

# 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. As stated before, this waiver application operates concurrently with an application to operate a managed care payment system for LTSS (i.e., CHC). A participant in CHC will have his or her rights to file a fair hearing request discussed as follows: 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.

At the time of application, the IEB is required to provide general information on due process and appeal rights to the applicant utilizing OLTL-issued standard forms. A denial notice with 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, by the IEB if they do not complete the application process, and by OLTL if they do not meet the clinical or program eligibility requirements of the waiver program. The applicant has 30 calendar days from the mailing date of the written notifications to file an appeal.

In the event the applicant is enrolled into the waiver, the CHC-MCO is required to have a complaint and grievance system in compliance with 42 CFR Part 438, Subpart F. An enrolled participant may request a State Fair Hearing only after exhausting the CHC-MCO's complaint and grievance process referenced in the CHC 1915(b) waiver. Upon determining that it will uphold an adverse benefit determination, the CHC-MCO is required to utilize Department issued standard forms to provide information on how the participant may appeal the CHC-MCO's decision by requesting a State Fair Hearing. A participant has 120 calendar days from the date of the CHC-MCO's notice of adverse resolution to request a State Fair Hearing. A participant may request a State Fair Hearing any time the following circumstances occur:

1. The participant is not given the choice of home or community-based waiver services, including the Living Independence for the Elderly (LIFE) program for individuals aged 55 and over, as an alternative to institutional care.
2. The individual is denied his or her preference of waiver, LIFE 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. The participant is denied the opportunity to self-direct their services.
7. 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.

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 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 IEB to provide any assistance the participant/applicant needs to request a hearing. The IEB provides assistance during the enrollment process and the CHC-MCO provides assistance after the participant has been enrolled. 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 Functional Eligibility Determination and Redeterminations is required to participate in preparation for the hearing and at the hearing whenever an applicant appeals the Functional Eligibility Determination. CHC-MCOs are expected to participate when the CAO sends a notice confirming the Functional Eligibility Redetermination and the individual appeals that notice through the CAO.

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.

## 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"/>	<b>No. This Appendix does not apply</b>
<input checked="" type="radio"/>	<b>Yes. The state operates an additional dispute resolution process</b>

- 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 concurrent 1915(b) waiver application describes the complaint and grievance process required of the CHC-MCO.

## Appendix F-3: State Grievance/Complaint System

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

<input type="radio"/>	<b>No. This Appendix does not apply</b>
<input checked="" type="radio"/>	<b>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>

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

OLTL operates a customer service line to address callers' concerns.
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**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>In addition to the MCO grievance process described in the concurrent 1915(b) waiver application, OLTL operates a Customer Service line, also known as the OLTL Participant HelpLine. The OLTL Participant HelpLine (1-800-757-5042) is located in the Bureau of Fee for Service Programs and is staffed by OLTL personnel during normal business hours. Participants, family members and other interested parties use the Participant HelpLine to report complaints/grievances regarding the provision/timeliness of services, provider performance, and reports of alleged abuse, neglect or exploitation.</p> <p>Individuals calling the OLTL Participant HelpLine with a complaint/grievance are logged into the Enterprise Information System (EIM), a web-based database, and the information is then referred to the appropriate Bureau for resolution. Complaints are classified as Urgent if immediate action is required to assist in safeguarding the participant's health and welfare or Non-Urgent if the participant is not at risk of immediate health and jeopardy and immediate action is not required. Any complaints determined to be an incident as described in Appendix G are entered into EIM as an incident and are treated as such for purposes of investigation and follow-through. In addition, any reports of alleged abuse, neglect or exploitation of a participant are immediately referred to the appropriate protective services agency as described in Appendix G.</p> <p>Investigations of Urgent complaints must be initiated within one business day, while Non-Urgent complaints have a five day timeframe for complaint initiation of the investigation. Any complaint determined to be an incident as described in Appendix G will be handled in accordance with all applicable requirements. The receiving Bureau contacts the participant, their CHC service coordinator, and/or other necessary parties in order to determine all circumstances regarding the complaint and to make a determination about an appropriate resolution. Documentation of any actions and the resolution is entered into the database by OLTL staff and the complaint is submitted through EIM for supervisory review. The reviewing supervisor can accept the resolution allowing for closure of the complaint or send it back to staff for further action. The timeframe for additional follow-up and resolution is 45 days, but</p>
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additional time can be requested through EIM in accordance with OLTL requirements. OLTL is able to generate reports from EIM about the types of participant complaints received, timeliness of resolution and examines general patterns and trends for system improvement.

In addition, EIM is designed to collect complaints received from any source, such as direct phone calls, emails, and letters or faxes in order to standardize collection and processing of all complaints in one data collection system.