a final decision on an appeal when:

- The appeal is filed before the effective date of the intended action, or
- The appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting or canceling benefits or services. The date that the notice is received is considered to be five days after the date on the notice, unless the appellant shows the notice was not received within the five-day period.

See When Assistance Continues for Food Assistance and When Assistance Continues for Managed Care Organization Health Care Services to determine when benefits must continue for these types of appeals.

Benefits continue if an appeal is based on a notice of cancellation only when a completed review form has been submitted. If the notice period ends on a weekend or holiday, and the appellant files the day after the weekend or holiday, the request shall be considered to have been timely received. Benefits will continue.

To determine continuation of benefits, the date the appeal is filed is the date of the postmark on the envelope for a written appeal. When the postmarked envelope is not available, the filing date is the date the Department receives the appeal. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form or facsimile, the appeal is filed on the date it is submitted. If there is no date recorded by the electronic delivery method, the filing date is the date the Department receives the appeal. Document the receipt date of all appeals.

If benefits are continued pending a final decision on the appeal, then the factor appealed must be held constant. Assistance shall continue on the basis authorized immediately before the notice of adverse action. Once benefits are continued or reinstated, do not reduce or terminate benefits while the appeal is pending, unless:

- A change is reported. Act on that change and issue a new *Notice of Decision*, if applicable.
- It is determined at hearing that the issue involves only federal or state law or policy. Immediately discontinue assistance.

Form 470-0487 or 470-0487(S), *Appeal and Request for Hearing*, contains space for the appellant to request continued benefits or not. If the form does not positively indicate that the household has waived continuation of benefits, assume that continuation of benefits is desired and act accordingly.

General Standards for When Assistance Does Not Continue

Legal reference: 441 IAC 7.9(2)

The adverse action appealed to suspend, reduce, restrict, discontinue or terminate assistance, revoke a license, registration, certification, approval or accreditation, or other proposed action may be implemented pending a final decision on appeal when:

- An appeal is not filed before the effective date of the intended action or within ten days from the date notice is received. The date that the notice is received is considered to be five days after the date on the notice, unless the appellant shows that the notice was not received within the five-day period.
- Benefits or services were time-limited through a certification period or prior authorization for which notice was given when established or for which adequate notice was provided.
- The appellant directs the worker in writing to proceed with the intended action.
- The appellant failed to return a completed review form.

Do not reinstate benefits when an appeal is filed eleven or more days after the date of a *Notice of Decision* or *Notice of Action* is issued based on information reported on the completed review form.

Do not reinstate or continue benefits when a certification period ends.

When Assistance Continues for Food Assistance

Legal reference: 441 IAC 7.9(3), 7 CFR 273.13(a)(1), 7 CFR 273.15(k)(1) and (2)

Assistance shall not be suspended, reduced, restricted, discontinued or terminated, or other proposed adverse action taken pending a final decision on an appeal when the appellant requests a hearing within ten days of receipt of a notice suspending, reducing, restricting or canceling benefits or services.

The date that the notice is received is considered to be five days after the date on the notice, unless the appellant shows the notice was not received within the five-day period.

Benefits continue if an appeal is based on a notice of cancellation only when a completed review form has been submitted. If the notice period ends on a weekend or holiday, and the appellant files the day after the weekend or holiday, the request shall be considered to have been timely received. Benefits will continue.

To determine continuation of benefits, the date the appeal is filed is the date of the postmark on the envelope for a written appeal. When the postmarked envelope is not available, the filing date is the date the Department receives the appeal. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form or facsimile, the appeal is filed on the date it is submitted. If there is no date recorded by the electronic delivery method, the filing date is the date the Department receives the appeal. Document the receipt date of all appeals.

If benefits are continued pending a final decision on the appeal, then the factor appealed must be held constant. Assistance shall continue on the basis authorized immediately before the notice of adverse action. Once benefits are continued or reinstated, do not reduce or terminate benefits while the appeal is pending, unless:

- A change is reported. Act on that change and issue a new *Notice of Decision*, if applicable.
- It is determined at hearing that the issue involves only federal or state law or policy. Immediately discontinue assistance.

Form 470-0487 or 470-0487(S), *Appeal and Request for Hearing*, contains space for the appellant to request continued benefits or not. If the form does not positively indicate that the household has waived continuation of benefits or the appeal was filed verbally, assume that continuation of benefits is desired and act accordingly.

When Assistance Does Not Continue for Food Assistance

Legal reference: 441 IAC 7.9(4)

The adverse action appealed to suspend, reduce, restrict, discontinue or terminate assistance, or other proposed action may be implemented pending a final decision on appeal when:

- An appeal is not filed within ten days from the date notice is received. The date that the notice is received is considered to be five days after the date on the notice, unless the appellant shows that the notice was not received within the five-day period.
- Benefits or services were time-limited through a certification period for which adequate notice was provided.
- The appellant directs the worker in writing to proceed with the intended action.
- The appellant failed to return a complete review form.

Do not reinstate benefits when an appeal is filed eleven or more days after the date of a *Notice of Decision* or *Notice of Action* issued based on information reported on the completed review form.

Do not reinstate or continue benefits when a certification period ends.

When Assistance Continues for Managed Care Organization Health Care Services

Legal reference: 441 IAC 7.9(5), 42 CFR 48.420(b)

Health care services may not be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

- An appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date that the notice is received is considered to be five days after the date on the notice, unless the appellant shows the notice was not received within the five-day period;
- The appeal involves a termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The appellant requested continuation of health care services.

When the managed care organization continues or reinstates the appellant's health care services while the appeal is pending, the benefits must continue until one of the following occurs:

- The appellant withdraws the appeal.
- The appellant fails to request an appeal within ten calendar days from the date the managed care organization mails the notice of action.
- A hearing decision is issued that is adverse to the appellant.

When Assistance Does Not Continue for Managed Care Organization Health Care Services

Legal reference: 441 IAC 7.9(6)

Health care services may be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

- An appeal is not filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date that the notice is received is considered to be five days after the date on the notice, unless the appellant shows the notice was not received within the five-day period;
- The appeal does not involve a termination, suspension or reduction of a previously authorized course of treatment;
- The services were not ordered by an authorized provider;
- The period covered by the original authorization has expired; and
- The appellant failed to request continuation of health care services.

