

DDD-PI-094
Appeals Protocol
Developmental Disabilities Services
February 17, 2005

Section I - Overview

In North Dakota, an individual must be Medicaid eligible and screened to the ICF/MR level in order to receive most services authorized through the Developmental Disabilities Case Management System. (See DDD-PI-077 dated 7-1-03). Therefore, Medicaid appeal rights must be followed. The only DD services that are not affected by PI-077 include DD Case Management, Corporate Guardianship, and Family Subsidy. Although North Dakota does not require a person to be Medicaid eligible and screened to receive DD Case Management, case management is an authorized service under the DD Waiver. Therefore, eligibility for DD Case Management will have the appeal rights afforded to Medicaid applicants/recipients for the purposes of this policy.

Corporate Guardianship and Family Subsidy are non-Medicaid services (funded solely with state general funds) and do not carry the appeal rights guaranteed under Medicaid.

Appeals regarding financial eligibility and authorization for Medicaid State Plan Services are not addressed in this policy as the County and/or the Medical Services Division is responsible to process these appeals. Also, this policy does not pertain to licensing of providers or rate setting methodology. Appeals for those purposes are set forth in NDAC 75-04-01 and 75-04-05.

Procedural Safeguards, Rights and Protections:

Medicaid applicants/recipients and/or their legal decision maker have the right to disagree with and appeal decisions when:

- A request for service(s) is denied, or
- A service is reduced, suspended or terminated.

DD Case Management is responsible to notify applicants and recipients of DD services of their right to appeal when the following action will be taken:

- Eligibility for DD Case Management is denied.
- Eligibility for ICF/MR level of care screening is denied or terminated.
- Choice between ICF/MR institution and DD HCBS waiver services is denied
- Specific services under the DD HCBS waiver are denied or terminated.
- Amount of service under the DD HCBS waiver is denied or reduced.
- Choice of qualified providers of service is denied.

The right to appeal under each of these circumstances will be discussed in detail later in the policy.

Section II - Giving of Notice

DD Case Management must provide the applicant/recipient of the intent to take proposed action that will deny, terminate or reduce DD Medicaid benefits/services. Medicaid requires that notice be given at least 10 days prior to the date of the proposed action. **DD Case Management will make every effort to provide written notice to the individual 30 days prior to the date of the proposed action.** Date of action means the date upon which an action is intended to become effective.

The written notice must include:

- a. An explanation of the type of proposed action;
- b. An explanation of the reason for the proposed action; and the regulation or law upon which the action is based; and
- c. The person's right to request a fair hearing, and
- d. The circumstances under which assistance will be continued if a fair hearing is requested.

Notice may be given by first-class mail or personal delivery.

Continuation of Benefits/Services:

An individual may be eligible to receive continued Medicaid benefits/services pending an appeal hearing decision. If the individual requests a hearing before the date of action, services will not terminate or be reduced until a decision is rendered after the hearing, or the individual withdraws the request for hearing, fails to appear at the hearing without good cause, or it is decided that the only issue in the appeal is one of federal or state law requiring an automatic change adversely affecting some or all recipients.

If benefits are continued, and the hearing decision is not in the individual's favor, the person may be required to re-pay cost of services received and covered by Medicaid during the appeals process. If the fair hearing decision is in the individual's favor, services will be reinstated, if they were terminated

Example 1: An individual no longer meets the ICF/MR level of care. A notice is mailed dated 3-1-05 informing the individual of the intent to terminate the ICF/MR level of care screening and Medicaid funding, effective 3-31-05. If the individual files a written appeal request to the Appeals supervisor prior to the effective date of the screening termination, the screening will not be terminated and services will continue to be funded through Medicaid until the hearing decision is made. If the hearing decision is in the individual's favor, the Medicaid screening and funding will remain in place. If the hearing decision is not in the individual's favor, the ICF/MR level of care screening will be terminated effective the date of the hearing decision and the Department of Human Services may try to recover the cost of services provided through Medicaid during the appeals process.

Example 2: An individual is receiving ISLA services but it is determined by the Department/DDCM that the individual no longer meets the criteria as prescribed in NDAC 75-04-07. The DDCM provides a 30-day written notice of the intent to terminate ISLA services effective March 31. If the individual files a written request for appeal prior to the proposed termination date of 3-31, ISLA will not be terminated until after the hearing decision is made. If the decision is made in favor of the individual, ISLA will continue. If the hearing decision is in favor of the Department, the ISLA will be terminated effective the date of the hearing decision.

Please note: The person is still required to report any other necessary changes in circumstances while the hearing is pending, which may affect the benefits or services.

