

CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: MyCare Ohio rule 5160-58-08.4 revisions

Rule Number(s): 5160-58-08.4

Date: July 17, 2014

Rule Type:

New

5 Year Review

☒ Amended

Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. Please briefly describe the draft regulation in plain language.

Please include the key provisions of the regulation as well as any proposed amendments.

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OAC 5160-58-08.4

Rule 5160-58-08.4 requires a MyCare Ohio plan to have three avenues allowing a member to challenge certain actions taken by the MyCare Ohio plan: (1) a grievance process, (2) an appeal to the MyCare Ohio plan, and (3) a process allowing members to access the State's hearing system through the Ohio Department of Job and Family Services (ODJFS).¹ The proposed rule sets forth detailed requirements for each of these three avenues, and prescribes the manner in which members must be advised of actions by the MyCare Ohio plan, so that the members receive clear and timely notice of MyCare Ohio plan actions that will affect the services they receive. It also describes the circumstances under which benefits may be continued while an appeal is pending. Changes to the rule update language regarding the obligations of the MCPs with respect to the State hearings system. Additional amendments to the rule update a cross-reference and form references.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**
Ohio Revised Code Sections 5164.02, 5166.02, and 5167.02.
3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
If yes, please briefly explain the source and substance of the federal requirement.

Yes. 42 C.F.R. Part 438 imposes comprehensive requirements on Medicaid managed care plans, including the MyCare Ohio plans. Subpart F of these regulations (42 C.F.R. 438.400—438.424) imposes detailed requirements requiring each Medicaid managed care plan to have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system. Other rules in this Subpart address the requirements for a notice of action that the plan intends to take, the handling of grievances and appeals, and the resolution of appeals and grievances.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

Although the federal regulations do not impose requirements directly on Medicaid managed care plans or MyCare Ohio plans, they do require state Medicaid agencies (e.g., ODM) to ensure plan compliance with federal standards.

¹ Although the MyCare Ohio program is administered by ODM, ODJFS continues to administer state hearings for issues raised by Medicaid recipients in accordance with R.C. 5101.35 and 5160.31.

5. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

This rule ensures that the MyCare Ohio plans comply with federal regulations governing Medicaid managed care, and maintain information that is readily available for the State, and if requested, for the Centers for Medicare and Medicaid Services (CMS).

6. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

Through the review of reports, the Agency verifies that plans are complying with federal standards. With five MyCare Ohio plans in the state, all will be expected to provide similar information, making missing information more obvious, measuring the success of the regulation.

Development of the Regulation

7. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.

If applicable, please include the date and medium by which the stakeholders were initially contacted.

In 2012, Ohio Medicaid issued a request for applications (RFA) for health plans to contract with the State Medicaid agency to serve Medicare-Medicaid enrollees under a fully integrated system of care that comprehensively manages the Medicare-Medicaid benefits for members. The applying plans were aware of the expectations and requirements they would be held to if they were to contract with the State of Ohio. The plans selected for the MyCare Ohio program are Aetna, Buckeye, CareSource, Molina, and UnitedHealthCare.²

ODM and the MyCare Ohio plans continue to meet to review the MyCare Ohio program and to discuss the department's expectations around program operational matters.

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

² Notably, four of the five plans selected for MyCare Ohio were previously selected to provide services to Ohio's other Medicaid managed care populations and are already required to comply with most, if not all, of the same reporting requirements required by these rules as part of their obligations under Medicaid managed care. The fifth plan, Aetna, is a national Medicaid managed care organization providing services to managed care populations in many states and accordingly should be very familiar, and capable of complying with, the federal reporting requirements upon which the Ohio requirements are based.

Stakeholders have provided informal input regarding the development of the MyCare Ohio program that has been the basis for the draft regulations. Additionally, bi-weekly meetings have been held with the above-referenced stakeholders since May 2013. A thoughtful and thorough review of the existing rules occurred, and stakeholders were actively involved in the drafting and review of the proposed new rules.

