

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 OLTL policies. A participant will have his or her rights to file a fair hearing request discussed at time of enrollment, annually during the PCSP annual review meeting and at any time the participant requests to change services or add new services.

The IEE is required to provide information on due process and appeal rights to the applicant utilizing OLTL issued standard forms when the applicant does not meet the clinical eligibility requirements for the waiver. Appeal rights will be provided to applicants by the County Assistance Office if they do not meet the financial eligibility requirements of the waiver program.

The CHC-MCO is required to provide information on due process and appeal rights to the participant utilizing Department issued standard forms any time the following circumstances occur:

1. The participant is not given the choice of home or community-based waiver services as an alternative to institutional care.
2. The individual is denied his or her preference of waiver or nursing facility services.
3. The participant is denied his or her request for a new Waiver-funded service(s), including the amount, duration, and scope of service(s).
4. The participant experiences a reduction in the amount, duration and scope of services.
5. The participant is denied the choice of willing and qualified Waiver provider(s).
6. A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver-funded service authorized on the participant's ISP or when the participant is involuntarily terminated from participant direction.

The IEE and the CHC-MCO are required to make all such notices in writing utilizing Department issued documents. Should the applicant/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

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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.” The agency which receives the appeal from the participant will forward it to the Department’s Bureau of Hearings and Appeals (BHA) for action.

It is the responsibility of the CHC-MCO and the IEE to provide any assistance the participant/applicant 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 applicant or participant.
- Providing the necessary forms and explaining to the applicant or participant how to file his or her appeal and, if necessary, how to fill out the forms.
- Advising the applicant or participant that he or she may be represented by an attorney, relative, friend or other spokesperson and providing information to assist the applicant or participant to locate 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). The conflict-free entity making the Clinical Eligibility Determination and Redeterminations is required to participate in preparation for the hearing and at the hearing whenever an applicant appeals the Clinical Eligibility Determination. CHC-MCOs are expected to participate when the CAO sends a notice confirming the Clinical Eligibility Redetermination and the individual appeals that notice through the CAO.

The CHC-MCO is required to provide an advance written notice of at least 10 calendar days to the participant anytime the CHC-MCO initiates action to reduce, suspend, change, or terminate a Waiver service. The advance notice, which is sent by the CHC-MCO, shall contain a date that the appeal must be received by the CHC-MCO 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 CHC-MCO, 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 CHC-MCO. The postmark of a mailed appeal will be used to determine if the 10 day requirement was met by the participant.

CHC-MCOs will submit reports to OLTL as outlined in Program Requirements, documenting the appeals filed, reasons for the appeal and results of the hearing.

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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:*

<input type="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- 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 CHC-MCO must develop, implement, and maintain a Complaint and Grievance process that provides for settlement of Participants' Complaints and Grievances and the processing of requests for DHS Fair Hearings as outlined in the Provider Requirements of the Agreement. The CHC-MCO must use the required templates to inform Participants regarding decisions and the process.

The CHC-MCO must require each of its subcontractors to comply with the Participant Complaint, Grievance, and DHS Fair Hearing Process. This includes reporting requirements established by the CHC-MCO, which have received advance written approval by the Department. The CHC-MCO must provide to the Department for approval, its written procedures governing the resolution of Complaints and Grievances and the processing of DHS Fair Hearing requests. There must be no delegation of the Complaint, Grievance and Fair Hearing process to a subcontractor without prior written approval of the Department.

The CHC-MCO must abide by the final decision of DOH when a Participant has filed an external appeal of a second level Complaint decision.

When a Participant files an external appeal of a second level Grievance decision, the CHC-MCO must abide by the decision of the DOH's certified review entity (CRE), which was assigned to conduct the independent external review, unless appealed to the court of competent jurisdiction.