Section III - Fair Hearing and Appeal

(42 CFR Part 431 Subpart E)

If an individual is dissatisfied with a decision, they have the right to request a fair hearing. The written request must be sent to the following address **within 30 calendar days** from the date of the written notice. Unless a written request is made within the 30 calendar days of the date of the notice, the decision will be final and binding. The DD Case Manager will offer to assist the applicant/recipient in filing the appeal.

Appeals Supervisor
North Dakota Department of Human Services
600 East Blvd. Ave. - Dept. 325
Bismarck, ND 58505-0250

If a fair hearing is granted, the individual and/or their representative and agency will receive written notice of the scheduled time, date, and place of the hearing. A fair hearing is a formal meeting, which includes the individual, an impartial administrative hearing officer and a representative(s) from the agency (regional human service, State DD Unit) and may include legal representation from the Attorney General's Office to represent the Department of Human Services. At this hearing, the parties present evidence and arguments to the administrative law judge assigned to conduct the hearing. The administrative law judge will then issue a written recommended decision based on the facts of the case and federal and state law and regulations. The Department may accept or reject the administrative law judge's recommended decision. The Department's final decision will be mailed to the individual who appealed the matter or his or her.

The individual has the right to bring witnesses, their own attorney, or some other advisor/friend to the hearing. The Department of Human Services cannot pay for a lawyer to represent the individual, but can direct the person to find free legal assistance or at a reduced cost. The case manager may suggest the individual contact Legal Services of North Dakota or the Protection and Advocacy Project may also be a possible resource during the appeal process.

The individual has the right to see the agency's written materials about the case before the hearing and during the hearing. The individual and their representative have the right to question anyone who testifies against them at the fair hearing, and to present their own arguments and written materials.

If the fair hearing decision is in the individual's favor, no action will be taken against the person and benefits will be reinstated, if they were terminated. If the fair hearing decision is not in the individual's favor, the agency's (Department's) action will stand.

If the individual does not agree with the fair hearing decision, they can appeal to the district court and the North Dakota Supreme Court.

Informal Options:

Although the Department of Human Services has the formal appeal process to manage complaints and disagreements about Medicaid Services, the individual may wish to try a less formal approach to resolving the problem before proceeding to the fair hearing.

The individual is not required to participate in an informal conference And may proceed directly to fair hearing. The use of informal conference will NOT preclude or delay the individual's right to a fair hearing.

An individual who is dissatisfied with a determination, may request an informal conference in an attempt to resolve the matter. The request for informal conference must be submitted to the regional human service director within ten (10) days after written notice of the determination. The center director shall, within five working days of an oral or written request for informal conference, convene a conference with the aggrieved party. The human service center director may request involvement of appropriate center staff.

Within five (5) working days after the informal conference, the regional director will issue a written decision. In the event that the center director's decision is contrary to that of regional DD program staff, has the effect of allocating resources contained within a central office division, and/or is related to the eligibility for DD Case Management or ICF/MR level of care, the director shall consult with the Director of the Disability Services Division and/or designee before issuing a decision.

The use of informal conference will NOT preclude or delay the individual's right to a fair hearing. Regional DD Case Management must provide assistance to the aggrieved individual in order to assist them in submitting a formal appeal to the Department's Appeals Supervisor. It is recommended that the case manager advise the individual to file the written request for appeal with the Appeals Supervisor immediately, even if they request an informal conference. In the event the matter is resolved at the informal conference, the individual may withdraw their request for a fair hearing by notifying the

Appeals Supervisor. The time period in which to file an appeal will not be extended because an informal conference is requested.

Section IV - What can be appealed?

DD Case Management Eligibility Decision:

(North Dakota Department of Human Services - DD policy)

An applicant has the right to appeal if they are dissatisfied with the eligibility determination, e.g., eligibility for DD Case Management services is denied.

Denial or Termination of ICF/MR Level of Care Screening

42 CFR 441.302 (c) 42 CFR 440.150

Screening is used to determine eligibility for Medicaid long-term care services (and is separate and distinct from the eligibility for DD Case Management Services in NDAC 75-04-06). Medicaid Long-term Care Services for DD services include the Home and Community-Based Waiver and institutional placement in Intermediate Care Facilities for people with mental retardation. To determine eligibility, an individual must meet the ICF/MR level of care standards. Eligibility for an institution is the same eligibility used to determine eligibility for HCBS services.

Screening must occur if requested by an individual who is eligible for DD Case Management and must be free. If it is determined that the person does not meet the ICF/MR level of care, they have a right to appeal that decision.

If an individual is currently screened to the ICF/MR level of care for the DD services they are receiving, but is found ineligible for continued ICF/MR level of care, the individual has the right to appeal the decision to terminate the ICF/MR level of care screening.

