Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

An individual/participant is advised routinely of his or her due process and appeal rights in accordance with ODP policies. The SC is responsible for notifying participants of the opportunity to request a fair hearing at his or her initial service plan meeting and at least annually during the service plan annual review meeting and any time the participant requests to change services or add new services. The discussion will be documented on the service plan and through a service note in Home and Community Services Information System (HCSIS).

The AE or ODP (for services that require prior authorization) is required to issue due process and appeal rights to the individual/ participant utilizing standard forms any time the following circumstances occur:
• The individual, who is determined likely to meet an ICF/ID or ICF/ORC level of care and is enrolled in Medical Assistance, is not given the opportunity to express a service delivery preference for either Waiver-funded or ICF/ID or ICF/ORC services.

• The individual is denied his or her preference of Waiver-funded or ICF/ID or ICF/ORC services.

• Based on a referral from the AE or County Program, a Qualified Developmental Disability Professional (QDDP) determines that the individual/participant does not require an ICF/ID of ICF/ORC level of care as a result of the level of care determination or redetermination process and eligibility for services is denied or terminated.

• The individual/participant is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s).

• The individual/participant is denied the choice of willing and qualified Waiver provider(s).

• A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the participant's service plan.

The Department's fair hearing and appeals process does not apply to the following actions:
• Changes caused solely by Federal or State law or regulations requiring an automatic change adversely affecting some or all recipients (42 CFR 431.220 [relating to Hearings]).

• Changes solely established by a Waiver amendment approved by the Centers for Medicare and Medicaid Services.

• A non–Medicaid service funded outside of the Waiver.

• A service provided during a period in which the individual is ineligible for Waiver funding.

The AE or ODP is required to make all such notices in writing. Should the individual/participant choose to file an appeal, they must do so with the agency that made the determination being questioned. Title 55 Pa. Code §275.4(a)(2) states that individuals must file an appeal with the agency that made the determination being questioned, and §275.1(a)(3) specifically includes social service agencies: "the term Department includes, in addition to County Assistance Offices, agencies which administer or provide social services under contractual agreement with the Department."

It is the responsibility of the Supports Coordinator to provide any assistance the individual or participant needs to request a hearing. This may include the following:

• Clearly explaining the basis for questioned decisions or actions.

• Explaining the rights and fair hearing proceedings of the individual or participant.

• Providing the necessary forms and explaining to the individual or participant how to file his or her appeal and, if necessary, how to fill out the forms.

• Advising the individual or participant that he or she may be represented by an attorney, relative, friend or other spokesman and explaining that he may contact his local bar association to locate the legal services available in the county.

Certain Waiver actions related to level of care and Medicaid ineligibility are also subject to fair hearing and appeal procedures established through the local County Assistance Office (CAO). AE participation is expected in preparation for the hearing and at the hearing whenever the CAO sends a notice confirming the level of care determination and the individual or surrogate appeals that notice through the CAO. The AE will receive notice of the hearing from the Department.

In situations where services are denied without first being authorized in the service plan or for actions taken regarding waiver service delivery preference, the individual or participant is provided 30 days from the written notice mailing date to appeal the decision. The AE or ODP is required to provide an advance written notice of at least 10 calendar days to the participant anytime the AE initiates action to reduce, suspend, change, or terminate a Waiver service. The advance notice, which is sent by the AE or ODP, shall contain a date that the appeal must be received by the AE or ODP to have the services that are already being provided at the time of the appeal continue during the appeal process.

If the participant files an appeal (written or oral) within 10 calendar days of the mailing date of the written notification from the AE, the appealed Waiver service(s) are required to continue until a decision is rendered after the appeal hearing (55 Pa. Code § 275.4(a)(3)(v)(C)(I)). As noted above, the continuation language is included in the written notice that is sent to the participant by the AE or ODP. The postmark of a mailed appeal will be used to determine if the 10 day requirement was met by the participant or surrogate.

