CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Managed Care Appeals and Grievance System Revisions

Rule Number(s): 5160-26-08.4 and 5160-58-08.4; Rule 5160-20-01 is not subject to CSIO review, but is included for reference.

Date: September 2017

Rule Type:

X **New**

Amended

5-Year Review

X **Rescinded**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.***

   In Ohio, approximately 86% of Medicaid recipients receive their Medicaid services through a Managed Care Plan (MCP) or MyCare Ohio Plan (MCOP). MCPs/MCOPs are health insurance companies that are licensed by the Ohio Department of Insurance and have a provider agreement (contract) with the Ohio Department of Medicaid (ODM) to provide coordinated health care to Medicaid beneficiaries. There are six MCPs/MCOPs (referred to as plans) in Ohio each with a network of health care professionals. The rules outlined in Chapter 5160-26 of the Administrative Code set forth the requirements of MCPs and the Ohio Medicaid managed care program.

   OAC Rule 5160-26-08.4, Managed health care programs: MCP grievance system, sets forth Medicaid MCP member appeal and grievance rights. This rule is being revised to update state policy related to

the managed care grievance and appeals process to align with federal policy, specifically related to managed care delivery system updates within the final rule recently issued by the Centers for Medicare and Medicaid Services (CMS). Several provisions within the rule are being updated to align with new federal regulations.

OAC Rule 5160-58-08.4, Appeals and Grievances for MyCare Ohio, sets forth Medicaid MCP member appeal and grievance rights. This rule is being revised to update state policy related to the managed care grievance and appeals process to align with federal policy, specifically related to managed care delivery system updates within the final rule recently issued by the Centers for Medicare and Medicaid Services (CMS). Several provisions within the rule are being updated to align with new federal regulations.

The MCP provider agreement may be found online at:
http://www.medicaid.ohio.gov/PROVIDERS/ManagedCare/ProgramResourceLibrary/CombinedProviderAgreement.aspx

The MCOP provider agreement may be found online at:
http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Ohio Revised Code Section 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 the state around Medicaid managed care plans. Several changes are being made to align with changes implemented in the federal regulation.

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 managed care plans, they do require state Medicaid agencies to ensure managed care plan compliance with federal standards. The rules are consistent with federal managed care requirements outlined in 42 CFR Part 438.

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)?**

The purpose of this regulation is to ensure managed care plan (MCP) and MyCare Ohio plan (MCOP) compliance with federal regulations related to the member's right to grieve a plan issue or appeal an adverse benefit determination made by a plan.

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

Through reporting requirements established within OAC rules and the MCP/MCOP provider agreements, ODM is able to monitor compliance with the regulation. Successful outcomes are measured through a finding of compliance with these standards as determined by monitoring and oversight.

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.***

The Medicaid Managed Care and MyCare Ohio Plans listed below were provided with the draft rules on August 7, 2017. The plans were given until August 14, 2017 to comment. ODM held a meeting with all applicable stakholders, including representatives from each managed care plan, on Wednesday, August 23, 2017 to discuss these process updates. As a result of that meeting, plans were given until August 25th to provide additional comments related to these OAC rules.

- Aetna
- Buckeye Health Plan
- CareSource
- Molina Healthcare of Ohio
- Paramount Advantage
- UnitedHealthcare Community Plan of Ohio

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

As a result of stakeholder outreach, the following changes were made to the rules:

- In paragraph (A)(3) – the state definition of grievance was updated to reflect what is in federal regulations (42 CFR 438.400). This change was made in both OAC rule 5160-26-08.4 and 5160-58-08.4.
- In paragraph (C)(1) – removed the words "the member becomes aware of an issue" from the sentence regarding the timeframe for a member to file an appeal. This change reflects what is in federal regulations (42 CFR 438.402) and was made to both OAC rule 5160-26-08.4 and 5160-58-08.4.

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 these 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?**

    The changes to the rules correspond directly with updates made to the C.F.R, therefore no alternative regulations were discussed during the rule revision process.

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.***

    A performance-based regulation would not be appropriate as ODM is required to comply with detailed federal requirements set forth in 42 C.F.R. 438.

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

    All Medicaid regulations governing MCPs and MCOPs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid program.

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.**

    ODM will notify the MCPs and the MCOPs of the final rule changes and implementation/effective date via email notification.

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;**

       These rules only impact MCPs and MCOPs in the State. The MCPs and MCOPs that will be impacted are Aetna, Buckeye, CareSource, Molina, Paramount and UnitedHealthCare.

    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**

The rules in this packet contain requirements for the MCPs and MCOPs to maintain records and other documentation, to provide notice to members in specified timeframes, and to submit reports to ODM. These requirements are federally mandated.

