441—7.2(17A) Conditions of an aggrieved person. To be eligible for an appeal hearing, a person must meet the definition of "aggrieved person" in rule 441—7.1(17A) and qualify on a program-specific basis.

7.2(1) *Financial assistance.* Financial assistance includes, but is not limited to, the family investment program; refugee cash assistance; child care assistance; emergency or disaster assistance; family or community self-sufficiency grants; family investment program hardship exemptions; and state supplementary assistance dependent person, in-home health-related care, and residential care facility benefits. Issues may include:

a. A request to be given an application was denied.

b. An application for assistance has been denied or has not been acted on in a timely manner.

c. The effective date of assistance is contested.

d. The amount of benefits granted is contested.

e. The assistance will be reduced or canceled.

f. An overpayment of benefits has been established, and repayment is requested.

7.2(2) *Food assistance.* Issues may include:

a. A request to be given an application was denied.

b. An application for assistance has been denied or has not been acted on in a timely manner.

c. The effective date of assistance is contested.

d. The amount of benefits granted is contested.

e. The assistance will be reduced or canceled.

f. A request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.

g. An overpayment of benefits has been established, and repayment is requested.

7.2(3) *Medical assistance eligibility.* Medical assistance eligibility includes, but is not limited to, FMAP-related coverage groups, SSI-related coverage groups, the breast and cervical cancer treatment program, the health insurance premium payment program, healthy and well kids in Iowa (HAWK-I), the Iowa Health and Wellness Plan, and waiver services. Issues may include:

a. A request to be given an application was denied.

b. An application has been denied or has not been acted on in a timely manner.

c. The person's eligibility has been terminated, suspended or reduced.

d. The level of benefits the person is eligible to receive has been reduced.

e. A determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing is contested.

f. The level of care requirements have not been met.

g. The failure to take into account the appellant's choice in assignment to a coverage group.

h. The effective date of assistance is contested.

i. The amount or effective date of one of the following is contested:

(1) Health insurance premiums,

(2) Healthy and well kids in Iowa premiums,

(3) Medicaid for employed people with disabilities premiums,

(4) Iowa Health and Wellness Plan contributions,

(5) Client participation, or

(6) Medically needy program spenddown.

j. An overpayment of benefits has been established, and repayment is requested.

7.2(4) *Fee-for-service medical coverage.* Issues may include:

a. The level of services that the person is eligible to receive has been reduced.

b. The level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.

c. The effective date of services is contested.

d. A claim for payment or prior authorization has been denied.

e. The medical assistance hotline has issued notification that services not received or services for which an individual is billed are not payable by medical assistance.

f. Nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) have been denied.

7.2(5) *Managed care organization medical coverage.*

a. A Medicaid member, an authorized representative or a provider who is acting on behalf of a member has been notified that the first-level review process through a managed care organization has been exhausted and remains dissatisfied with the outcome.

b. If a provider or authorized representative is acting on behalf of a member by filing this type of appeal, the member's written consent to appeal must be submitted on Form 470-5526, Authorized Representative for Managed Care Appeals, with the appeal request. If the appeal is filed verbally, the managed care organization or agency is responsible for obtaining the member's written consent for the provider or authorized representative.

c. If the managed care organization fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Medicaid member, authorized representative or provider who is acting on behalf of the member is deemed to have exhausted the managed care organization's appeals process. The Medicaid member, authorized representative or provider who is acting on behalf of the member may initiate a state fair hearing.

7.2(6) *Providers.* Providers can be an individual or an entity. Issues may include:

a. A license, certification, registration, approval or accreditation has been denied or revoked or has not been acted on in a timely manner.

b. A fee-for-service claim for payment or request for prior authorization of payment has been denied in whole or in part and the provider states that the denial was not made according to department policy.

c. A medical assistance patient manager contract has been terminated.

d. A payment has been withheld to recover a prior overpayment, or an order to repay an overpayment pursuant to 441—subrule 79.4(7) has been received.

e. An application for child care quality rating has not been acted upon in a timely fashion.

f. A child care quality rating decision is contested.

g. A certificate of child care quality rating has been revoked.

h. An adverse action has been taken relating to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A), including:

(1) Provider eligibility determination,

(2) Incentive payments, or

(3) Demonstration of adopting, implementing, upgrading and meaningful use of technology.

i. An application or reapplication for licensure was issued as a provisional license.

j. A license has been issued for a limited time.