Additionally, stakeholders provided formal input to the recent amendment to OAC rule 5160-58-08.4 when the rule was distributed to stakeholders during the department's clearance process from May 28, 2014 – June 11, 2014. ODM received comments from Ohio Legal Aid representatives. All comments received to date have been considered in developing the draft regulations.

The department continues engaging in dialogue with the MyCare Ohio plans to determine if policy or process changes are needed to ensure the program is implemented as intended.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

No scientific data was used to develop the rules or the measurable outcomes of the rules.

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

Rule OAC 5160-58-08.4 is based directly upon federal regulations at 42 C.F.R. Part 438, which do not leave the State much latitude in crafting alternative regulations.

11. Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

No. Performance-based regulations would not comply with federal regulations governing managed care. However, through the submission of the requested information, the Agency is able to determine whether MyCare Ohio plans are meeting the standards specified in federal regulations.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

All Medicaid regulations governing MyCare Ohio plans are promulgated and implemented by ODM only. The regulation was reviewed by Medicaid's legal and legislative staff to ensure that there is no duplication.

13. Please describe the Agency’s plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

All of the MyCare Ohio plans are required to consistently and predictably maintain written policies and procedures for the required grievance, appeals and state hearing processes and notify their members, ODM or ODJFS, when applicable using the standard notices set forth in the rule.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

- a. Identify the scope of the impacted business community;**
- b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**
- c. Quantify the expected adverse impact from the regulation.**

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a. This rule only impacts managed care plans that have been selected for MyCare Ohio. The plans that will be impacted are Aetna, Buckeye, CareSource, Molina, and UnitedHealthCare.

b. A MyCare Ohio plan is required to maintain written policies and procedures governing grievances, appeals to the MyCare Ohio plan, and appeals to the ODJFS state hearing system. These policies and procedures must be described in a handbook distributed to members. A MyCare Ohio plan is required to provide clear and timely notice to a member of any action that will affect a member’s services, and notice of the process through which the member can challenge the proposed action. After an appeal to a MyCare Ohio plan is resolved, the MyCare Ohio plan must provide written notice of the decision arising from the appeal. For an appeal to the ODJFS state hearing system, a MyCare Ohio plan is required to complete a written appeal summary that provides all facts and documents relevant to the case. If the member prevails at a state hearing, the MyCare Ohio plan must complete a compliance form which must be returned to the Bureau of State Hearings.

c. Through the administrative component of the capitation rate paid to the MyCare Ohio plans by the Department of Medicaid, MyCare Ohio plans will be compensated for the cost of the time required in maintaining and submitting required reports, notices, policies and procedures. Furthermore, the MyCare Ohio plans were aware of the need to maintain and submit various reports prior to deciding to do business with the State.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The MyCare Ohio plans were aware of the federal requirements for the reporting of information prior to seeking contracts with the state, as well as before signing their contracts with the state. More importantly, without the requested reports the State would be out of compliance with federal regulations.

The participation of service providers in the MyCare Ohio Waiver is optional and at the providers' sole discretion. Compliance with program requirements is necessary to comply with the terms of the federal waiver and to ensure the health and safety of individuals enrolled in MyCare Ohio.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No, as none of the five MyCare Ohio plans qualifies as a small business.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

The Agency will not apply this section of the ORC as the waiving of penalties would render Ohio's Medicaid agency out of compliance with federal regulations.

18. What resources are available to assist small businesses with compliance of the regulation?

None, as none of the five MyCare Ohio plans qualifies as a small business.

*** DRAFT - NOT YET FILED ***

5160-58-08.4

Appeals and grievances for MyCare Ohio.

(A) Definitions.