- MCPs and MCOPs must provide a written notice to members of an adverse benefit determination
- MCPs and MCOPs must acknowledge receipt of an appeal or grievance with the member or authorized representative
- MCPs and MCOPs must provide the member or authorized representative written notice of the resolution
- MCPs and MCOPs must maintain records of all appeals and grievances and submit this information to ODM as directed

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

Managed care plans are paid per member per month. ODM must pay MCPs and MCOPs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.6(c) and CMS's "2017 Managed Care Rate Setting Consultation Guide." Ohio Medicaid capitation rates are "actuarially sound" for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. Costs include but are not limited to expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government mandated assessments, fees, and taxes.

All rates and actuarial methods can be found on the ODM website in Appendix E of both the Medicaid Managed Care and MyCare Ohio provider agreements. Through the administrative component of the capitation rate paid to the MCPs and MCOPs by ODM, MCPs and MCOPs will be compensated for the cost of the time required in maintaining and submitting required documents and reports. For CY 2017, the administrative component of capitation rate varies by program/population and ranges from 3.5% to 6.475% for MCPs and from 2% to 8.5% for MCOPs.

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

The MCPs and MCOPs 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.

Regulatory Flexibility

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

    The requirements of these rules must be applied uniformly and no exception is made based on a plan's size.

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?**

    These rules impose no sanction.

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

    While there are no small businesses impacted by this rule, the managed care plans may contact ODM directly through their assigned Contract Administrator.

TO BE RESCINDED

5160-26-08.4 **Managed health care programs: MCP grievance system.**

This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code. Provisions regarding appeals and grievances for MyCare Ohio are described in Chapter 5160-58 of the Administrative Code.

(A) Definitions.

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

(1) An "action" is the managed care plan's (MCP'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 MCP;

(c) Denial, in whole or part, of payment for a service;

(d) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code; or

(e) Failure to act within the resolution timeframes specified in this rule.

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

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

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

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

(B) Each MCP 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 the Ohio department of medicaid (ODM), and must include the following:

(1) A process by which members may file grievances with the MCP, in compliance with paragraph (H) of this rule;

(2) A process by which members may file appeals with the MCP, 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 an MCP.

(1) When an MCP action has occurred or will occur, the MCP must provide the affected member(s) with a written NOA.

(2) The NOA must meet the language and format requirements for member materials specified in rule 5160-26-08.2 of the Administrative Code and explain:

(a) The action the MCP 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 MCP;

(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, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services;

(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 MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

(3) An MCP 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 MCP must issue an NOA simultaneously with the MCP's decision.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP, the MCP must give notice fifteen calendar days before the date of action except:

(i) If probable recipient fraud has been verified, the MCP 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, 2015), the MCP must give notice on or before the date of action.

(c) For denial of payment for a noncovered service, MCPs must give notice simultaneously with the MCP'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 MCP's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal or grievance resolution, the MCP must give notice simultaneously with the MCP becoming aware of the action. A service authorization decision not reached within the timeframes specified in rule 5160-26-03.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse action. Notice must be given on the date that the authorization decision timeframe expires.

(D) Standard appeal to an MCP.

(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 MCP 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 MCP must begin processing the appeal pending receipt of the written consent.

(3) The MCP 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 MCP within three working days of the receipt of the appeal.

(4) The MCP 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 MCP must consider the member, member's authorized representative, or estate representative of a deceased member as parties to the appeal.

(6) The MCP 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 MCP must provide written notice to the member, and to the member's authorized representative if applicable, 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 MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP;

(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,

(ii) How to request the continuation of benefits; and

(iii) If the MCP action is upheld at the state hearing that the member may be liable for the cost of any continued benefits.

(9) For appeals decided in favor of the member, the MCP 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.

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

(E) Expedited appeals to an MCP.

(1) Each MCP must establish and maintain an expedited review process to resolve appeals when the MCP 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 MCP must comply with the standard appeal process specified in paragraph (D) of this rule, except the MCP 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 three working days from the date the MCP received 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 MCP denies the request for expedited resolution of an appeal the MCP 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;

(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.

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

(2) An MCP may request that the timeframe to resolve a standard or expedited appeal be extended up to fourteen calendar days. The MCP 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 MCP must immediately give the member written notice of the reason for the extension and the date by which a decision must be made.

(3) The MCP must maintain documentation of any extension request.

(G) Continuation of benefits for an appeal to the MCP.

(1) The MCP 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 working days of the MCP mailing the NOA; or

(ii) The intended effective date of the MCP'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 MCP 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 MCP's notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing in which case 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 services 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 MCP 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 MCP's original action.

(H) Grievances to an MCP.

(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 MCP, orally or in writing, within ninety calendar days of the date that the member became aware of the issue.

(3) The MCP 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 MCP 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 non claims-related grievances except as specified in paragraph (H)(4)(a) of this rule.

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

(5) At a minimum, the MCP must provide oral notification to the member of a grievance resolution. However, if the MCP is unable to speak directly with the member or the resolution includes information that must be confirmed in writing, the resolution must be provided in writing simultaneously with the MCP's decision.