The CHC-MCO must abide by the final decision of BHA for those cases when a Participant has requested a DHS Fair Hearing, unless the CHC-MCO or the Participant files a timely request for reconsideration before the Secretary of the Department. A request for reconsideration to the Secretary of the Department will and a stay the action proposed in of the BHA decision. In cases where a timely request for reconsideration is made, and the Secretary issues timely decision on reconsideration, the reconsideration decision is the final administrative action which must be complied with by the CHC-MCO and the Participant. Only pending reconsideration and the stay is granted only the Participant may appeal the final administrative action to the Commonwealth Court. The decisions of the Secretary and the Court are binding on the CHC-MCO. During all phases of the CHC-MCO Grievance process, and in some instances involving Complaints, the Participant has the right to request a Fair Hearing with the Department.

A request for a DHS Fair Hearing does not prevent a Participant from also utilizing the CHC-MCO's Complaint or Grievance process. If a Participant requests both an external appeal/review and a DHS

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Fair Hearing, and if the decisions rendered are in conflict with one another, the CHC-MCO must abide by the decision most favorable to the Participant. In the event of a dispute or uncertainty regarding which decision is most favorable to the Participant, the CHC-MCO will submit the matter to DHS' Grievance and Appeals Coordinator for review and resolution.

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Appendix F-3: State Grievance/Complaint System

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

<input checked="" type="radio"/>	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 <i>(complete the remaining items)</i> .
<input type="radio"/>	No. This Appendix does not apply <i>(do not complete the remaining items)</i>

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

<p>The CHC-MCOs are responsible for the operation of the grievance/complaint system. The OLTL Bureau of Participant Operations is the state agency responsible for monitoring the grievance/complaint system in place with the CHC-MCOs. OLTL will operate a customer service line to address callers' concerns</p>

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).

<p>The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated hotline to respond to Participants' inquiries, issues and problems regarding services. The CHC-MCO's internal Participant hotline staff is required to ask the callers whether or not they are satisfied with the response given to their call. The CHC-MCO must document all calls and if the caller is not satisfied, the CHC-MCO must refer the call to the appropriate individual within the CHC-MCO for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call.</p> <p>The CHC-MCO must provide the Department with the capability to monitor the CHC-MCO's Participant services and internal Participant dedicated hotline from each of the CHC-MCO's offices. The Department will only monitor calls from Participants or their representatives and will cease all monitoring activity as soon as it becomes apparent that the call is not related to a Participant.</p> <p>The CHC-MCO is not permitted to utilize electronic call answering methods, as a substitute for staff persons, to perform this service. The CHC-MCO must ensure that its dedicated hotline meets the following Participant services performance standards:</p> <ul style="list-style-type: none"> • Provides for a dedicated toll-free phone line for its Participants. • Provides for necessary translation and interpreter assistance for LEP Participants. • Requires representatives to document calls and forward call notes to the Participant's Service Coordinator. • Be staffed by individuals trained in: <ul style="list-style-type: none"> – Cultural, Linguistic, and Disability Competency. – addressing the needs of covered populations. – the availability of, contact information for, and the functions of the Service Coordination Unit. – the requirements for accessibility. – coordination with BH-MCOs. – how to identify and handle any emergency.

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- when to transfer callers to the nurse hotline.
 - Covered Services, the availability of protective and social services within the community. Medicare coverage and to address questions that relate to the CHC-MCO’s companion D-SNP plan.
 - Medical and non-medical transportation.
- Be staffed with adequate service representatives so that the abandonment rate of less than or equal to five percent (5%) of the total calls.
 - Be staffed with adequate service representatives so that at least 85% of all calls are answered within thirty (30) seconds.
 - Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Participants who are deaf or hard of hearing.

Participants are advised through the CHC-MCOs orientation materials that the CHC-MCO’s grievance/complaint system is neither a pre-requisite, nor a substitute for a fair hearing.

The CHC-MCO will cooperate with OLTL and other DHS Hotlines, which are intended to address clinically-related systems issues encountered by Participants and their advocates or Providers.

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