For the purposes of this rule the following terms are defined as:

(1) An "action" is the MyCare Ohio plan's

- (a) Denial or limited authorization of a requested service, including the type or level of service;
- (b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the plan;
- (c) Denial, in whole or part, of payment for a service not covered by medicaid, including a service denied through the plan's prior authorization process as not medically necessary;
- (d) Denial of a request for a specific plan-contracted non-agency or participant-directed waiver services provider pursuant to paragraph ~~(F)~~(G) of rule 5160-58-03.2 of the Administrative Code; or
- (e) Failure to provide services in a timely manner as specified in rules 5160-26-03.1 and 5160-58-01.1 of the Administrative Code; or
- (f) Failure to act within the resolution timeframes specified in this rule.

(2) An "appeal" is the request for a plan's review of an action.

(3) A "grievance" is an expression of dissatisfaction with any aspect of the plan's or provider's operation, provision of health care services, activities, or behaviors, other than the plan's action as defined in paragraph (A)(1) of this rule.

(4) "Resolution" means a final decision is made by the plan and the decision is communicated to the member.

(5) "Notice of action (NOA)" is the written notice the plan must provide to members when a plan action has occurred or will occur.

(6) "Plan" is a MyCare Ohio plan.

(B) Each plan must have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of this rule. The policies and procedures must be made available for review by ODM, and must include the following:

- (1) A process by which members may file grievances with the plan, in compliance with paragraph (H) of this rule;
- (2) A process by which members may file appeals with the plan, in compliance with paragraphs (C) to (G) of this rule; and
- (3) A process by which members may access the state's hearing system through the Ohio department of job and family services (ODJFS), in compliance with paragraph (I) of this rule.

(C) Notice of action (NOA) by a MyCare Ohio plan.

- (1) When a plan action has or will occur, the plan must provide the affected member(s) with a written NOA.
- (2) The NOA must explain:
 - (a) The action the plan has taken or intends to take;
 - (b) The reasons for the action;
 - (c) The member's or authorized representative's right to file an appeal to the plan;
 - (d) If applicable, the member's right to request a state hearing through the state's hearing system;
 - (e) Procedures for exercising the member's rights to appeal or grieve the action;
 - (f) Circumstances under which expedited resolution is available and how to request it;

- (g) If applicable, the member's right to have benefits continue pending the resolution of the appeal, and how to request that benefits be continued;
 - (h) The date that the notice is being issued;
 - (i) Oral interpretation is available for any language;
 - (j) Written translation is available in prevalent languages as applicable;
 - (k) Written alternative formats may be available as needed; and
 - (l) How to access the plan's interpretation and translation services as well as alternative formats that can be provided by the plan.
- (3) The following language and format requirements apply to a NOA issued by a plan:
 - (a) It must be provided in a manner and format that may be easily understood;
 - (b) When directed by ODM, it must be printed in the prevalent non-English languages of members in the plan's service area; and
 - (c) It must be available in alternative formats in an appropriate manner that takes into consideration the special needs of members, including but not limited to members who are visually limited and members who have limited reading proficiency.
- (4) A plan must give members a written NOA within the following timeframes:
 - (a) For a decision to deny or limit authorization of a requested service, including the type or level of service, the plan must issue a NOA simultaneously with the plan's decision.
 - (b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the plan, the plan must give notice fifteen calendar days before the date of action except:
 - (i) If probable recipient fraud has been verified, the plan must give notice five calendar days before the date of action.

(ii) Under the circumstances set forth in 42 C.F.R. 431.213 (October 1, 2013), the plan must give notice on or before the date of action.

(c) For denial of payment for a noncovered service, the plan must give notice simultaneously with the plan's action to deny the claim, in whole or part, for a service that is not covered by medicaid, including a service that was determined through the plan's prior authorization process as not medically necessary.

(d) For denial of a request for a provider pursuant to paragraph (A)(1)(d) of this rule, the plan must give notice simultaneously with the plan's decision.

(e) For untimely prior authorization, appeal or grievance resolution, the plan must give notice simultaneously with the plan becoming aware of the action. Service authorization decisions not reached within the timeframes specified in rules 5160-26-03.1 and 5160-58-01.1 of the Administrative Code constitute a denial and are thus adverse actions. Notice must be given on the date that the authorization decision timeframe expires.