(6) If the MCP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service or billing of a member due to the MCP's denial of payment for that service, the MCP 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.

(I) Access to state's hearing system.

(1) The MCP 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 MCP 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, the MCP must notify members, and any authorized

representatives on file with the MCP, of the right to a state hearing. The following requirements apply:

(a) If the MCP denies a request for the authorization of a service, in whole or in part, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Medical Services By Your Managed Care Plan" (ODM 04043, 7/2014).

(b) If the MCP decides to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the MCP, the MCP 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" (ODM 04066, 7/2014).

(c) If the MCP learns that a member has been billed for services received by the member due to the MCP's denial of payment, and the MCP upholds the denial of payment, the MCP must immediately complete and mail or personally deliver the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (ODM 04046, 7/2014).

(d) If the MCP proposes enrollment in the coordinated services program (CSP), the MCP must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed enrollment, the "Notice of Proposed Enrollment in the Coordinated Services Program (CSP) " (ODM 01717, 7/2014).

(e) If the MCP decides to continue enrollment in CSP, the MCP must simultaneously complete and mail or personally deliver the "Notice of Continued Enrollment in the Coordinated Services Program (CSP) " (ODM 01705, 7/2014).

(f) If the MCP denies a CSP member's request to change designated provider(s) within the MCP's provider panel, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Designated Provider or Pharmacy in the Coordinated Services Program (CSP) " (ODM 01718, 7/2014).

(4) The member or member's 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 notice of action.

(5) There are no state hearing rights for a member(s) terminated from the MCP pursuant to an MCP-initiated membership termination as permitted in rule 5160-26-02.1 of the Administrative Code.

(6) Following the bureau of state hearings' notification to the MCP that a member has requested a state hearing the MCP must:

(a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014) 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 MCP's action or decision.

(b) Send a copy of the completed appeal summary to the member and the member's authorized representative, if applicable, the bureau of state hearings, the local agency, and the designated ODM contact.

(c) Continue or reinstate the benefit(s) specified in rule 5101:6-4-01 of the Administrative Code, if the MCP is notified that the member's state hearing request was received within the prior notification period.

(d) Not enroll the individual in the coordinated services program (CSP) if the MCP is notified that the member's state hearing request was received within the prior notification period.

(7) The MCP must participate in the hearing in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, rev. 01/2015) sent to the MCP by the bureau of state hearings.

(8) The MCP must comply with the state hearing officer's decision provided to the MCP via the "State Hearing Decision" (JFS 04005, rev. 01/2015). If the hearing officer's decision is to sustain the member's appeal, the MCP must submit, to the bureau of state hearings, the infomation required by the "State Hearing Compliance" non-fillable form (JFS 04068, rev. 01/2015). , The information, 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 MCP must:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

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

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

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

(J) Logging and reporting of appeals and grievances.

(1) The MCP 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) The MCP 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.

(3) The MCP is required to submit information regarding appeal and grievance activity as directed by ODM.

(K) Other duties of an MCP regarding appeals and grievances.

(1) The MCP must give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including but not limited to:

(a) Explaining the MCP'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 MCP 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, grievance, or state hearing request must be described in the MCP's member handbook and must include the telephone number(s) for the MCP's toll-free member services hotline, the MCP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file an appeal or grievance must also be made available through the MCP's member services program.

(4) Appeals and grievance procedures must include the participation of individuals authorized by the MCP to require corrective action.

(5) The MCP is prohibited from delegating the appeal or grievance process to another entity unless approved by ODM.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5167.02
Rule Amplifies:	5162.03, 5167.10, 5167.03, 5164.02
Prior Effective Dates:	7/1/03, 6/1/06, 9/15/08, 7/1/09, 8/1/10, 1/1/12, 3/6/15

DRAFT - NOT FOR FILING

5160-26-08.4 Managed health care programs: managed care plan appeal and grievance system.

This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code. Provisions regarding appeals and grievances for MyCare Ohio are described in Chapter 5160-58 of the Administrative Code.

(A) Definitions.

(1) "Adverse benefit determination" is a managed care plan (MCP)'s:

(a) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP;

(c) Denial, in whole or part, of payment for a service;

(d) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code;

(e) Failure to act within the resolution time frames specified in this rule; or

(f) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities, if applicable.

(2) "Appeal" is the member's request for an MCP's review of an adverse benefit determination.

(3) "Grievance" is the member's expression of dissatisfaction with any aspect of an MCP's or provider's operation, provision of health care services, activities, or behaviors, other than an MCP's adverse benefit determination.

(4) "Notice of action (NOA)" is the written notice an MCP must provide to members when an MCP adverse benefit determination has occurred or will occur.

(5) "Resolution" means a final decision is made by an MCP and the decision is communicated to the member.

