TO BE RESCINDED

5101:3-26-08.3 **Managed health care programs: enrollee rights and grievance process.**

(A) MCPs must develop and implement written policies which ensure that enrollees have and are informed of the following rights:

(1) To be treated with respect, consideration, and dignity.

(2) To be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history.

(3) To be provided information about an enrollee's health. Such information should be made available to the individual legally authorized by the enrollee to have such information or the person to be notified in the event of an emergency when concern for an enrollee's health makes it inadvisable to give him/her such information.

(4) To be given the opportunity to participate in decisions involving their health care unless contraindicated.

(5) To be assured of auditory and visual privacy during all health care examinations or treatment visits.

(6) To be afforded the opportunity to approve or refuse the release of information except when release is required by law.

(7) To be afforded the opportunity to refuse treatment or therapy. Enrollees who refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation will be entered into the medical record accordingly.

(8) To be afforded the opportunity to file grievances about the MCP, the MCP's providers and the health care provided, pursuant to the provisions of paragraph (B) of this rule.

(9) To be assured that all written enrollee information provided by the MCP is available in the primary language of LEP and visually-impaired enrollees as specified by ODJFS.

(10) To be provided the services of sign language or bilingual language assistance in the primary language of a hearing impaired or LEP enrollee.

(11) To be informed of specific student practitioner roles and the right to refuse student care.

(12) To refuse to participate in experimental research.

(13) To formulate advance directives.

(14) To change PCPs no less often than monthly. MCP's must mail written confirmation to the enrollee of their new PCP selection prior to or on the effective date of the change.

(15) To provide at least fifteen days advance notice of the right to a state hearing, as required by rule 5101:6-2-35 of the Administrative Code, when the MCP proposes to reduce or terminate a medicaid-covered service.

(16) To request a state hearing whenever a provider bills the enrollee for a service due to MCP denial of payment for that service.

(17) To be notified of the right to a state hearing when the MCP denies a requested medicaid-covered services, as required by rule 5101:6-2-35 of the Administrative Code.

(18) To appeal to or file directly with the United States department of health and human services office of civil rights any complaints of discrimination on the basis of race, color, national origin, age or disability in the receipt of health services.

(19) To appeal to or file directly with the ODJFS office of civil rights any complaints of discrimination on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.

(B) Enrollee grievance process.

(1) Each MCP must develop and implement written grievance procedures which address both medical and nonmedical areas of enrollee dissatisfaction. All MCP grievance procedures and any changes thereto must be prior approved in writing by ODJFS.

(2) Each MCP's grievance procedures must include, at a minimum, the following

provisions for the processing of grievances:

(a) Enrollee grievances must be accepted by the MCP by any method of communication.

(b) The procedure to be followed to file a grievance must be described in the MCP's member handbook and must include the telephone number for the MCP's toll-free member services hotline, the MCP's mailing address, and a copy of the optional form that enrollees may use to file grievances with the MCP. Copies of the grievance form must also be available through the MCP's member services program.

(c) Procedures must include the participation of individuals authorized by the MCP to require corrective action.

(3) MCPs must provide resolution to all grievances. For the purposes of this rule, resolution means a final decision was communicated to the enrollee by the MCP. MCPs must provide grievance resolution within the following time frames:

(a) Within two working days of receipt if the grievance is related to:

(i) Access to medicaid-covered services; or

(ii) The reduction, termination, or denial of medicaid-covered services.

(b) Within thirty calendar days of receipt for non-claim related grievances except as specified in paragraph (B)(3)(a) of this rule.

(c) Within sixty calendar days of receipt for claim-related grievances.

(d) If the MCP's response to a grievance is to affirm the denial, termination, or reduction of medicaid-covered services or billing of an enrollee due to MCP denial of payment for that service, the MCP must notify the enrollee of this decision and if not previously notified, the right to request a state hearing utilizing the procedures and forms specified in rule 5101:6-2-35 of the Administrative Code.

(e) All medically-related grievances must be reviewed by the MCP's medical director before the MCP resolves the grievance.

(4) Grievance appeals.

(a) Enrollees may appeal the MCP's resolution to their grievance by submitting a written request to the MCP for reconsideration within fifteen working days of the date of the MCP's resolution.

(b) All grievance appeals shall be reviewed by the MCP's grievance committee. One member of the grievance committee must be designated as the coordinator. The medical director must be a member of the grievance committee for the review of all medically-related grievance appeals. At least one member of the committee must not have been involved in the original grievance response and at least one member must have the authority to require corrective action.

(c) If a grievance appeal is regarding the denial of a medicaid-covered service, a medical appropriateness review by a physician consultant from the appropriate specialty area must be performed.

(d) The enrollee and/or their designee must be given the opportunity to present information at the grievance hearing where their appeal will be reviewed by at least three members of the MCP's grievance committee, including the medical director, as appropriate. The hearing must be held within ten working days of the date of request for reconsideration.

(e) The MCP must notify enrollees by certified mail of the MCP's reconsideration decision within three working days of the grievance hearing. A copy of the notification shall be maintained in the enrollee's MCP file.

(5) Logging and reporting of grievances.

(a) All enrollee grievances and appeals must be listed individually as specified by ODJFS in a written log. These logs must be maintained for a period of six years and made available upon request to ODJFS and the MFCU.

(b) MCPs must identify a key staff person as responsible for the logging and reporting of grievances and assuring that the processing of grievances is in accordance with this rule.

(c) As specified by ODJFS, all MCPs will be required to submit reports on all

grievance activity.

(6) Continuation of services while a state hearing is pending.

(a) As required by rule 5101:6-4-01 of the Administrative Code, when a hearing request involving an MCP's proposed reduction or termination of a medicaid covered service is received by either ODJFS or the CDJFS within the timely notice period of fifteen calendar days, the MCP shall be responsible for assuring that services are continued at or reinstated to the previous level for the pendency of the hearing.

(b) Services shall be continued or reinstated when a timely hearing request is received unless the enrollee's physician certifies in writing to the ODJFS district hearings bureau, that continuation of the service would pose a substantial risk of adverse health consequences.

(7) When an enrollee requests a state hearing, the MCP must comply with the provisions of division level designation 5101:6 of the Administrative Code.

(8) Notwithstanding the consideration of any enrollee's complaint by ODJFS or any other public entity, the MCP must adhere to the requirements contained in this rule.

Effective:

R.C. 119.032 review dates: 04/15/2003

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Certification

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Date

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