(D) Standard appeal to a MyCare Ohio plan.

(1) A member, provider, or a member's authorized representative may file an appeal orally or in writing within ninety days from the date on the NOA. The ninety day period begins on the day after the mailing date of the NOA. An oral filing must be followed with a written appeal. The plan must:

(a) Assist members that file an oral appeal by immediately converting an oral filing to a written record;

(b) Ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal; and

(c) Consider the date of the oral filing as the filing date if the member follows the oral filing with a written appeal.

(2) Any provider acting on the member's behalf must have the member's written consent to file an appeal. The plan must begin processing the appeal pending receipt of the written consent.

- (3) The plan must acknowledge receipt of each appeal to the individual filing the appeal. At a minimum, acknowledgment must be made in the same manner that the appeal was filed. If an appeal is filed in writing, written acknowledgment must be made by the plan within three working days of the receipt of the appeal.
- (4) The plan must provide members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member and/or member's authorized representative must be allowed to examine the case file, including medical records and any other documents and records, before and during the appeals process.
- (5) The plan must consider the member, member's authorized representative, or estate representative of a deceased member as parties to the appeal.
- (6) The plan must review and resolve each appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph (F) of this rule.
- (7) The plan must provide written notice to the parties of the resolution including, at a minimum, the decision and date of the resolution.
- (8) For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding:
 - (a) Oral interpretation that is available for any language;
 - (b) Written translation that is available in prevalent languages as applicable;
 - (c) Written alternative formats that may be available as needed;
 - (d) How to access the plan's interpretation and translation services as well as alternative formats that can be provided by the plan;
 - (e) The right to request a state hearing through the state's hearing system; and
 - (f) How to request a state hearing, and if applicable:
 - (i) The right to continue to receive benefits pending a state hearing; and

(ii) How to request the continuation of benefits.

(9) For appeals decided in favor of the member, the plan must:

- (a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending; and
- (b) Pay for the disputed services if the member received the services while the appeal was pending.

(E) Expedited appeal to a MyCare Ohio plan.

- (1) Each plan must establish and maintain an expedited review process to resolve appeals when the plan determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- (2) In utilizing an expedited appeal process, the plan must comply with the standard appeal process specified in paragraph (E) of this rule, except the plan must:
 - (a) Not require that an oral filing be followed with a written, signed appeal;
 - (b) Make a determination within one working day of the appeal request whether to expedite the appeal resolution;
 - (c) Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution;
 - (d) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;
 - (e) Resolve the appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed seventy-two hours from receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph (F) of this rule;
 - (f) Make reasonable efforts to provide oral notice of the appeal resolution in

addition to the required written notification;

(g) Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal; and

(h) Notify ODM within one working day of any appeal that meets the criteria for expedited resolution as specified by ODM.

(3) If the plan denies the request for expedited resolution of an appeal, the plan must:

(a) Transfer the appeal to the standard resolution timeframe of fifteen calendar days from the date the appeal was received unless the resolution timeframe is extended as outlined in paragraph (F) of this rule; and

(b) Provide the member written notice of the denial to expedite the resolution within two calendar days of the receipt of the appeal, including information that the member can grieve the decision.

(F) Appeal resolution extensions for an appeal to a MyCare Ohio plan.

(1) A member may request that the plan extend the timeframe to resolve a standard or expedited appeal up to fourteen calendar days.

(2) A plan may request that the timeframe to resolve a standard or expedited appeal be extended up to fourteen calendar days. The plan must seek such an extension from ODM prior to the expiration of the regular appeal resolution timeframe and its request must be supported by documentation that the extension is in the member's best interest. If ODM approves the extension, the plan must immediately give the member written notice of the reason for the extension and the date that a decision must be made.

(3) The plan must maintain documentation of all requests for extension.

(G) Continuation of benefits for an appeal to a MyCare Ohio plan.