(B) An MCP shall have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of this rule, which shall include:

(1) A process by which members may file grievances with the MCP, in compliance with paragraph (D) of this rule;

(2) A process by which members may file appeals with the MCP, in compliance with paragraphs (E) through (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 (H) of this rule.

(C) NOA by an MCP.

(1) When an MCP adverse benefit determination has occurred or will occur, the MCP shall provide the

affected member with a NOA.

(2) The NOA shall explain:

(a) The adverse benefit determination the MCP has taken or intends to take;

(b) The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other relevant determination information;

(c) The member's right to file an appeal to the MCP;

(d) Information related to exhausting the MCP appeal;

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the MCP appeal;

(f) Procedures for exercising the member's rights to appeal the adverse benefit determination;

(g) Circumstances under which expedited resolution is available and how to request it;

(h) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services;

(i) The date the notice is issued;

(j) Oral interpretation is available for any language;

(k) Written translation is available in prevalent non-English languages as applicable;

(l) Written alternative formats may be available as needed; and

(m) How to access the MCP's interpretation and translation services, as well as alternative formats that can be provided by the MCP.

(3) An MCP shall issue each NOA within the following time frames:

(a) For a decision to deny or limit authorization of a requested service, including the type or level of service, the MCP shall issue a NOA simultaneously with the MCP's decision.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP, the MCP shall give notice at least fifteen calendar days before the date of the adverse benefit determination except:

(i) If probable recipient fraud has been verified, the MCP shall give notice five calendar days before the date of the adverse benefit determination.

(ii) Under the circumstances set forth in 42 C.F.R. 431.213 (October 1, 2017), the MCP shall give notice on or before the date of the adverse benefit determination.

(c) For denial of payment for a non-covered service, the MCP shall give notice simultaneously with the MCP's determination to deny the claim, in whole or part, for a service not covered by medicaid,

including a service determined through the MCP's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal or grievance resolution, the MCP shall give notice simultaneously with the MCP becoming aware of the untimely resolution. Service authorization decisions not reached within the time frames specified in rule 5160-26-03.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse benefit determination. Notice shall be given on the date the authorization decision time frame expires.

(D) Grievances to an MCP.

(1) A member may file a grievance with an MCP orally or in writing at any time the member becomes aware of an issue. An authorized representative must have the member's written consent to file a grievance on the member's behalf.

(2) An MCP shall acknowledge the receipt of each grievance to the member filing the grievance. Oral acknowledgment by an MCP is acceptable. If the grievance is filed in writing, written acknowledgment shall be made within three business days of receipt of the grievance.

(3) An MCP shall review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, shall meet the following time frames:

(a) Within two business days of receipt if the grievance is regarding access to services.

(b) Within thirty calendar days of receipt for non claims-related grievances except as specified in paragraph (D)(4)(a) of this rule.

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

(4) At a minimum, an MCP shall provide oral notification to the member of a grievance resolution. If an MCP is unable to speak directly with the member, or the resolution includes information that must be confirmed in writing, the resolution shall be provided in writing simultaneously with the MCP's resolution.

(5) If an MCP's resolution to a grievance is to uphold the denial, reduction, suspension, or termination of a service or billing of a member due to the MCP's denial of payment for that service, the MCP shall notify the member of his or her right to request a state hearing as specified in paragraph (H) of this rule, if the member has not previously been notified.

(E) Standard appeal to an MCP.

(1) A member, a member's authorized representative, or a provider may file an appeal orally or in writing within sixty calendar days from the date that the NOA was issued. An oral appeal filing must be followed with a written appeal. An MCP shall:

(a) Immediately convert an oral appeal filing to a written appeal on behalf of the member; and

(b) Consider the date of the oral appeal filing as the filing date.

(2) Any provider acting on the member's behalf must have the member's written consent to file an appeal. An MCP shall begin processing the appeal upon receipt of the written consent.

(3) An MCP shall acknowledge receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment shall be made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment shall be made by an MCP within three business days of receipt of the appeal.

(4) An MCP shall provide the member reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, and inform the member of this opportunity sufficiently in advance of the resolution time frame. The member and/or member's authorized representative shall be provided, free of charge and sufficiently in advance of the resolution time frame, the case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by the MCP, or at the direction of the MCP, in connection with the appeal of the adverse benefit determination.

(5) An MCP shall consider the member, the member's authorized representative, or an estate representative of a deceased member as parties to the appeal.

(6) An MCP shall review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution time frame shall not exceed fifteen calendar days from the receipt of the appeal unless the resolution time frame is extended as outlined in paragraph (G) of this rule.

(7) An MCP shall provide written notice of the appeal's resolution to the member, and to the member's authorized representative if applicable. At a minimum, the written notice shall include the resolution decision and date of the resolution.