Recovery of Excess Assistance Paid Pending a Final Decision

Legal reference: 441 IAC 7.9(7), (9), and (10); 7 CFR 273.15(k)(1)

Continued assistance is subject to recovery by the Department if the Department's action is affirmed in the final decision, except when the decision affirms:

- A limited benefit plan will be established with a new effective date, or
- An ineligibility period for using an electronic access card at a prohibited location will be established with a new effective date.

When the Department's action is affirmed in the final decision, recover excess assistance paid pending a hearing decision back to the effective date of the original decision. No appeals will be heard over excess assistance paid pending a hearing decision that was not in the appellant's favor. However, appeals may be heard on the computation of excess assistance paid pending a hearing decision.

If the Department action is affirmed by the final decision, establish a claim against the appellant for all overissuances. (See Final Decision later in this chapter for instructions on implementing the final appeal decision.)

Recovery of Excess Assistance When Benefits Change Before a Final Decision

Legal reference: 441 IAC 7.9(8), 7 CFR 273.15(k)

Recover excess assistance paid when the appellant's benefits are changed because:

- A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law, and not one of incorrect grant computation, and the grant is adjusted.
- A change affecting the appellant's grant occurs while the hearing decision is pending and the appellant fails to request a hearing after notice of the change.

Recover assistance paid from the date of change that affects the incorrect payment.

Prehearing Conference

Legal reference: 441 IAC 7.8(4) and (5)

For certain types of appeals, the Department of Inspections and Appeals, Administrative Hearings Division will schedule a prehearing conference. The appellant, a representative of the office that took the action and the administrative law judge shall attend the prehearing conference. The appellant's representative may attend and participate in the prehearing conference, unless precluded by federal rule or state statute. If the Attorney General's Office is representing the Department, contact the attorney involved to determine who needs to attend the conference.

The merits of the appeal will not be discussed at a prehearing conference. DIA is responsible for notifying all parties to the appeal in writing when it schedules a prehearing conference. DIA will attempt to schedule the conference as soon as possible.

The purpose of the prehearing conference is to:

- Discuss the appealed issue.
- Inquire as to the possibility of a voluntary settlement.
- Establish the hearing date.

- Establish the location of the hearing including whether the hearing will be held by telephone or in person.
- Discuss procedural matters relevant to the case.

Do not use the prehearing conference to discourage appellants from proceeding with their appeals. The appellant's right to appeal shall not be limited or interfered with in any way, even though the appellant's complaint may be without basis in fact, or because of their own misinterpretation of law, agency policy or methods of implementing policy. For further information on interference, refer to Rights of Appellants During Hearings.

Appeals Procedures

The following sections describe the procedures used by the DHS Appeals Section and the Department of Inspections and Appeals Administrative Hearings Division, including:

- Granting a hearing
- Scheduling a hearing
- Determining the method and location of hearing
- The role of the administrative law judge
- Conduct of the hearing
- Issuing subpoenas for witnesses or evidence
- Obtaining a medical examination

Granting a Hearing

Legal reference: 441 IAC 7.10(3), 7 CFR 273.15(j), 42 CFR 431.223

The DHS Appeals Section determines whether an appellant may be granted a hearing and the issues to be discussed at the hearing, in accordance with applicable rules, state statutes, and federal regulations.

The appeals of those appellants who are granted a hearing are certified to the Department of Inspections and Appeals for the hearing to be conducted. The DHS Appeals Section indicates at the time of certification the issues to be discussed at the hearing.

If an appeal is not eligible for hearing, a denial letter is sent to the appellant. The appeal will not be closed until a denial letter is issued. Any appellant who disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the DHS Appeals Section or a hearing over the denial.

The following sections address:

- Expedited hearing
- Group hearings

See also Right of Department to Deny or Dismiss an Appeal and Time Limit for Granting an Appeal Hearing.

Expedited Hearings

Legal reference: 441 IAC 7.10(4)(e) and (f); 7 CFR 273.15(i)(2); 42 CFR 431.244, 42 CFR 438.408, and 42 CFR 438.410

The DHS Appeals Section will expedite Food Assistance appeal requests from households that plan to move from the project area, such as migrant farm workers. Appeal requests from these households are processed faster than others to enable them to receive a decision and a restoration of benefits, if the decision so indicates, before they leave the area.

The local office is responsible for notifying the DHS Appeals Section that an expedited hearing is needed.

For Medicaid appeals, appellants may at any time request an expedited review of their appeal. Expedited review will be granted when the Department determines a Medicaid member's life, physical or mental health, or ability to attain, maintain or regain maximum function could be in jeopardy if the regular appeals process were to take place. Either the appellant or a provider who is acting on the appellant's behalf may request an expedited hearing.

The DHS Appeals Section will notify the appellant whether the request for expedited review is granted. If denied, the appellant is notified either orally or in writing by mail, facsimile or electronic mail as expeditiously as possible. If oral notice is provided, notice will be followed up in writing.

Expedited Managed Care Appeals

When an expedited appeal is requested and the managed care organization handled their first level review expeditiously, the state fair hearing request will also be handled expeditiously. An additional request is not necessary if the appeal request indicates the first level review was expedited and provides the basis for the expedited relief.

The administrative law judge will hold a hearing and issue a Proposed Decision as expeditiously as the Medicaid member's health condition requires, but no later than three working days after the Department receives the case file or any other necessary information from the managed care organization.

Expedited Medicaid Eligibility Appeals

For expedited appeals relating to Medicaid eligibility, nursing facility transfer or discharges, or preadmission and annual resident review requirements, the administrative law judge will hold a hearing and issue a Proposed Decision as expeditiously as the Medicaid member's health condition requires, but no later than seven working days after the Department receives a request for an expedited fair hearing.

Expedited Medicaid Fee-for-Service Covered Benefits or Services Appeals

For expedited appeals relating to Medicaid fee-for-service covered benefits or services, the administrative law judge will hold a hearing and issue a Proposed Decision as expeditiously as the Medicaid member's health condition requires, but no later than five working days after the Department receives a request for an expedited fair hearing.