(1) The plan must continue a member's benefits when an appeal has been filed if the following conditions are met:

(a) The member or authorized representative files the appeal on or before the

later of the following:

- (i) Within fifteen calendar days of the plan mailing the NOA; or
 - (ii) The intended effective date of the plan's proposed action.
- (b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized course of treatment;
 - (c) The services were ordered by an authorized provider;
 - (d) The authorization period has not expired; and
 - (e) The member requests the continuation of benefits.
- (2) If the plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
- (a) The member withdraws the appeal;
 - (b) Fifteen calendar days pass following the mailing date of the MyCare Ohio plan's notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing ~~with continuation of benefits~~ and therefore the benefits must be continued as specified in rule 5101:6-4-01 of the Administrative Code.
 - (c) A state hearing regarding the reduction, suspension or termination of the benefits is decided adverse to the member; or
 - (d) The initial time period for the authorization expires or the authorization service limits are met.
- (3) At the discretion of ODM, the plan may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the plan's original action.

(H) Grievances to a MyCare Ohio plan.

- (1) A member or authorized representative can file a grievance. An authorized

representative must have the member's written consent to file a grievance on the member's behalf.

- (2) Grievances may be filed only with the plan, orally or in writing, within ninety calendar days of the date that the member became aware of the issue.
- (3) The plan must acknowledge the receipt of each grievance to the individual filing the grievance. Oral acknowledgment is acceptable. However, if the grievance is filed in writing, written acknowledgment must be made within three working days of receipt of the grievance.
- (4) The plan must review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions including member notification must meet the following timeframes:
 - (a) Within two working days of receipt if the grievance is regarding access to services.
 - (b) Within thirty calendar days of receipt for all other grievances that are not regarding access to services.
- (5) At a minimum, the plan must provide oral notification to the member of a grievance resolution. However, if the plan is unable to speak directly with the member and/or the resolution includes information that must be confirmed in writing, the resolution must be provided in writing simultaneously with the plan's decision.
- (6) If the plan's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service, denial of a provider pursuant to paragraph (A)(1)(d) of this rule, or billing of a member due to the plan's denial of payment for that service, the plan must notify the member of his or her right to request a state hearing as specified in paragraph (I) of this rule, if the member has not previously been notified.
- (7) If the plan's resolution to a grievance is to affirm the denial, reduction, suspension or termination of a service or denial of a provider pursuant to paragraph (A)(1)(d) of this rule, the plan must notify the member of his or her right to request an appeal to the plan as specified in paragraph (C)(4) of this rule, if the member has not previously been notified.

(I) Access to state's hearing system.

- (1) A plan must develop and implement written policies and procedures that ensure the plan's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code.
- (2) Members are not required to exhaust the appeal or grievance process through the plan in order to access the state's hearing system.
- (3) When required by paragraph (C) of this rule and division 5101:6 of the Administrative Code, a plan must notify members, and any authorized representatives on file with the plan, of the right to a state hearing. The following requirements apply:
 - (a) If the plan denies a request for the authorization of a service, in whole or in part, the plan must simultaneously complete and mail or personally deliver the "Notice of Denial of Medical Services By Your Managed Care Plan" (JFSODM 04043, rev. 7/2009 formerly JFS 04043, rev. 7/2014).
 - (b) If the plan decides to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the plan, the plan must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension, or termination, the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (JFSODM 04066, rev. 7/2009 formerly JFS 04066, rev. 7/2014).
 - (c) If the plan denies a request for the authorization to receive waiver services from a provider pursuant to paragraph (A)(1)(d) of this rule, the plan must simultaneously complete and mail or personally deliver the required notice of state hearing rights.
 - (d) If the plan learns that a member has been billed for services received by the member due to the plan's denial of payment, and the plan upholds the denial of payment, the plan must immediately complete and mail or personally deliver the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (JFSODM 04046, rev. 7/2009 formerly JFS 04046, rev. 7/2014).
- (4) The member or his or her authorized representative may request a state hearing within ninety calendar days by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS). The ninety-day period begins on the day after the mailing date on the state hearing

form.