(8) For appeal resolutions not resolved wholly in the member's favor, the written notice to the member shall also include the following information:

(a) The right to request a state hearing through the state's hearing system;

(b) How to request a state hearing; and if applicable:

(i) The right to continue to receive benefits pending a state hearing;

(ii) How to request the continuation of benefits; and

(iii) If the MCP's adverse benefit determination is upheld at the state hearing, the member may be liable for the cost of any continued benefit.

(c) Oral interpretation is available for any language;

(d) Written translation is available in prevalent non-English languages as applicable;

(e) Written alternative formats may be available as needed; and

(f) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

(9) For appeal resolutions decided in favor of the member, an MCP shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date, if the services were not furnished while the appeal was pending.

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

(F) Expedited appeals to an MCP.

(1) An MCP shall establish and maintain an expedited review process to resolve appeals when the member requests and the MCP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function.

(2) In utilizing an expedited appeal process, an MCP shall comply with the standard appeal process specified in paragraph (D) of this rule, except the MCP shall:

(a) Not require an oral appeal filing be converted to a written appeal;

(b) Determine within one business 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 time frame shall not exceed seventy-two hours from the date the MCP received the appeal unless the resolution time frame is extended as outlined in paragraph (G) of this rule;

(f) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification;

(g) Ensure 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 business day of any appeal that meets the criteria for expedited resolution as specified by ODM.

(3) If an MCP denies a member's request for expedited resolution of an appeal, the MCP shall:

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

(b) Make reasonable efforts to provide the member prompt oral notification of the decision not to expedite, and within two calendar days of the receipt of the appeal, provide the member written notice of the reason for the denial, including information that the member can grieve the decision.

(G) Grievance and appeal resolution extensions.

(1) A member may request the time frame for an MCP to resolve a standard or expedited appeal or grievance be extended up to fourteen calendar days.

(2) An MCP may request the time frame to resolve a standard or expedited appeal or grievance be extended

up to fourteen calendar days. The following requirements apply:

(a) The MCP shall seek such an extension from ODM prior to the expiration of the standard or expedited appeal or grievance resolution time frame;

(b) The MCP request shall be supported by documentation of the need for additional information and that the extension is in the member's best interest; and

(c) If ODM approves the extension, the MCP shall make reasonable efforts to provide the member prompt oral notification of the extension and, within two calendar days, provide the member written notice of the reason for the extension and the date by which a decision shall be made.

(3) An MCP shall maintain documentation of any extension request.

(H) Access to state's hearing system.

(1) An MCP shall develop and implement written policies and procedures that ensure the MCP's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code.

(2) Except as set forth in paragraph (H)(3) of this rule, in accordance with 42 CFR 438.402, members may request a state hearing only after exhausting the MCP's appeal process. If an MCP fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the MCP appeal process and may request a state hearing.

(3) In accordance with rule 5160-20-01 of the Administrative Code, members proposed for enrollment or currently enrolled in the coordinated services program (CSP) are afforded state hearing rights in accordance with division 5101:6 of the Administrative Code and are not subject to the requirement of first appealing to the MCP.

(4) When required by paragraph (E)(8) of this rule, and division 5101:6 of the Administrative Code, an MCP shall notify members, and any authorized representatives on file with the MCP, of the right to a state hearing subject to the following requirements:

(a) If an MCP appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the MCP shall simultaneously issue the "Notice of Denial of Medical Services By Your Managed Care Plan" (ODM 04043, 1/2015).

(b) If an MCP appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as previoysly authorized by the MCP, the MCP shall issue the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (ODM 04066, 1/2015) no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension, or termination.

(c) If an MCP learns a member has been billed for services received by the member due to the MCP's denial of payment, and the MCP upholds the denial of payment, the MCP shall immediately issue the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (ODM 04046, 7/2014).

(5) The member or member's authorized representative may request a state hearing within one hundred twenty days by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS). The one hundred twenty-day period begins on the day after the mailing date

on the forms referenced in paragraph (H)(4) of this rule.

(6) There are no state hearing rights for a member terminated from an MCP pursuant to an MCP-initiated membership termination as permitted in rule 5160-26-02.1 of the Administrative Code.

(7) Following the bureau of state hearing's notification to an MCP that a member has requested a state hearing, the MCP shall:

(a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014) with appropriate supporting attachments, and file it with the bureau of state hearings at least three business days prior to the scheduled hearing date. The appeal summary shall include all facts and documents relevant to the issue, in accordance with rule 5160-26-03.1 of the Administrative Code, and be sufficient to demonstrate the basis for the MCP's adverse benefit determination or appeal resolution;

(b) Send a copy of the completed ODM 01959 to the member and the member's authorized representative, if applicable, the CDJFS, and the designated ODM contact; and

(c) Continue or reinstate the benefit(s) if the MCP is notified that the member's state hearing request was received within the prior notification period specified in division 5101:6 of the Administrative Code.

(8) An MCP shall participate in the state hearing, in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, 01/2015) sent to the MCP by the bureau of state hearings.