Group Hearings

Legal reference: 441 IAC 7.5(3), 7 CFR 273.15(e), 42 CFR 431.222

The DHS Appeals Section may respond to a series of individual requests for a hearing by requesting that the Department of Inspections and Appeals conduct a single group hearing in cases that the sole issue is one of state or federal law or policy or changes in state or federal law. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

In all group hearings, the policies governing individual hearings shall be followed. Each individual household shall be permitted to present its own case or have its case presented by a representative.

Scheduling the Hearing

Legal reference: 441 IAC 7.10(4) and (7), 7 CFR 273.15(l), 42 CFR 431.240

The Department of Inspections and Appeals establishes the date, time, method, and place of the hearing for the records certified for hearing by the DHS Appeals Section.

In appeals certified for hearing, DIA sends a notice to the appellant at least ten calendar days in advance of the hearing date. Intentional Program Violation hearing notices are mailed at least 30 calendar days in advance of the date of the hearing.

The notice states:

- The date, time, method, and place of the hearing.
- The name of the administrative law judge.
- The issues to be discussed at the hearing.
- Whom to contact with questions about the hearing date or issues.
- The rights of the appellant to:
  - Review the evidence that will be used at the hearing.
  - Obtain one free copy of the evidence that will be used at the hearing.
  - Present any evidence orally or through documents to establish pertinent facts.
  - Argue case freely.
  - Question or refute any testimony.
  - Bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal statute or law.

If the hearing is conducted by telephone, the notice will provide instructions on how to participate in teleconference calls. If the hearing is conducted in person, the notice will provide information on the location of the hearing.

DIA will send a copy of this notice to all the parties to the appeal, as certified by the DHS Appeals Section. The *Notice of Hearing* is delivered by first class mail.

Scheduling Requests

Legal reference: 441 IAC 7.10(6)

There are times when the person handling the appeal has a scheduling conflict that may interfere with the date and time of the hearing. Notify the DHS Appeals Section about the scheduling conflict when a hearing has not been scheduled. See Requests to Reschedule a Hearing after the hearing is scheduled.

Scheduling requests should be kept to a minimum and reserved for a period when unavailable for multiple days at a time, such as a multi-day vacation or scheduled medical leave.

It is expected a supervisor or coworker will handle an appeal hearing when the person handling the appeal is unavailable for half-a-day or one full day. It is the worker's responsibility to find a supervisor or coworker to handle the hearing before medical leave or vacation time begins. If out of the office unexpectedly for an illness, it is still the responsibility of the individual handling the appeal to notify a supervisor of the scheduled appeal hearing.

The Department of Inspections and Appeals will determine if a scheduling request can be accommodated. There will be times when DIA cannot accommodate the schedules of all persons involved and the hearing will proceed as scheduled.

Requests to Reschedule a Hearing

Legal reference: 441 IAC 7.10(6), 7 CFR 273.15(c)(4)

The Department of Inspections and Appeals is responsible for scheduling all appeal hearings and handling rescheduling requests.

Make all requests concerning the scheduling of a hearing directly to DIA. This includes requests by the appellant or the DHS staff to set another date, time, method or place of hearing.

Reschedule requests made by Department staff may only be granted in instances of inclement weather when the Department office is closed. Department staff should arrange for coverage by a coworker in instances, including, but not limited to:

- When inclement weather is present and the Department office remains open, or
- When a family emergency, sudden illness or death occurs.

Only the administrative law judge can rule on a request to continue an appeal hearing at a later date. Do not assume the hearing will be continued just because a request was made. The judge will rule on the request and notify the parties to the appeal when a continuance is granted.

Food Assistance appellants are automatically allowed one rescheduling upon request. However, the postponement cannot exceed 30 days.

An administrative disqualification hearing for an Intentional Program Violation may be rescheduled if the request for postponement is made at least ten days in advance of the date of the scheduled hearing. However, the postponement cannot exceed 30 days.

The appellant may request the teleconference hearing be rescheduled as an in-person hearing. All requests made for a teleconference hearing to be rescheduled as an in-person hearing will be granted.

Upon receipt of a request to reschedule a teleconference hearing as an in-person hearing, upload the request into the Appeals Information System.

Failure to Appear

Legal reference: 441 IAC 7.13(4)

When a party fails to appear at a hearing after proper service of notice, the administrative law judge may:

- Reschedule the hearing, or
- Proceed with the hearing in the absence of that party and make a decision, or
- Consider the appeal abandoned and dismiss it.

Where appropriate and not contrary to law, any party may move for a default decision against a party who has failed to file a required pleading or has failed to appear after proper service for a hearing. A Proposed Decision on the merits of the appeal may be issued in the absence of a defaulting party.

The administrative law judge may award any relief against the party who fails to appear, as long as the relief is consistent with the relief requested before the abandonment. The judge cannot award relief that would exceed the requested relief.

Motion to Vacate

When someone fails to appear or participate in an appeal hearing and the judge either issues an abandonment order or renders a decision based on the merits of the case, the decision becomes final agency action unless a party files a motion to vacate, which is also known as a "request for good cause."

A motion to vacate must state all facts establishing the party had good cause for failing to appear or participate in the appeal hearing. The motion must be filed with the DHS Appeals Section within ten calendar days of the date on the Proposed Decision.

Each fact must be substantiated by at least one sworn affidavit of a person with personal knowledge of each fact. Parties may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause, instead of submitting an affidavit. The affidavit or other documentation should be submitted with the motion to vacate.

The DHS Appeals Section will provide a copy of the motion to vacate to all parties to the appeal. Each party has ten calendar days to respond to the motion to vacate. All parties may present evidence on the issue before a decision is made on the motion to vacate, if a request to do so is included in that party's response. If Department staff respond to a party's motion to vacate, all parties will be allowed another ten days to respond.

After all parties response times have been exhausted, the DHS Appeals Section will notify the Department of Inspections and Appeals about the motion to vacate. The administrative law judge will review the motion, hold any additional proceedings, if necessary, and determine if good cause exists to set aside the default.