7.2(7) *Social services.* Social services include, but are not limited to, adoption, foster care, and family-centered services. Issues may include:

a. A request to be given an application was denied.

b. An application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.

c. An application or license has been denied based on a record check evaluation.

d. A determination that a person must participate in a service program is contested.

e. A claim for payment of services has been denied.

f. A protective or vendor payment has been established.

g. The services have been reduced or canceled.

h. An overpayment of services has been established, and repayment is requested.

i. An adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.

j. A referral to community care was not made as provided in rule 441—186.2(234).

k. A referral to community care as provided in rule 441—186.2(234) was made and the community care provider's dispute resolution process has been exhausted.

7.2(8) *Child support recovery.* Issues may include:

a. A person is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or a dispute based on the date of collection has not been acted on in a timely manner.

b. A claim or offset is contested as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by a person's alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or in whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

c. A name has been certified for passport sanction as provided in Iowa Code section 252B.5.

d. A termination in services has occurred as provided in rule 441—95.14(252B).

7.2(9) *PROMISE JOBS.* Issues may include:

a. A claim for participation allowances has been denied, reduced, or canceled.

b. The contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.

c. The results of informal grievance resolution procedures are contested, an opportunity for an informal grievance resolution has been declined, or a decision was not made within the 14-day period.

d. PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.

e. An overpayment of benefits has been established, and repayment is requested.

f. Acts of discrimination are alleged on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.

7.2(10) *Child abuse registry, dependent adult abuse registry, or record check evaluation.* Issues may include:

a. A person is alleged responsible for child abuse.

b. A correction of dependent adult abuse information has been requested.

c. A record check evaluation restricted or denied employment in a health care facility, state institution, or other facility. "Employment" includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. "Facility" includes, but is not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.

d. A record check evaluation results in the restriction of participation in an educational training program.

7.2(11) *Mental health and disability services.* Issues may include:

a. An application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.

b. Services under the state payment program have been reduced or canceled.

c. A request to be given an application was denied.

d. The person's eligibility has been terminated, suspended or reduced.

e. The level of benefits or services the person is eligible to receive has been reduced.

f. The effective date of assistance or services is contested.

g. The reconsideration process has been exhausted, and a person remains dissatisfied with the outcome.

h. The amount or effective date of cost-sharing requirements for the autism support program is contested.

i. A service authorization request for applied behavioral analysis services has been denied or reduced.

7.2(12) *HIPAA (Health Insurance Portability and Accountability Act).* A current or former applicant for or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:

a. To restrict use or disclosure of protected health information was denied.

b. To change how protected health information is provided was denied.

c. For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1)*"i,"* persons denied access due to a licensed health care

professional's opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.

d. To amend protected health information was denied.

e. For an accounting of disclosures was denied.

7.2(13) *Drug manufacturers.* A manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement disagrees with the decision.

7.2(14) *Bidders that have participated in a competitive procurement bid process.* Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

7.2(15) *Family planning program.* Issues may include:

a. A request to be given an application was denied.

b. An application has been denied or has not been acted on in a timely manner.

c. The person's eligibility has been terminated or reduced.

d. Who contests the effective date of assistance or services.

e. Whose claim for payment or prior authorization has been denied.

f. Who has received notice from the medical assistance hotline that services not received or services for which an individual is being billed are not payable by the family planning program.

g. Who has been notified that an overpayment of benefits has been established and repayment is requested.

7.2(16) *Other individuals or providers.* Individuals or providers that are not listed in rule 441—7.2(17A) may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

[**ARC 3093C**, IAB 6/7/17, effective 7/12/17; **ARC 3199C**, IAB 7/19/17, effective 7/1/17; **ARC 3389C**, IAB 10/11/17, effective 11/15/17; **ARC 3871C**, IAB 7/4/18, effective 8/8/18]