(9) An MCP shall comply with the state hearing officer's decision provided to the MCP via the "State Hearing Decision" (JFS 04005, 01/2015). If the hearing officer's decision is to sustain the member's appeal, the MCP shall submit the information required by the "State Hearing Compliance" (JFS 04068, 01/2015) to the bureau of state hearings. The information, including applicable supporting documentation, is due to the bureau of state hearings and the designated ODM contact by no later than the compliance date specified in the hearing decision. If applicable, the MCP shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the date it receives notice reversing the adverse benefit determination if services were not furnished while the appeal was pending.

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

(I) Continuation of benefits while the appeal to an MCP or state hearing are pending.

(1) Unless a member requests that previously authorized benefits not be continued, an MCP shall continue a member's benefits when all the following conditions are met:

(a) The member files the request for an appeal or state hearing timely in accordance with this rule;

(b) The appeal or state hearing 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; and

(d) The authorization period has not expired.

(2) If an MCP continues or reinstates the member's benefits while the appeal or state hearing are pending, the

benefits shall be continued until one of the following occurs:

(a) The member withdraws the appeal or the state hearing request;

(b) Fifteen calendar days pass following the mailing date of the MCP's notice to the member of an adverse appeal decision unless the member, within the fifteen-day time frame, requests a state hearing and therefore benefits shall be continued as specified in division 5101:6 of the Administrative Code;

(c) A state hearing regarding the reduction, suspension or termination of services is decided adverse to the member; or

(d) The initial time period for the authorization expires or the authorization service limits are met.

(3) If the final resolution of the appeal or state hearing upholds an MCP's original adverse benefit determination, at the discretion of ODM, the MCP may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

(J) Other duties of an MCP regarding appeals and grievances.

(1) An MCP shall give members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:

(a) Explaining the MCP'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 appeals and grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) An MCP shall ensure the individuals who make decisions on appeals and grievances are individuals who:

(a) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 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 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 involving clinical issues.

(3) In reaching an appeal resolution, an MCP shall take into account all comments, documents, records, and other information submitted by the member or their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

DRAFT - NOT FOR FILING

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 (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 Ohio department of medicaid (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, 2015), 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 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" (ODM 04043, 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" (ODM 04066, 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" (ODM 04046, 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 notice of action.

(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" (ODM 01959, 7/2014) 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 member and the member's authorized representative, if applicable, 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.

(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. 01/2015) sent to the plan by the bureau of state hearings.

(8) The plan must comply with the state hearing officer's decision provided to the plan via the "State Hearing Decision" (JFS 04005, rev. 01/2015). If the hearing officer's decision is to sustain the member's appeal, the plan must submit, to the bureau of state hearings, the information required by the "State Hearing Compliance" non-fillable form (JFS 04068, rev. 01/2015). The information, 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.

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

(10) 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.

DRAFT - NOT FOR FILING

5160-58-08.4 Appeals and grievances for "MyCare Ohio".

(A) Definitions.

(1) "Adverse benefit determination" is a MyCare Ohio plan (MCOP)'s:

(a) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCOP;

(c) Denial, in whole or part, of payment for a service not covered by medicaid, including a service denied through the MCOP's prior authorization process as not medically necessary;

(d) Denial of a request for a specific MCOP-contracted non-agency or participant-directed waiver services provider pursuant to paragraph (G) of rule 5160-58-03.2 of the Administrative Code;

(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;

(f) Failure to act within the resolution timeframes specified in this rule; or

(g) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities, if applicable.

(2) "Appeal" is the member's request for an MCOP's review of an adverse benefit determination.

(3) "Grievance" is the member's expression of dissatisfaction with any aspect of an MCOP's or provider's operation, provision of health care services, activities, or behaviors, other than an MCOP's adverse benefit determination.

(4) "Notice of action (NOA)" is the written notice an MCOP must provide to members when an MCOP adverse benefit determination has occurred or will occur.

(5) "Resolution" means a final decision is made by an MCOP and the decision is communicated to the member.

(B) An MCOP shall have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of this rule, which shall include:

(1) A process by which members may file grievances with the MCOP, in compliance with paragraph (D) of this rule;

(2) A process by which members may file appeals with the MCOP, in compliance with paragraphs (E) through (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 (H) of this rule.

(C) NOA by an MCOP.

(1) When an MCOP adverse benefit determination has or will occur, the MCOP shall provide the affected member with a NOA.

(2) The NOA shall explain:

(a) The adverse benefit determination the MCOP has taken or intends to take;

(b) The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other relevant determination information;

(c) The member's right to file an appeal to the MCOP;

(d) Information related to exhausting the MCOP appeal;

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the MCOP appeal;

(f) Procedures for exercising the member's rights to appeal the adverse benefit determination;

(g) Circumstances under which expedited resolution is available and how to request it;

(h) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of those services;

(i) The date the notice is issued;

(j) Oral interpretation is available for any language;

(k) Written translation is available in prevalent non-English languages as applicable;

(l) Written alternative formats may be available as needed; and

(m) How to access the MCOP's interpretation and translation services as well as alternative formats that can be provided by the MCOP.