Properly substantiated and timely filed motions to vacate will be granted only for good cause shown. The burden of proof is on the party who failed to appear at the hearing.

For a motion to vacate, "good cause" is defined as an emergency circumstance that is beyond the control of the person who failed to appear and prevented the individual from being able to participate in the hearing. Examples of good cause include, but are not limited to:

- Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).
- Death or serious illness in the party's immediate family.
- Other circumstances where an emergency situation occurred that was beyond the party's control and was not reasonably forseeable.

Examples of circumstances that do not constitute good cause include, but are not limited to:

- A lost or misplaced notice of hearing.
- Confusion as to the date and time for the hearing.
- Failure to follow the directions on the notice of hearing.
- Oversleeping.
- Other acts demonstrating a lack of due care by the party.

The administrative law judge will issue a Proposed Decision on the motion to vacate. If the judge determines the party had good cause for missing the appeal hearing, DIA will schedule a new date, time, and issue a Notice of Hearing to all parties.

If the judge determines the party did not have good cause for missing the appeal hearing, the party may request a director's review. If no review is received within ten calendar days of the date on the Proposed Decision, the DHS Appeals Section will issue a Final Decision at which time the default decision becomes final agency action.

Motion to Vacate When Hearing Conducted In Absence of Party

In cases where a party fails to appear at the appeal hearing and the administrative law judge decides to conduct the hearing without the party, the party who failed to appear may file a motion to vacate if the party feels they had a good reason for not attending the hearing. As the judge ruled on the issue that was appealed, any other party may request a director's review if they disagree with the judge's decision.

If a motion to vacate and a request for director's review are both made in a timely manner, the review by the director will be stayed pending the outcome of the motion to vacate. However, the review on the merits of the case will be conducted upon the issuance of Final Decision denying the motion to vacate.

Method and Location of Hearing

Legal reference: 441 IAC 7.10(4)"a" and "b," 7.10(5); 42 CFR 431.240

The Department of Inspections and Appeals determines whether the appeal hearing is conducted in person, by videoconference or by teleconference call. Parties to the appeal may participate from multiple locations for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if desired.

Upon advance request, a witness may appear by teleconference unless the administrative law judge determines the physical presence of the witness is necessary for the administration of justice and does not impose an undue burden on the witness. All parties are granted the same rights during a teleconference hearing as listed at Rights of Appellants During Hearings.

Appeals involving the determination of the community spouse resource allowance may be held by teleconference call, in-person or administratively.

Teleconference Call

The Department of Inspections and Appeals uses a telephone conferencing call system for appeal hearings. Parties may participate from any location; however, cell phone usage is discouraged. The Notice of Telephone Hearing provides the date, time, and instructions on how to participate in the hearing.

Call in as early as five minutes before the hearing is scheduled to begin. If the conference is locked, the judge is finishing another appeal hearing. Hang up and call back at the scheduled time for the hearing.

The judge will give all parties five minutes after the time the hearing is scheduled to start to allow all parties to call in. If a party fails to appear within this timeframe, the judge may dismiss the appeal and may grant any remedy the judge sees fit.

If the appellant does not have a phone or wishes to participate in the appeal hearing at a local DHS county office or at a Child Support office, the appellant shall contact the office and the judge at least five working days before the hearing. This will give the county or CSRU office time to find a room for the hearing.

Department staff shall arrange for an appropriate room in which the hearing may be held. The place for the hearing shall allow for privacy and be free from interruptions. If the hearing is being conducted by telephone, the local office is responsible for providing telephones located in a place that will ensure privacy. The worker and appellant shall each have a telephone, unless a speakerphone is available.

Notify the receptionist that hearings are scheduled and instruct the receptionist to ensure that persons appearing for a hearing are directed to the proper place at the time scheduled for hearing.

In-Person Hearing

The appellant has the right to request an in-person appeal hearing, which are held solely in Des Moines.

The Notice of Hearing will indicate if the hearing is in-person and provide the location of where the appellant and the administrative law judge will appear.

Department staff may be allowed to participate by telephone. Upload a written statement into the Appeals Information System to request to participate by phone. The written statement should include:

- The appellant's name.
- Appeal number.
- Date and time of the scheduled appeal hearing.
- Reasons why need to participate by phone, such as budget constraints, inability to travel, previous work engagements that require staff to be in local office before and after appeal hearing, etc.

Send a copy of the written request to the appellant and the appellant's representative.

The judge will determine which parties, if any, may participate by teleconference call.

Administrative Hearing

An administrative hearing is a type of hearing that an appellant may choose for attribution appeals. The judge will review the contents of the appeal file and make a decision based on the information provided. An administrative hearing does not require an in-person or teleconference hearing.

The *Appeal and Request for Hearing* form allows the appellant to indicate if an administrative hearing is being requested. Only the appellant may ask an administrative hearing. This is not at the worker's discretion.

In order for the administrative law judge to rule on the attribution appeal, the judge will need copies of the following:

- *Notice of Attribution of Resources*, form 470-2588
- Medicaid *Notice of Decision* or *Notice of Action*, if there is one
- *Attribution of Resources Appeal Summary*, form 470-3144
- Single-premium lifetime annuity cost estimate that would generate income equal to the difference between the amount of income available to the community spouse and the minimum monthly maintenance needs allowance that is in effect when the appeal was filed

Upload these documents into the Appeals Information System and use the send email feature.

Administrative hearings shall be held within 30 days of the date on the appeal request.

Administrative Law Judge

Legal reference: 441 IAC 7.3(217), 7 CFR 273.15(m), 42 CFR 431.240

Appeal hearings are conducted by an administrative law judge appointed by the Department of Inspections and Appeals pursuant to Iowa Code section 10A.801. The administrative law judge is an employee of DIA and is charged with the responsibility of determining the facts, based upon evidence presented at the hearing, and applying the appropriate policy to these facts in order to arrive at a decision.

The administrative law judge shall be impartial and shall not have been involved in the initial action taken. The administrative law judge shall not be connected in any way with the previous actions or decisions on which the appeal is made.

The administrative law judge shall not be subject to the authority, directions or discretion of any person who has prosecuted and advocated in connection with that case, the specific controversy underlying that case, or any pending factually related contested case or controversy involving the same parties.

