# Medicaid Waiver Procedural Safeguards
# Rights and Protections

*Procedural safeguards protect your rights in the Medicaid system. This section of the Guide will provide you with some basic information about your rights regarding appeals, choice, confidentiality, consent, enrollment, financial eligibility, human rights, planning, providers, records, screening, waiting lists, and written notice.*

## APPEALS

Appeal information can be viewed at http://dmasva.dmas.virginia.gov/Content_pgs/appeal-home.aspx

Medicaid appeals can be requested to challenge decisions and actions regarding Medicaid. Appeals can be requested for any of the following reasons:

X services are denied, reduced, partially approved, suspended or terminated;
X screening is denied or unreasonably delayed;
X request for services is not acted on within a required timeframe; and
X eligibility is denied or unreasonably delayed.

Appeals must be requested in writing within 30 days of the agency's decision that adversely affects eligibility or services.

Hearing officers should issue a decision within 90 days of your request for an appeal.

Hearing requests should be submitted in writing to the Department of Medical Assistance Services: Appeals Division, DMAS, 600 East Broad Street, Richmond, VA 23219.

There are two parts to the appeal system. The first part is the administrative appeal which is heard by a hearing officer who is an employee of DMAS. If you do not prevail during the administrative appeal, you can appeal to the courts.

You do not need to have an attorney or other person represent you in the administrative appeal, but such representation is permitted.

The hearing officer will establish a date and time for the hearing. All witnesses will be sworn to tell the truth. The hearing will be recorded and a written transcript of the hearing will be made. You have the right to review evidence that others provide to the hearing officer prior to the hearing.
During the hearing you, or your representative, will present facts and describe why you are appealing. The agency that denied services or delayed a response will be given the opportunity to present facts and respond to the testimony being presented. The hearing officer, the agency, you and your representative will be given the opportunity to ask questions.

All information and documentation must be presented at the hearing or a request to leave the hearing record open must be made and accepted by the hearing officer.

The hearing summary and hearing officer's decision will be mailed to you. You can request copies of all evidence and a transcript of the hearing.

If you continued to receive Medicaid during the appeal process, you may be asked to pay Medicaid back if the appeal is not decided in your favor. Talk with a Waiver Mentor or other advocate if you are concerned about this possibility.

If you disagree with the hearing officer's decision you can appeal through the courts. Before you file an appeal with the court, you must give notice to the Director of DMAS. It is highly likely that you will need attorney representation for the appeal process through the courts.

APPEAL CONSIDERATIONS -

As described, DMAS has the formal appeal process to manage complaints and disagreements about Medicaid. You may want to first try a less formal approach to resolving the problem. Keep in mind that you only have 30 days to request an appeal. So your informal attempts should be done quickly. Then if the problem continues after your informal attempts to resolve the problem you will be able to submit your request for an appeal before the 30-day time line expires.

DMAS or the provider may not be receptive to your informal attempts to resolve the problem and then you will have to proceed with an appeal if you want to continue to try and resolve the problem.

For example, if you are having difficulty accessing a service that you have been authorized to receive, take action. First call the provider, discuss the issue with them and establish a time line for resolution of the problem. If the provider does not resolve the problem by the agreed upon date, call your case manager. If the problem is not resolved in a timely manner, write a letter to the case manager asking them for assistance. In your letter, explain the problem and what you have done to resolve the problem. Keep copies of your letters. Maintain a diary of your efforts to deal with the problem. If the issue is still not resolved, call and/or write DMAS. If the problem persists, submit an appeal to DMAS. Your attempts to resolve the problem could be important documentation in an appeal. Similar steps could be taken for any problem you are having with Waivers.

**CHOICE**

You have the right to receive services in the community. It is your choice whether to receive services in the community through a Medicaid Waiver or to be placed in a nursing facility or other institution. Money Follows the Person is a demonstration project that can provide guidance, supports and services to people who want to leave nursing facilities and other institutions. Information about MFP is available from the Waiver Mentors listed on page 37 and at www.olmsteadva.com/mfp/

You have the right to choose your DD Waiver case management organization.