If the AE initiates an action on Waiver services and does not provide the written notice as required, the participant will have 6 calendar months from the effective date of the action to file an appeal. When this appeal is filed, services will be reinstated retroactively to the date of discontinuance and will continue until an adverse decision is rendered after the appeal hearing.

Per the AE Operating Agreement, each AE is required to keep notices of adverse actions and the opportunity to request a Fair Hearing in accordance with the timeframes enumerated in the agreement.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The participant has the right to request an optional pre-hearing conference with the AE or ODP, as applicable (55 Pa. Code § 275.4(a)(3)(ii) [relating to Procedures]). The pre-hearing conference gives both parties the opportunity to discuss and attempt to resolve the matter prior to the hearing. Neither party is required to change its position. The prehearing conference does not replace or delay the fair hearing process.

In addition to pre-hearing conferences, service reviews are conducted by ODP for fair hearing requests for

participants that relate to the denial, reduction, suspension, or termination of waiver services by the AE and do not require prior authorization. Service Reviews are used to ensure AE compliance with regulations, approved Waivers, the State Medicaid Plan and applicable Bulletins.

The AE must track decisions and timely implementation of the service review or Bureau of Hearings and Appeals decision ODP has established a database to track appeals submitted and the outcome.

Final orders issued by the Department's Bureau of Hearings and Appeals must be implemented within 30 calendar days of the final order if ruled in favor of the appellant. If there is continued failure to implement the service, the ODP regional office will notify the County Commissioners/AE Governing Board of the program's failure to provide waiver services in accordance with their Operating Agreement and require an immediate plan from the Commissioners/AE Governing Board to comply. Any further failure to implement the service will result in sanctions being imposed in accordance with the AE Operating Agreement.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

ODP is responsible for the operation of a grievance/complaint system.

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

ODP's grievance/complaint system is comprised of two main components. The first is a Customer Service Line; the second is via email. Participants, family members and representatives, AEs, providers, advocates, and other interested parties may use these two components to ask questions, request information, or report any type of issue or complaint, including issues/complaints regarding AE performance.

The Customer Service Line (1-888-565-9435) is a general information line operated by ODP. The phone is located at ODP Headquarters and staffed by ODP personnel during normal business hours. Contacts can also be received via email at RA-odpcontactdpw@pa.gov. The DHS website also offers a "feedback" page for users who wish to comment on intellectual disability and autism services. Feedback, when received, is automatically forwarded to ODP.

When a complaint/grievance is received through the Customer Service Line or by email, information relating to the complaint/grievance is obtained and entered into a database. Information collected includes, but it not limited to the complainant's contact information and the nature of the complaint. The information is then referred to headquarters staff or the appropriate ODP regional office for follow-up. The complainant is contacted within 24 hours and corrective action is planned in conjunction with the AE or provider, if warranted.

Corrective action must occur or be planned within 21 business days, unless there is an imminent health and safety risk, in which case corrective action is taken immediately. If corrective action is not carried out by the AE or provider as planned, then ODP staff will contact the appropriate entity to ensure that corrective action is undertaken or planned within 72 hours.

In addition all ODP regional offices utilize a "duty officer" system whereby assigned staff are responsible for any complaints/grievances received directly at the regional office. Phone calls and letters are also received directly at ODP and responded to accordingly.

Providers are required to develop procedures to receive, document and manage grievances. The provider is responsible for informing the participant, and persons designated by the participant, upon initial entry into the provider's program and annually thereafter, of the right to file a grievance and the procedure for filing a grievance. The grievance shall be resolved within 21 days from the date the grievance was received. The initiator of the grievance shall be provided a written notice of the resolution or findings within 30 days from the date the grievance was received.

The AE, ODP or the provider is responsible for informing individuals that any of the grievance/complaint systems described above is neither a pre-requisite, nor a substitute for a fair hearing.