(3) The following language and format requirements apply to a NOA issued by an MCOP:

(a) It shall be provided in a manner and format that may be easily understood;

(b) When directed by ODM, it shall be printed in the prevalent non-English languages of members in the MCOP's service area; and

(c) It shall be available in alternative formats, and in an appropriate manner, taking 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) An MCOP shall issue a 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 MCOP shall issue a NOA simultaneously with the MCOP's decision.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCOP, the MCOP shall give notice at least fifteen calendar days before the date of the adverse benefit determination except:

(i) If probable recipient fraud has been verified, the MCOP shall give notice five calendar days before the date of the adverse benefit determination.

(ii) Under the circumstances set forth in 42 C.F.R. 431.213 (October 1, 2017), the MCOP shall give notice on or before the date of the adverse benefit determination.

(c) For denial of payment for a non-covered service, the MCOP shall give notice simultaneously with the MCOP'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 MCOP'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 MCOP shall give notice simultaneously with the MCOP's decision.

(e) For untimely prior authorization, appeal or grievance resolution, the MCOP shall give notice simultaneously with the MCOP becoming aware of the untimely resolution. Service authorization decisions not reached within the timeframes specified in rules 5160-26-03.1 and 5160-58-01.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse benefit determination. Notice shall be given on the date the authorization decision timeframe expires.

(D) Grievances to an MCOP.

(1) A member may file a grievance with an MCOP orally or in writing at any time the member becomes aware of an issue. An authorized representative must have the member's written consent to file a grievance on the member's behalf.

(2) An MCOP shall acknowledge the receipt of each grievance to the member filing the grievance. Oral acknowledgment by an MCOP is acceptable. If the grievance is filed in writing, written acknowledgment shall be made within three business days of receipt of the grievance.

(3) An MCOP shall review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, shall meet the following timeframes:

(a) Within two business 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.

(4) At a minimum, an MCOP shall provide oral notification to the member of a grievance resolution. If an MCOP is unable to speak directly with the member, or the resolution includes information that must be confirmed in writing, the resolution shall be provided in writing simultaneously with the MCOP's resolution.

(5) If an MCOP'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 MCOP's denial of payment for that service, the MCOP shall notify the member of his or her right to request a state hearing as specified in paragraph (H) of this rule, if the member has not previously been notified.

(E) Standard appeal to an MCOP.

(1) A member, a member's authorized representative, or a provider may file an appeal orally or in writing within sixty calendar days from the date that the NOA was issued. An oral appeal filing must be followed by a written appeal. An MCOP shall:

(a) Immediately convert an oral appeal filing to a written appeal on behalf of the member; and

(b) Consider the date of the oral appeal filing as the filing date.

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

(3) An MCOP shall acknowledge receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment shall be made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment shall be made by an MCOP within three business days of receipt of the appeal.

(4) An MCOP shall provide members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, and inform the member of this opportunity sufficiently in advance of the resolution timeframe. The member and/or member's authorized representative shall be provided, free of charge and sufficiently in advance of the resolution timeframe, the case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon or generated by an MCOP, or at the direction of an MCOP, in connection with the appeal of the adverse benefit determination.

(5) An MCOP shall consider the member, the member's authorized representative, or an estate representative of a deceased member as parties to the appeal.

(6) An MCOP shall review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution timeframe shall not exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph (G) of this rule.

(7) An MCOP shall provide written notice of the appeal's resolution to the member, and to the member's authorized representative if applicable. At a minimum, the written notice shall include the resolution decision and date of the resolution.

(8) For appeal resolutions not resolved wholly in the member's favor, the written notice to the member shall also include the following information:

(a) The right to request a state hearing through the state's hearing system;

(b) 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.

(c) Oral interpretation is available for any language;

(d) Written translation is available in prevalent non-English languages as applicable;

(e) Written alternative formats may be available as needed; and

(f) How to access the MCOP's interpretation and translation services as well as alternative formats that can be provided by the MCOP.

(9) For appeal resolutions decided in favor of the member, an MCOP shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date, if the services were not furnished while the appeal was pending.

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

(F) Expedited appeals to an MCOP.

(1) An MCOP shall establish and maintain an expedited review process to resolve appeals when the member requests and the MCOP 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, physical or mental or health or ability to attain, maintain, or regain maximum function.

(2) In utilizing an expedited appeal process, an MCOP shall comply with the standard appeal process specified in paragraph (D) of this rule, except the MCOP shall:

(a) Not require an oral appeal filing be followed with a written, signed appeal;

(b) Determine within one business 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 shall not exceed seventy-two hours from the date the MCOP received the appeal unless the resolution timeframe is extended as outlined in paragraph (G) of this rule;

(f) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification;

(g) Ensure 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 business day of any appeal that meets the criteria for expedited resolution as specified by ODM.