Communication With Administrative Law Judge or Director

Legal reference: 441 IAC 7.18(17A)

The worker or the appellant may contact the administrative law judge regarding procedural issues, such as:

- Requests for rescheduling.
- Telephone numbers to connect the hearing.

The worker or the appellant may not discuss the merits (substantive issues) of the appeal outside the appeal hearing. Communication conducted by the worker or the appellant regarding the merits of the appeal are considered ex parte communications.

Ex parte communication is communication done for or on behalf of one party only. Ex parte communication by the county office to the administrative law judge can result in the appeal being dismissed and other penalties being assigned.

Where ex parte prohibited communications are directed to the administrative law judge or director, the judge or the director may take whichever of the following sanctions are deemed necessary:

- Provide for a decision against the party who violates the rules.
- Censor, suspend or revoke a privilege to practice before the Department.
- Recommend that any Department personnel who violate this rule should be censored, suspended or dismissed.

Any information sent to the administrative law judge should also be sent to the appellant and the appellant's legal representative.

Communication of the Administrative Law Judge or Director

Legal reference: 441 IAC 7.18(1)

The administrative law judge, the director or the director's designee may communicate with any person or party concerning any appeal issue, provided that the substance of the communication and any information received in reply are presented to all parties, allowing them an adequate opportunity to respond.

However, persons assigned to render a proposed or final decision, or to make findings of fact and conclusions of law in a contested case, may communicate with members of the Department without notice to the parties.

They may have the aid and advice of persons other than those with a personal interest in, or those engaged in prosecuting or advocating, either the case under consideration or a pending factually related case involving the same parties.

Conduct of Hearing

Legal reference: 441 IAC 7.13(2) and (3), 7 CFR 273.15(p), 42 CFR 431.240

The hearing is an informal rather than formal judicial procedure, and is designed to serve the best interest of the appellant. Persons answering questions or presenting testimony will be asked to swear or affirm that they will tell the truth. A verbatim record is kept of the evidence presented. The administrative law judge is responsible for tape recording the hearing.

The formal rules of evidence do not apply in contested case proceedings. Evidence may be admitted in hearings that would not be admissible in a court of law. The administrative law judge has the authority to determine what evidence may be submitted for the record. Irrelevant, immaterial or unduly repetitious evidence should be excluded.

The worker is responsible for presenting all evidence at the time of the hearing. The decision on the appeal can be based only upon this information and other information admitted to the appeal record. The worker who took the adverse action under appeal is expected to make a presentation of the facts and policy relied upon in making that decision. Use the written summary submitted to the DHS Appeals Section to review and explain the actions taken. (See Appeal Summary.)

Opportunity will be afforded all parties to respond and present evidence and arguments on all issues involved, and to be represented by counsel at their own expense. The appellant and the worker will each have an opportunity to cross-examine each other and other witnesses, as appropriate, and to review evidence submitted by each of them. The appellant and the worker will each be provided an opportunity to make a closing statement.

For appeal hearings regarding child abuse, the administrative law judge, upon request of any party to the hearing, may stay the hearing until the conclusion of the adjudicatory phase of a pending juvenile or district court case relating to the data or findings.

Subpoenas

Legal reference: 441 IAC 7.12(17A)

The Department of Inspections and Appeals has all subpoena power conferred upon it by statute. Subpoenas are issued to a party on request.

The county office is responsible for requesting subpoenas. Complete a *Request for Subpoena in a Contested Case* form for each subpoena that is requested. The form can be found on the Department of Inspections and Appeals Administrative Hearings website. Follow the directions at the bottom of the form to submit the subpoena request. Give the full name and address of persons and a full and complete description of documents to be subpoenaed.

A request for a subpoena shall be submitted at least seven days in advance of the hearing. Additional time is highly recommended.

The county office is also responsible for service of the subpoenas. Subpoenas must be served at least five days in advance of the hearing date.

Medical Examination

Legal reference: 441 IAC 7.15(17A), 7 CFR 273.15(m)(2)(v)

When the hearing involves medical issues and the administrative law judge or appellant considers it necessary, the Department shall obtain a medical assessment or examination by a person or physician other than the one involved in the decision under question and make the report a part of the hearing record. The administrative law judge shall order the medical examination when appropriate either before or at the time of hearing.

Any required examination shall be performed at Department expense by a physician satisfactory to both the appellant and the Department. Use forms 470-0502, *Authorization for Examination and Claim for Payment*, and 470-0447, *Report on Incapacity,* to obtain medical information for use in the appeal and to authorize payment for the examination.

If the person to be examined is eligible for Medicaid, bill for the examination through Medicaid. If the person has other health insurance coverage, those resources should be used for payment of the examination.

Record Held Open

During the appeal hearing, someone may request additional time to submit evidence. When this occurs, the administrative law judge will determine if the record will be held open for a short time after the close of the hearing.

The judge will state on the record the amount of time the party has to submit the information to the judge and to the remaining parties. The judge will also allow the remaining parties the opportunity to respond to the additional information.

If a request to hold the record open is granted, gather the requested information by the due date and upload the information into the Appeals Information System. Send a paper copy of your document to the appellant, their attorney, and their representative, if applicable.

Rights of Appellants During Hearings

Legal reference: 441 IAC 7.8(5) and (7), 7.13(17A); 7 CFR 273.15(p); 42 CFR 431.242

The right of appeal shall not be limited or interfered with in any way, even though:

- The person's complaint may be without basis in fact, or
- The person may be misinterpreting the law, Department policy or methods of implementing the policy.

The appellant has the right to introduce any evidence on points at issue believed necessary, to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. The administrative law judge will make every reasonable effort to ensure that the appellant presents his or her case in any way desired. This may include telling what happened, or having a relative, friend or legal counsel present the case.

The following actions are prohibited:

- Acts of harassment.
- Threats of prosecution.
- Denial of pertinent information needed by the appellant in preparing the appeal.

Any of these actions shall be taken into consideration by the administrative law judge in reaching a proposed decision.