- (5) There are no state hearing rights for a member(s) terminated from the plan pursuant to a plan-initiated membership termination as permitted in rule 5160-58-02.1 of the Administrative Code.
- (6) Following notification by the bureau of state hearings to a plan that a member has requested a state hearing, the plan must:
 - (a) Complete the "Appeal Summary for Managed Care Plans" (JFS 01959, rev. 06/03) with appropriate attachments, and file it with the bureau of state hearings, at least three business days prior to the scheduled hearing date. The appeal summary must provide all facts and documents relevant to the issue, and be sufficient to demonstrate the basis for the plan's action or decision;
 - (b) Send a copy of the completed appeal summary to the appellant, the bureau of state hearings, the local agency, and the designated ODM contact; and
 - (c) Continue or reinstate the benefit(s) as specified in rule 5101:6-4-01 of the Administrative Code, if the plan is notified that the member's state hearing request was received within the prior notification period, ~~and the member requested that the benefits be continued.~~
- (7) The plan must participate in the hearing in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, rev. 09/02) sent to the plan by the bureau of state hearings.
- (8) In addition to the plan and member, other parties to a state hearing may include an authorized representative of a member, or the representative of the member's estate, if the member is deceased.
- (9) The plan must comply with the state hearing officer's decision provided to the plan via the "State Hearing Decision" (JFS 04005, rev. 03/03). If the hearing officer's decision is to sustain the member's appeal, the plan must complete the "State Hearing Compliance" form (JFS 04068, rev. 05/01). A copy of the completed form, including applicable documentation, is due by no later than the compliance date specified in the hearing decision to the bureau of state hearings and the designated ODM contact. If applicable, the plan must:
 - (a) Authorize or provide the disputed services promptly and as expeditiously

as the member's health condition requires; and

(b) Pay for the disputed services if the member received the disputed services while the appeal was pending.

(10) The plan must provide a copy of the state hearing forms referenced in this paragraph to ODM, as directed by ODM.

(11) Upon request, the plan's state hearing policies and procedures must be made available for review by ODM.

(J) Logging and reporting of appeals and grievances.

(1) A plan must maintain records of all appeals and grievances including resolutions for a period of eight years, and the records must be made available upon request to ODM and the medicaid fraud control unit.

(2) A plan must identify a key staff person responsible for the logging and reporting of appeals and grievances and assuring that the grievance system is in accordance with this rule.

(K) Other duties of a MyCare Ohio plan regarding appeals and grievances.

(1) A plan must give members all reasonable assistance in filing an appeal, a grievance, or accessing the state's hearing system, including but not limited to:

(a) Explaining the plan's process to be followed in resolving the member's appeal or grievance;

(b) Completing forms and taking other procedural steps as outlined in this rule; and

(c) Providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) The plan must ensure that the individuals who make decisions on appeals and grievances are individuals who:

(a) Were not involved in previous levels of review or decision-making; and

- (b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease, if deciding any of the following:
 - (i) An appeal of a denial that is based on lack of medical necessity;
 - (ii) A grievance regarding the denial of an expedited resolution of an appeal; or
 - (iii) An appeal or grievance that involves clinical issues.
- (3) The procedure to be followed to file an appeal or grievance must be described in the plan's member handbook and must include the telephone number(s) for the plan's toll-free member services hotline, the plan's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the plan. Copies of the form(s) to file an appeal or grievance must also be made available through the plan's member services program.
- (4) The procedure to be followed to file a state hearing request must be described in the plan's member handbook.
- (5) Appeals and grievance procedures must include the participation of individuals authorized by the plan to require and implement corrective action.
- (6) A plan is prohibited from delegating the appeal or grievance process to another entity.
- (7) A plan must maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. Plan records must include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

Effective:

R.C. 119.032 review dates: 03/01/2019

Certification

Date

Promulgated Under: 119.03
Statutory Authority: 5164.02, 5166.02, 5167.02
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