Case Management for people with intellectual disability is provided by the CSB and organizations that the CSB may opt to contract with.
You have the right to choose your Waiver service providers and to change providers.

A list of available providers must be given to you by the Waiver screener or case manager.

Services that are provided should be services that you choose and that you agree are needed.

**CONFIDENTIALITY**

Case managers and providers must protect the confidentiality of people who apply for and receive Medicaid services. Personal identifying information about you cannot be disclosed without your written consent.

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## CONSENT

Your written consent must be given before your Medicaid Waiver services can begin or before services are changed.

## ENROLLMENT

Individuals must be 6 years or older to qualify for the DD Waiver. DD Waiver screening can be requested when the child is 5 years 9 months old. Children under the age of 6 who are at developmental risk may be eligible for the ID Waiver, until the age of 6, even if they do not have a diagnosis of intellectual disability. At the age of 6 the child must have a diagnosis of ID for the ID Waiver, and if not, the child may be able to receive DD Waiver services using a specified process.

Once a Waiver slot (funding) becomes available to you, your enrollment process can begin.

In addition to receiving Waiver services, you will also be eligible for all other Medicaid benefits provided in Virginia.

If you have other health insurance, Medicaid will be your secondary insurance.

You must use Virginia Medicaid providers in order for Virginia Medicaid to pay for your services.

## FINANCIAL ELIGIBILITY

Financial eligibility for long-term care (Waivers and institutions) is determined by the local Department of Social Services (DSS). DSS has 45 days to determine eligibility. The 45-day time line begins once you have provided DSS with a completed Medicaid financial application. Your case manager, provider agency, or services facilitator for EDCD Waiver services will give DSS notification of Waiver eligibility. The 45-day timeline may be longer if disability determination must be made. Disability determination must be made for adults who are not elderly who are applying for Waiver services.

Parental income and resources are not considered when determining eligibility for Virginia Medicaid Home and Community-Based Waivers. This includes children under the age of 18.

DSS will determine if you have a patient pay for your Waiver services.

DSS will annually review your financially eligibility. You will receive notice about this review in the mail and you must respond within the time frame stipulated in the notice.

If you disagree with the DSS decision regarding your financial eligibility, you have the right to appeal. Keep in mind that you have only 30 days to appeal adverse decisions such as the denial of eligibility. If you have missed this 30-day time line you can request another screening and eligibility determination.

## HUMAN RIGHTS REGULATIONS

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"Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services" are regulations of the Department of Behavioral Health and Developmental Services. These Regulations are often referred to as Human Rights Regulations. The regulations address the rights of people receiving services from certain providers including ID Waiver providers and certain DD Waiver providers (day support, in-home support, and crisis stabilization.)

Information about the Human Rights Regulations is at www.dbhds.virginia.gov/OHR-default.htm. The State Human Rights Committee and Local Human Rights Committees are responsible for addressing alleged violations of the Human Rights Regulations.

## PLANNING

Individualized planning is required for all Waivers. Services can be planned in a variety of ways. Some people see this as a very personal process in which they do not want or need others to be involved. Meeting with their case manager/support coordinator and providers separately is what they want and need. Others want to have all of their providers come together in one meeting to discuss services. Some people want intensive, personal meetings to discuss all aspects of their life and to plan in depth for supports and services.

There are different kinds of planning processes that can be used to develop your Waiver and other services. Planning and services should focus on your needs and choices. Everyone has unique personalities, needs, perspectives, supports - the type of meeting you will have is your choice.

Waiver services are individualized and personal. Your case manager and providers should work with you to establish the type of meeting you want. You should have planning opportunities that will be meaningful and dignified.

Each Waiver has a process for requesting a change to the plan for your services. Plans must be updated annually. However, a plan can be revised anytime there is a need.

## PROVIDERS

Providers must have the specific knowledge, skills and abilities as described in the Regulations for each Waiver.

Choosing your providers is your right. The Waiver screener or case manager should give you a list of all available providers for the services you need.

Changing providers is your right.

You should research and interview providers before making your choice of providers. Case managers can assist you with this. You will want to be comfortable with the agency and the staff that will be assisting you with personal needs, support and learning tasks.