The following sections give more information:

- Representation
- Examination of evidence
- Limits on persons attending the hearing

Representation

Legal reference: 441 IAC 7.6(2), 7.11(17A); 7 CFR 273.15(f); 42 CFR 431.221, 42 CFR 435.923

Advise all persons that they may be represented at hearings by others, including legal counsel, relatives, friends or any other spokesperson of choice. The representative can be an individual, organization or provider.

Anyone the appellant chooses may represent the appellant unless federal regulation or state statute disallows it. For example, because the Iowa Code specifies who may have access to a child abuse record, only an attorney may represent an appellant at a child abuse hearing.

Representation by an attorney occurs only at the appellant's request. Upon request, each county office must:

- Issue a written list of legal services available in the area (such as Legal Services Corporation of Iowa, Legal Aid Society or H.E.L.P.).
- Assist in securing the services.

In authorizing an attorney to act on the appellant's behalf, an appellant essentially assigns to the attorney the right and responsibility to speak and act as if the attorney were the appellant. Additionally, the appellant relinquishes the right to act independently of the attorney in disposing of the matter under appeal. An appellant may regain the right to act independently only by discharging the attorney.

Therefore, once an attorney of record becomes known to the Department, any discussion or disposition of the matter under appeal is properly conducted only with the attorney's knowledge and consent.

This does not prohibit Department staff from responding to the appellant's questions or inquiries regarding the matter under appeal when the attorney is absent. It does, however, obligate the Department to include the attorney when making any inquiries or requesting any action of the appellant in regard to the matter under appeal.

Authorized Representative for Managed Care Appeals

The designation of an authorized representative must be in writing and include the signature of both the appellant and the person who is designated as the authorized representative.

Medicaid members may appoint an authorized representative or provider to act on their behalf during the appeals process regarding an adverse benefit determination made by a managed care organization by signing form 470-5526, *Authorized Representative for Managed Care Appeals.* Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or power of attorney, shall serve in place of a signed designation by the person.

An authorized representative or responsible party must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or beneficiary provided by the Department.

A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must affirm that such provider, staff member or volunteer will adhere to state and federal regulations relating to conflicts of interest and confidentiality of information.

An authorized representative or responsible party may file an appeal on the appellant's behalf, receive copies of appeal correspondence, and act on behalf of the appellant in all other matters regarding the appeal. The authorized representative or responsible party is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible party represents.

The power to act as an authorized representative is valid until:

- The appellant modifies the authorization or notifies the Department that the representative is no longer authorized to act on the appellant's behalf,
- The authorized representative informs the agency that the authorized representative is no longer acting in such capacity, or
- There is a change in the legal authority upon which the individual's or organization's authority was based.

Notice must be in writing and include the appellant's, authorized representative's or responsible party's signature as appropriate.

Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted by mail, by electronic mail, by fax or in person.

Designations previously submitted to the Department will continue to apply for purposes of appeals, consistent with their terms.

Examination of the Evidence

Legal reference: 441 IAC 7.13(1), 7 CFR 273.15(p), 42 CFR 431.242

The Department shall provide the appellant, the appellant's representative or both the opportunity to examine all materials permitted under administrative rules on confidentiality or to be offered as evidence.

Contested Cases with No Factual Dispute

Legal reference: 441 IAC 7.23(17A)

If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs, and oral arguments to the presiding officer for approval.

The office which took the action being appealed shall provide copies of all information submitted for the appeal file to the appellant and the appellant's legal representative. This information should be provided at the time it is uploaded into the Appeals Information System.

Allow the appellant and the appellant's legal representative to examine the contents of the case record, including application forms and verification documents used to determine eligibility and level of benefits. Provide free copies of the relevant portions of the case record if requested by the appellant or appellant's legal representative.

Confidential information, such as the names of persons who have disclosed information about the appellant without the appellant's knowledge, or the nature or status of pending criminal prosecutions, is protected from release. Remove all confidential names and information before providing copies of information or before the case record is reviewed by the appellant or the appellant's representative.

Off-the-record or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceeding or considered in reaching a decision.

Evidence examined or admitted in camera by the administrative law judge may be considered in reaching a decision. ("In camera" means an administrative law judge may review a document, without release to all parties, before ruling on its admissibility or its use.)

Limit on Persons Attending

Legal reference: 441 IAC 7.14(17A)

Attendance at the hearing shall be limited to the following persons, unless otherwise specified by statute or federal regulations:

- The appellant.
- The appellant's representative.
- DHS employees.
- DHS's legal representatives.
- Other persons present for the purpose of offering testimony pertinent to the issues in controversy.
- Others upon mutual agreement of the parties.

For appeal hearings regarding child abuse:

- Subjects who file a motion to intervene, as provided in Iowa Code section 235A.19, will have the opportunity to appear at the prehearing conference. Any motion to intervene shall be considered by the administrative law judge at the prehearing conference.
- The Department shall not be considered to be a party who can adequately represent the interests of any other subject.
- Subjects allowed to intervene as specified in 441 IAC 7.5(4), will be considered a party to the hearing and will be allowed to attend the proceedings.

The administrative law judge may sequester witnesses during the hearing or allow only the appellant's legal representative to act on the appellant's behalf. Nothing in this policy shall be construed to allow members of the press, news media or any other citizens' group to attend the hearing without the written consent of the appellant.

Federal regulations governing programs require confidentiality be protected. The Iowa Code provides civil and criminal penalties for the unauthorized disclosure of confidential information from Department records.

Appeal Decision

Legal reference: 441 IAC 7.10(4) and 7.16(10); 7 CFR 273.15(c); 42 CFR 431.244(f)

Prompt, definite, and final administrative action to carry out the decision rendered shall be taken within 90 days from the date of the appeal, except for Food Assistance and Intentional Program Violation decisions.

Food Assistance-only decisions shall be rendered in 60 days. Appeals involving a joint appeal on Food Assistance and medical assistance shall be rendered in 60 days. Appeals involving a joint appeal on Food Assistance and other public assistance programs shall be rendered in 90 days.

Intentional program violation decisions shall be rendered within 90 days of the date the individual accused of an intentional program violation has been notified in writing that a hearing has been scheduled. If the hearing was postponed, the 90-day period for notifying the individual of the final decision shall be extended for as many days as the hearing is postponed.

PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

In cases involving an appeal of a sex offender risk assessment, the hearing or administrative review shall be held within 30 days of the date of the appeal request.

In cases involving appellants who indicate that their lives, physical or mental health, or ability to attain, maintain or regain maximum function could seriously be jeopardized if they wait for standard resolution of their appeals, the hearing shall be held within three working days of the date on the appeal request if:

- The managed care organization handled the first-level review expeditiously; and
- The appellant or provider acting on the appellant's behalf requested an expedited appeal hearing.

Timeframes may be extended based on continuances or additional timeframes as approved by the administrative law judge. Should the appellant request a delay in the hearing in order to prepare the case or for other essential reasons, reasonable time shall be granted. This time shall not exceed 30 days, except with the approval of the administrative law judge. The extra time shall be added to the maximum for final administrative action.

Failure to reach a decision within the timeframes shall not affect the merits of the appellant's appeal.

The following sections explain:

- The proposed decision
- Review of the proposed decision
- The final decision
- The appeal record
- The accessibility of hearing decisions

Proposed Decision

Legal reference: 441 IAC 7.16(2) and (3); 7 CFR 273.15(q); 42 CFR 431.244

After the hearing is held, the administrative law judge will issue a Proposed Decision in writing. The Proposed Decision will list the issues to be determined, the decision reached, findings of fact, conclusions of law, and the order.

The issues to be determined are those that were certified for hearing by the Department. In some situations, the issues may be expanded if both parties agree.

Any party may submit proposed findings of fact and the presiding officer will rule on each fact. The findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact portion of the Proposed Decision will consist of a summary of the information determined by the administrative law judge to be factual and pertinent to the issue or issues under appeal.

The Proposed Decision will be based upon the information presented at the hearing and upon other information incorporated into the record. If needed, the administrative law judge may reopen the hearing to allow a party to cross-examine or present further information based upon the information submitted at the administrative law judge's request after the close of the original hearing.

The Proposed Decision will state whether the action under appeal is affirmed (found correct), reversed (found incorrect), or modified (changed). The conclusions of law section will review all applicable law including rules published in the Iowa Administrative Code, state law, federal regulations, federal statutes, case law and other official policy interpretations determined pertinent to the issue or issues under appeal.

The administrative law judge may interpret or construe a law as it relates to a Department policy, but the administrative law judge cannot declare the Department policy to be invalid, as that is the function of a court of law. After researching applicable laws and policies, the administrative law judge will determine if DHS acted correctly or not. In some situations, a case may be returned or remanded to the county office for further action.

The order statement of the Proposed Decision specifies what actions the local office or Department shall take to implement the decision, once it becomes final. **Do not take any action based on a proposed decision. You must receive a Final Decision before taking any corrective action.** See Final Decision later in this chapter.

Federal regulations require managed care organizations take prompt, definite, and final administrative action required by the decision within 72 hours of the date of the Proposed Decision.

If the administrative law judge reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the managed care organization must authorize or provide the disputed services promptly and as expeditiously as the appellant's health condition requires but no later than 72 hours from the date on the Proposed Decision.

If the administrative law judge reverses a decision to deny authorization of services and the appellant received the disputed services while the appeal was pending, the managed care organization must pay for the services. Managed care organizations must upload documentation in the Appeals Information System proving final administrative action has been taken.

The Proposed Decision will have a cover letter that explains the right to request a review of the proposed decision. All parties to the appeal will receive a copy of the Proposed Decision. The Proposed Decision will be sent by first-class mail to all parties that require a mailed copy. Department staff will be notified of the issuance of the Proposed Decision electronically through the Appeals Information System.

If the appellant contacts a local office for an explanation of the proposed decision, make every effort to assist the appellant in reaching a full understanding of the proposed decision. The local office (following the chain of communication) may call the DHS Appeals Section for clarification if necessary.

Review of the Proposed Decision

Legal reference: 441 IAC 7.16(4) through (8), 7.16(10)"f" and "g";
7 CFR 273.15(q)

The Proposed Decision is issued to the appellant with copies to all parties of the appeal, including the appropriate Department representatives.

The appellant, appellant's representative, the Department or any other party to the appeal may request that the director review the proposed decision.

The written request must be mailed or submitted in person or through an electronic delivery method, such as electronic mail or facsimile. The request must be postmarked or received within ten calendar days of the date that the Proposed Decision was signed and mailed. A written review request by a managed care organization must be submitted directly to the DHS Appeals Section within 72 hours of the date that the Proposed Decision was signed and mailed.

The day after the Proposed Decision is mailed is the first day of the ten-day period within which a request for review must be filed. When the time limit for filing falls on a holiday or weekend, the time extends to the next workday. The day after the Proposed Decision is mailed is the first day of the 72-hour period within which a request for review must be filed by a managed care organization. However, the time limit for filing is not extended when the 72-hour period expires on a holiday or weekend.

If no one requests review of the proposed decision or a review is not granted, the proposed decision becomes the final decision.

Request for Review by Department or Managed Care Organization

Legal reference: 441 IAC 7.16(6) and (7)

Anyone representing the Department, including contract staff, may request a director's review when they disagree with a Proposed Decision.

When requesting a director's review, staff must submit a written review request. The review request shall indicate the reasons why the review is being requested and what portions of the proposed decision are incorrect. Be clear and precise when explaining the reasons as the content of the review request is used to determine if the proposed decision will be overturned.

Fill out and complete the *Referral for Review of Proposed Decision*. Email the referral form and the review request to the DHS Appeals Section.

Review requests must be submitted no later than the close of business ten calendar days from the date the administrative law judge signed the Proposed Decision. However, review request submitted by a managed care organization must be received no later than 72 hours from the date the administrative law judge signed the Proposed Decision.

The director may decide to grant a review of the proposed decision without a recommendation or review request from Department staff.

Review Process

Legal reference: 441 IAC 7.16(6) through (9)

When the director grants a review of the proposed decision, the DHS Appeals Section notifies all parties to the appeal. When the director grants a review based on a Department or managed care organization request, the notice includes the basis for the Department or the managed care organization's request for review.