The basis of the appeal is to permit the individual to establish that the information used to complete the level of care evaluation (Progress Assessment Review - PAR) and/or application of the professional judgment guidelines is in error or inaccurate. The individual may appeal the level of care determination as it relates specifically to the input and values assigned within the assessment process. The evaluation mechanism and computer-generated indicator are not subject to appeal.

Screenings for ICF/MR level of care must be completed at least annually. The DD Case Manager will receive an alert in ASSIST, two months before the re-screening documentation (Case Action Form) is due. The PAR should be reviewed, and activated prior to the completion of the annual Case Action Form. When it is determined (through the annual PAR assessment and/or the professional judgment of the DDCM) that an individual who is currently screened to the ICF/MR level of care no longer meets the criteria, the DDCM will inform the individual and/or guardian of the proposed action to terminate the screening 30 days prior to the termination date. Since Medicaid eligibility is for a full month, the termination date for the ICF/MR level of care screening will be the last day of the full calendar month in which the person is not eligible for ICF/MR level of care.

For example: It is determined by DDCM that the individual no longer meets the ICF/MR level of care on February 20, the date of the proposed action to terminate the screening will be March 31 (which is the first full month the person is not eligible). The notice will be mailed at least 30 days in advance informing the individual of the proposed action (e.g., at least 30 days prior to March 31).

See Notice of **Initial Denial** for ICF/MR Level of Care Screening Appendix A.

See Notice of **Termination** for ICF/MR Level of Care Screening Appendix B.

Choice of ICF/MR Institution vs. DD Home and Community-Based Services

(42 CFR 441.302 (d) and Section 1915c North Dakota Medicaid home and community based services waiver 16. Assurances d. "The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E to persons who are not given the choice of home or community-based services as an alternative to institutional care, or who are denied the service(s) of their choice, or the provider of their choice.)

Individuals who meet the ICF/MR level of care must be given the choice of whether they want placement in an institution (ICF/MR) or Home and Community Based Services Waiver services. If the Department does not give the individual a choice, e.g., DDCM does not authorize placement in an ICF/MR, or in the DD waiver, if the individual requests it, the decision can be appealed. That is not to say that the Department cannot deny services. Feasible alternatives may only be determined after the assessments of an individual's care needs and evaluation of level of care. Thus, it is not expected that an individual will be offered waiver services if the assessment indicates he or she cannot be adequately served in the community. Services can be denied if the Department (case manager and DD unit) believes the individual does not need the service, or the service(s) cannot meet the health and safety needs of the individual.

The choice of services is noted on the ISP. The right to choose between institution and HCBS Waiver, and right to appeal must be reviewed with the individual at the time the ISP is signed. If the individual disagrees with the services authorized on the plan, the individual will be informed of their right to appeal the decision and must file a written appeal request with the Appeals Supervisor within 30 days.

Choice of Services Offered Under the DD Home and Community-Based Services Waiver -- Denial and Termination

(Section 1915c North Dakota Medicaid home and community based services waiver 16. Assurances d. "The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E to persons who are not given the choice of home or community-based services as an alternative to institutional care, or who are denied the service(s) of their choice, or the provider of their choice.')

Requested services must be provided under the HCBS Waiver, unless it can be shown that the individual does not need the service, the service(s) cannot meet the health and safety needs of the individual, or Medicaid does not cover the service(s). It should be noted that some HCBS services provided under the DD Waiver, such as ISLA, have distinct eligibility criteria. Individuals have the right to request an appeal if they are denied the HCBS service of their choice or if the service(s) of their choice is terminated.

The choice of services is noted on the ISP. The right to choose and right to appeal must be reviewed with the individual at the time the ISP is signed. If the individual disagrees with the HCBS services authorized on the plan, the individual will be informed of their right to appeal the decision and must file a written appeal request with the Appeals Supervisor within 30 days.

A request for appeal through fair hearing only applies if the Department refuses to authorize a service to the individual. It does not pertain to situations when a private provider of service will not accept an individual for services, or makes a decision to involuntarily discharge an individual from service. In these situations, the Department is not denying or terminating a service to the individual. An appeal is not offered when there is no qualified provider available. See next section - Choice of qualified provider

The DDCM will make every effort to refer and assist the individual to obtain services through other qualified providers.

Choice of Qualified Provider

(Section 1915c North Dakota Medicaid home and community-based services waiver 16. Assurances d. "The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E to persons who are not given the choice of home or community-based services as an alternative to institutional care, or who are denied the service(s) of their choice, or the provider of their choice."