Services should be provided on the days that the services are needed and during the times you need to receive the services. Services must be effective. You may need to choose a different provider if the current provider is not able to provide services when you need them.

Some agency-directed providers will hire staff that you recruit. If you know of someone who is qualified and who would be a good provider for your services, refer that person to a provider and encourage the provider to hire the person you referred to them.

Providers must give you notice before they terminate their services to you. Time lines for termination of services by providers vary and are described in the Regulations for each Waiver.

**RECORDS**

You have the right to review all records and documentation about your Medicaid services including the documentation maintained by your case manager and providers. Copies should be provided to you when requested. You must give consent for your records to be shared with others.

**SCREENING**

Screening is used to determine eligibility for long-term care (Waivers, nursing facilities, long-stay hospitals, and ICF/DDs.)

Screening must occur if requested. If the screener denies the opportunity for you to be screened, then the screener must provide you with written notice of why the screening was denied. You have the right to appeal the denial of your screening request.

Screening must occur with reasonable promptness. If the screener does not act with reasonable promptness, you have the right to appeal the delay.

Screening must be free. You cannot be charged for screening to determine your eligibility for Medicaid.

There are two separate parts of the eligibility process. First, screening determines if you meet the criteria for long-term care (Waiver and institutions). Next, financial eligibility is determined by the local Department of Social Services.

**TRANSFERRING YOUR WAIVER IF YOU MOVE**

You can move anywhere in Virginia and have your Virginia Medicaid Waiver transfer with you to your new community. Your case manager must assist you with this transfer. If you move out of Virginia, your Virginia Medicaid Waiver does not transfer with you.

**WAITING LISTS**

As of March 2011, there were approximately 1,100 people on the DD Waiver waiting list and 5,600 people on the ID Waiver waiting list.

You have the right to be informed in writing if you are placed on a waiting list. For the DD Waiver, DMAS will provide you with a waiting list number. The ID Waiver has a two tiered waiting list - urgent and nonurgent. The CSB will inform you in writing if you are placed on the waiting list.

While you are on a waiting list, you can receive services through another Waiver, if you meet the criteria for both Waivers.

**WRITTEN NOTICE**

To ensure effective, meaningful participation in all aspects of screening, eligibility, planning and service delivery, people need to be provided details about these activities. The different Waivers have different requirements regarding when notice must be provided and how the notice must be provided.

If an agency denies screening, eligibility, specific services or the amount of services you are seeking, that organization must provide the denial in writing. You can appeal these denials.

Requested services must be provided unless it can be shown that you do not need the services or that the services are not covered by Medicaid. Services can be denied if the case manager, provider or DMAS believes you do not need the service and if you do not prevail in an appeal. You have 30 days to appeal a denial or reduction of services.

Written notice to you must include:

- X what action the agency intends to take;
- X reason for the intended action;
- X specific regulation or law that supports the intended action;
- X right to an evidentiary hearing, and the methods and time limits for doing so;
- X circumstances under which benefits continue if a hearing is requested; and
- X right to representation.

If an agency fails to provide you with written notice in response to your request for eligibility or specific services, you can request an appeal of the agency's failure to act with reasonable promptness.

**OLMSTEAD PLANNING IN VIRGINIA**

The Americans with Disabilities Act requires that "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." A 1999 U.S. Supreme Court decision, *Olmstead vs L.C.*, stated "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." The Court ruled that States cannot discriminate against people with disabilities by providing long-term care services only in institutions when people could be provided services in the community.

Federal agencies and many States are taking specific actions to reform policies and practices to ensure that people with disabilities have meaningful choices about where and how services are provided. In Virginia, the General Assembly has established the Community Integration Advisory Commission "to monitor the progress of all executive branch state agencies toward community integration of Virginians with disabilities in accordance with all applicable state and federal laws in order that persons with disabilities may enjoy the benefits of society and the freedoms of daily living."

Information about Virginia's efforts to comply with the Olmstead decision can be found at www.olmsteadva.com.

Money Follows the Person is a demonstration project implemented by DMAS to provide for supports and services people need to transition from a nursing facility, ICF/DD or long-stay hospital to their own home. Information about MFP can be found at www.olmsteadva.com/mfp/