The appellant or appellant's representative is allowed ten calendar days from the date of notification to file exceptions, present briefs, and submit further written arguments or objections for consideration upon review.

The day after the notification is mailed is the first day of the period within which a response to the Department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

The review will be based on the record, except the director is not required to listen to the recording of the hearing. The review is limited to issues raised before that time and specified by the party requesting the appeal or review. The director may designate someone else to act on the director's behalf in making the final decision.

Each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument must specifically request it. If granted, all parties shall be notified of the time and place.

If a request for an oral hearing is denied, ten calendar days will be allowed to submit additional arguments to support the request for review.

On a child abuse appeal, the director has 45 calendar days from the date of the Proposed Decision to issue a ruling. If the director fails to issue a ruling within the 45-day period, the Proposed Decision becomes the Final Decision as provided in Iowa Code section 235A.19. All other reviews are completed on a first come-first served basis.

Once the review is complete, a Final Decision is issued to all parties to the appeal.

Final Decision

Legal reference: 441 IAC 7.16(10)"e," 7 CFR 273.15(s)(1), 7 CFR 273.15(c)

The final decision is binding on the Department. The decision becomes a part of the record. The DHS Appeals Section issues a Final Decision to the appellant and their representative by first class mail. All other parties are notified electronically through the Appeals Information System.

Take prompt, definite, and final administrative action required by the decision within seven calendar days of the date of the final decision, except for a managed care organization. **The local office is responsible for ensuring that all final hearing decisions are acted upon within seven days.** If the local office is unable to implement the final decision, the worker or supervisor must immediately contact the DHS Appeals Section.

When the final decision is favorable to the appellant, or when the Department decides in favor of the appellant before the hearing, corrective payments retroactive to the date of the incorrect action are made.

Food Assistance decisions that result in an increase in household benefits must be reflected in the benefits within ten days of the receipt of the hearing decision, even if the Department must provide the household with an opportunity to obtain the benefits outside of the normal issuance cycle.

Decisions that Food Assistance households have been improperly denied benefits or have been issued in a lesser allotment than was due shall result in lost benefits being provided in accordance with 7-H, Restoration of Lost Benefits.

Food Assistance decisions that result in a decrease in household benefits shall be reflected in the next scheduled issuance following receipt of the hearing decision.

When an Appeal of a Limited Benefit Plan is Filed

Legal reference: 441 IAC 7.9(9)

Policy:
A new limited benefit plan period shall be established when:

- A participant appeals:
  - Before the effective date of the intended action on the *Notice of Decision* establishing the beginning date of the limited benefit plan, or
  - Within 10 days from the date the participant receives the notice establishing the beginning date of the limited benefit plan. The date that the notice is received is considered to be five days after the date on the notice, unless the participant shows that the participant did not receive the notice within the five-day period, and
- Assistance is continued pending the appeal, and
- The final decision affirms the Department's action.

FIP assistance paid pending the appeal is not subject to recovery.

When an Appeal of an Ineligibility Period for Using an Electronic Access Card at a Prohibited Location is Filed

Legal reference: 441 IAC 7.9(10)

A new period of ineligibility shall be established when:

- A participant appeals:
  - Before the effective date of the intended action on the *Notice of Decision* establishing the beginning date of an ineligibility period, or
  - Within 10 days from the date the participant receives the notice establishing the beginning date of an ineligibility period. The date that the notice is received is considered to be five days after the date on the notice, unless the participant shows that the participant did not receive the notice within the five-day period, and
- Assistance is continued pending the appeal, and
- The final decision affirms the Department's action.

FIP assistance paid pending the appeal is not subject to recovery.

Appeal Record

Legal reference: 441 IAC 7.16(1), 7 CFR 273.15(q)

The record in a contested case shall include:

- The notice of appeal.
- All evidence received or considered and all other submissions, including the verbatim record of the hearing.
- All pleadings, motions, and intermediate rulings.
- All questions and offers of proof, objections, and rulings thereon.
- All findings of fact and conclusions of law.
- Settlement agreements in writing.

Accessibility of Hearing Decisions

Legal reference: 441 IAC 7.19(17A), 7 CFR 273.15(q)(5), 42 CFR 431.244

Summary reports of all hearing decisions must be made available to local offices and the public upon request. The information must be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

Copies of all final decisions are available from the Appeals Section upon request. However, all identifying information will be deleted and a fee may be charged, based on the nature of the request. See 1-C, Requests for Access to Records.

Rights of Appellants After the Final Decision

After receiving the Final Decision, the appellant has the right to request:

- A rehearing
- Court review of the decision

Rehearing

Legal reference: 441 IAC 7.17(17A), Iowa Code 17A.16(2)

The appellant may request a rehearing within 20 days after the date of the Final Decision. The DHS Appeals Section will mail a copy of the request for rehearing to all parties on record.

The DHS director determines if the rehearing is to be held. The application is considered denied if the Department has not granted the application within twenty days.

A party does not need to request a rehearing to exhaust all adequate administrative remedies when the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law or Department policy.

Judicial Review

Legal reference: 441 IAC 7.20(17A), 7 CFR 273.15(q)(3)(i)

If a director's review is requested, the final decision shall advise the appellant and the appellant's representative, if applicable, of the right to judicial review by the district court. When the appellant or someone acting on the appellant's behalf, like a representative or attorney, is dissatisfied with the final decision, that individual may file for judicial review in their county of residence or Polk County. A request for judicial review must be filed in the district court within 30 days of the date of the final decision.

When a request for judicial review is filed an Assistant Attorney General shall be assigned to represent the Department. The Department furnishes copies of the appeal file to the district court, including a written transcript of the hearing to the court.

The Department is unable to provide payment for attorneys to assist appellants in requesting judicial review. However, the local office should assist a person in obtaining legal assistance if the person indicates a desire to seek judicial review.

An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.

Stays of Agency Action

Legal reference: 441 IAC 7.20(2), Iowa Code 17A.19

Any party to the appeal may petition the director for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in Iowa Code section 17A.19(5)"c." A stay may be vacated by the director pending judicial review upon application of the Department or any other party.