Individuals must be offered a choice of qualified service providers. If the Department denies the individual a choice of provider, the individual has a right to request an appeal. An appeal is not offered through the Department when the person has been approved to receive the service, referrals have been made, but there is no qualified provider available.*

**Private providers of service are not required to provide services to an individual. Although providers are bound by federal, state, and local laws against discrimination, providers may determine which applicants to admit or which recipients they will serve. According to policy, DD licensed providers must provide a 30 day written notice if they plan to terminate services to an individual which results in an involuntary discharge unless it is an emergency situation and is approved by DD Case Management. The provider must provide written documentation explaining why they refuse to serve the individual and describe the individual's right to appeal the provider's decision within the organization. Licensed DD providers are required to have an internal grievance or appeals process available to individuals who are dissatisfied with provider agency decisions.*

Also see following section regarding the ND Developmental Center.

Reduction of HCBS Service Amount for Individually Authorized Services (Family Support Services/ISLA/Ext. Services HCBS, Day Supports and AETS)

(42 CFR Part 431 Subpart E - 431.200(b)-"Prescribes procedures for an opportunity for a hearing if the state agency... takes action, as stated in this subpart, to suspend, terminate, or reduce services ... ")

If Medicaid services under the DD Waiver are reduced, an individual must be given the right to request an appeal for a fair hearing.

□ **Family Support Services**

In-Home Supports - An individual and/or legal guardian or decision maker must be informed of their right to request an appeal if the **number of In-Home Support hours requested is denied or reduced**. The written notification of hours that will be authorized and the right to appeal is contained on the Family Support Service authorization, which is sent to the individual/guardian at least 30 days prior to the start date of the authorization period. The individual/family must sign and return the authorization prior to the start of the authorization period in order for services to be provided. If the individual/guardian disagrees with the amount of hours to be authorized, they must file an appeal within 30 days of the date of the notice (FSS/In-Home Support Authorization).

Family Care Option - The parent/guardian or legal decision maker of a child can appeal the number of days of Family Care Option that are authorized. The daily rate paid to the foster care family cannot be appealed.

Family Care Option III -Reduction is not applicable in this program. In FCO III the rate is negotiated with the provider of service, not the individual. The provider agrees to meet the health and safety needs of the individual during the time period that is authorized. Any change/reduction in rate is within the rate setting process, not a reduction in service to the individual.

Notice of appeal only needs to be given if the individual is denied authorization of FCO III or is terminated from FCO III.*

**If an individual has been receiving FCO III and reaches the age when FCO III is no longer available, a notice of termination and appeal right does not need to be given unless the individual will NOT be transferring to ISLA. At that point a notice terminating the HCBS service of FCO III and right to appeal will be given because a service is being terminated and the service of choice/similar service of ISLA is being denied.*

- ❑ **ISLA - Reduction is not applicable in this program.**
In ISLA the rate is negotiated with the provider of service, not the individual. The provider agrees to meet the health and safety needs to the individual during the time period that is authorized. Any change/reduction in rate is within the rate setting process, not a reduction in service to the individual.

A notice and right to appeal must only be provided to the individual when the service of ISLA is denied or when an individual will be terminated from the ISLA program. Refer to NDAC 75-04-07-06 to determine when an appeal may be granted.

- ❑ **Day Services - (Day Supports/ Day Support AETS, Extended Services HCBS/Extended Services AETS).** The right to appeal the amount and combinations of Day Services authorized is contingent upon the requirements contained in DDD-PI-088.
- ❑ **Excess absences from DD facilities** - An individual cannot appeal the denial of a request for excess absences from a DD facility.

Administrative Code 75-04-05-10-3.d and 75-04-05-10-3.g establishes excess absences as a reimbursement issue between the Department of Human Services and a licensed DD Provider. If a Regional DD Program Administrator "denies a providers request" for excess absences and the client is absent from the facility for more than the approved number of days, it becomes an issue between the provider and the Department upon audit. The Department continues to require that the provider make services available to the eligible client 365 days a year. No service is denied and the Department continues to pay for all services provided.

Section V- North Dakota Developmental Center at Grafton

The Developmental Center is a certified ICF/MR institution. However, the right to choose the Developmental Center as a provider is subject to the Center's admission policies, which require that all other community placement options and resources be exhausted before an individual is admitted. In addition, all referrals for admission to the Developmental Center must be initiated by the DD Case Management system. Therefore, before an individual is referred for admission, the DD Case Manager must not only determine that the individual meets the ICF/MR level of care, but also assure all community services have been exhausted through a statewide referral staffing with the eight regional DD program administrators.

Once a referral is made to the Developmental Center, the admissions screening team will review the referral information and determine whether the individual can be admitted. The Developmental Center serves as the safety net for individuals whose needs cannot be met in the community; therefore, referrals to the center are accepted but admission may be contingent upon space and resources at the time of referral.

By law, the Superintendent of the Developmental Center has the authority to decide whether the individual will be admitted. The decision is not subject to appeal.