

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.

Notification

ISC entities are responsible for informing participants of the right to appeal adverse decisions and actions upon Waiver enrollment. The Operating Agency has developed a standard form, Notice of Individual Right to Appeal (IL462-1202, in English and Spanish) for this purpose. The standard form states: If an appeal request is received within 10 calendar days after receipt of the notice of action, the decision in the notice shall be stayed, pending the results of the appeal.

ISC entities are also responsible for written notification when an adverse decision or actions occurs.

Operating Agency staff and Medicaid Agency staff are responsible for written notification when there is an adverse decision in the fair hearing process.

Written notifications contain information on the continuation of services pending the results of the appeal process. Notices of adverse actions and the opportunity to request a fair hearing are maintained by the entity that was responsible for the notifications.

Appeal Process

Participants and guardians, if appointed, are informed by the ISC of appeal rights when services are presented including the choice of HCBS as an alternative to institutional care, denying the service or the providers(s) of their choice and also upon notice of service denial, suspension, termination or reduction. Information about appeal rights is also available at any time upon request. 89 Ill. Admin. Code 104 and 59 Ill. Admin Code 120.110 describes the fair hearing request procedures in use for the Adult Developmental Disability Waiver.

Copies of notices are maintained in the individual's record by the ISC. If participants receive notice of adverse action, they have ten working days to file an appeal. Once the appeal is filed, the Operating Agency has 30 working days to conduct an informal review of the appealed action. The informal review process can reverse, modify, or leave the action unchanged.

If participants receive notice of adverse action, they have ten working days to file an appeal. Once the appeal is filed, the Operating Agency has 30 working days to conduct an informal review of the appealed action. The informal review process can reverse, modify, or leave the action unchanged.

At the conclusion of the informal hearing, the participant and the service provider, if applicable, is notified in writing of the decision within ten working days. The notice includes clear statements of the action to be taken, the reason for the action, supporting policy references, and the right to appeal the decision to the Medicaid Agency.

The participant has ten working days to appeal the informal review decision to the Medicaid Agency for final administrative action. The request for an appeal to continue existing services allows those services to continue until the hearing decision is reached or unless the appeal is withdrawn.

The Medicaid Agency appoints an impartial hearing officer to conduct the hearing at the Medicaid Agency or Operating Agency office nearest to the family's home unless all parties agree to an alternate location. The hearing officer may participate by video conference.

The Medicaid hearing officer conducts the formal appeal, drafts the decision and sends it to the Medicaid agency Hearing

Supervisor for final review and sign-off by the Medicaid Director. Once a final decision is released by the Medicaid agency, it is reviewable only through the Circuit Courts of the State of Illinois.

The Medicaid Agency rule (89 Ill. Adm. Code 104.70) provides that an appeal decision shall be given within 60 days of the date it was filed unless additional time is required, which may include postponement or continuance of a hearing for good cause as provided in 89 Ill. Adm. Code 104.45. The appeal process follows federally mandated rules that require all appeals to be treated equally and ensure due process is given for each appellant.

Training for the Medicaid hearing officers is conducted in several ways; by group training, one-on-one mentoring, and shadowing of experienced Medicaid hearing officers. Training encompasses the Medicaid Hearing Officer Manual, and the Medicaid waiver administrative codes and citations. All current HFS Medicaid Hearing Officers have experience in HFS programs—either Medical Programs or Child Support. Monitoring of the hearing process and final decisions occurs in several ways:

- The scheduling Medicaid Hearing Officer Supervisor creates a monthly report with the disposition of all cases to assure that hearings are being scheduled and moving through the process.

- Decisions go through three levels of HFS review:
 - o the Medicaid Hearing Officer drafts the case
 - o the Medicaid Hearing Supervisor reviews 100% of the cases
 - o the Medicaid Director makes the final decision on every case

- Quality Controls consist of reviewing cases for consistency in the application of the Medicaid laws and the use of sound legal reasoning. Trends and patterns are also considered as part of the quality oversight process.

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.

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:

The ISC entities, under contract with the OA, are responsible for hearing and resolving issues that arise at the local providers. The Operating Agency is responsible for providing technical assistance when the ISC entities cannot successfully resolve local issues. The OA maintains a database of complaints referred by ISCs or made directly by participants. Reports from the database are shared monthly by the OA with the MA via electronic communication and paper reports at the Quality Management Committee meetings. The data is analyzed and evaluated for trends on a quarterly and annual basis by the OA and MA. As individual problems and trends are identified, proactive remediation is initiated. The State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion. The Quality Management Committee collectively tracks the remediation activity.

The FMS entity/entities maintain a complaint log regarding issues concerning the payment of domestic employees. Summary data from the log is reported to and reviewed by the OA on a quarterly basis. This information is shared with and reviewed by the Quality Management Committee on an annual basis. Remediation is initiated and tracked as necessary. The State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion.

- 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).

Upon enrollment and annually thereafter, participants and guardians are informed by the ISC of their options for making complaints, and that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. The ISCs use the Rights of the Individuals form (IL462-1201) to document the notification. Options for filing complaints are also posted on the OA's website.

The type of complaints can include anything of concern to the participant or guardian, e.g., dissatisfaction with the participant's person centered plan, failure to implement the individual's person centered plan, quality of services or supports, risk of losing services, etc. In addition, individuals can identify and report issues that are program-wide and do not specifically apply to their individual services.

When a complaint is received, the OA will make an initial response to the individual making the complaint within two business days with the overall goal to resolve grievances within 30 days. Timeliness is tracked and monitored by the OA and reported regularly to the MA.

Upon receipt of a complaint, the OA records the complaint in a database that documents the person making the complaint; the type of complaint; the substance of the complaint; the names of any participants, providers, and/or ISC's involved; the person(s) at the OA assigned to review and address the complaint; action steps taken; final resolution; and dates of intake, action steps, and resolution.

An OA staff person is assigned to each complaint. The assigned staff person confirms and/or collects information from the ISC, provider(s), and any other parties involved. He or she then takes appropriate action steps depending upon the complaint. Final resolution is recorded in the log. Reports are produced twice monthly for managers within the OA to ensure open complaints are being addressed on a timely basis.

The data is analyzed and evaluated for trends on a quarterly and annual basis. The summary reports are regularly shared with the MA. As individual problems and trends are identified, proactive remediation is initiated. Based on the data, the OA and MA may develop system improvement plans by identifying the responsibilities of the MA and OA and identifying time frames for completion. The Waiver Quality Management Committee (QMC) tracks all system improvement plans until completion.