(3) If an MCOP denies the request for expedited resolution of an appeal, the MCOP shall:

(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 (G) of this rule; and

(b) Make reasonable efforts to provide the member prompt oral notification of the decision not to

expedite, and within two calendar days of the receipt of the appeal, provide the member written notice of the reason for the denial, including information that the member can grieve the decision.

(G) Grievance and appeal resolution extensions.

(1) A member may request the timeframe for an MCOP to resolve a standard or expedited appeal or grievance be extended up to fourteen calendar days.

(2) An MCOP may request that the timeframe to resolve a standard or expedited appeal or grievance be extended up to fourteen calendar days. The following requirements apply:

(a) The MCOP shall seek such an extension from ODM prior to the expiration of the standard or expedited appeal or grievance resolution timeframe;

(b) The MCOP request shall be supported by documentation of the need for additional information and that the extension is in the member's best interest; and

(c) If ODM approves the extension, the MCOP shall immediately give the member written notice of the reason for the extension and the date a decision shall be made.

(3) The MCOP shall maintain documentation of any extension request.

(H) Access to state's hearing system.

(1) An MCOP shall develop and implement written policies and procedures that ensure the MCOP's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code.

(2) In accordance with 42 CFR 438.402, members may request a state hearing only after exhausting the MCOP's appeal process. If an MCOP fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the MCOP appeal process and may request a state hearing.

(3) When required by paragraph (E)(8) of this rule and division 5101:6 of the Administrative Code, an MCOP shall notify members, and any authorized representatives on file with the MCOP, of the right to a state hearing subject to the following requirements:

(a) If an MCOP appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the MCOP shall simultaneously issue the "Notice of Denial of Medical Services By Your Managed Care Plan" (ODM 04043, 1/2015).

(b) If an MCOP appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the MCOP, the MCOP shall issue the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (ODM 04066, 1/2015) no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension or termination.

(c) If an MCOP appeal resolution upholds the denial of a request for the authorization to receive waiver services from a provider pursuant to paragraph (A)(1)(d) of this rule, the MCOP shall simultaneously issue the required notice of state hearing rights.

(d) If an MCOP learns a member has been billed for services received by the member due to the MCOP's denial of payment, and the MCOP upholds the denial of payment, the MCOP shall immediately

issue the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (ODM 04046, 7/2014).

(4) The member or the member's authorized representative may request a state hearing within one hundred twenty days by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS). The one hundred twenty-day period begins on the day after the mailing date on the forms referenced in paragraph (H)(3) of this rule.

(5) There are no state hearing rights for a member terminated from an MCOP pursuant to an MCOP-initiated membership termination as permitted in rule 5160-58-02.1 of the Administrative Code.

(6) Following the bureau of state hearing's notification to an MCOP that a member has requested a state hearing, the MCOP shall:

(a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014) with appropriate supporting attachments, and file it with the bureau of state hearings, at least three business days prior to the scheduled hearing date. The appeal summary shall include all facts and documents relevant to the issue, in accordance with rule 5160-26-03.1 of the Administrative Code, and be sufficient to demonstrate the basis for the MCOP's adverse benefit determination or appeal resolution;

(b) Send a copy of the completed ODM 01959 to the member and the member's authorized representative, if applicable, the CDJFS, and the designated ODM contact; and

(c) Continue or reinstate the benefit(s) if the MCOP is notified the member's state hearing request was received within the prior notification period specified in division 5101:6 of the Administrative Code.

(7) An MCOP shall participate in the state hearing, in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, 1/2015) sent to the MCOP by the bureau of state hearings.

(8) An MCOP shall comply with the state hearing officer's decision provided to the MCOP via the "State Hearing Decision" (JFS 04005, 1/2015). If the hearing officer's decision is to sustain the member's appeal, the MCOP shall submit the information required by the "State Hearing Compliance" (JFS 04068, 1/2015) to the bureau of state hearings. The information, including applicable supporting documentation, is due to the bureau of state hearings and the designated ODM contact by no later than the compliance date specified in the hearing decision. If applicable, the MCOP shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the date it receives notice reversing the adverse benefit determination if services were not furnished while the appeal was pending.

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

(I) Continuation of benefits while the appeal to an MCOP or state hearing are pending.

(1) Unless a member requests that previously authorized benefits not be continued, an MCOP shall continue a member's benefits when all the following conditions are met:

(a) The member files the request for an appeal or state hearing timely in accordance with this rule;

(b) The appeal or state hearing 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; and

(d) The authorization period has not expired.

(2) If an MCOP continues or reinstates the member's benefits while the appeal or state hearing are pending, the benefits shall be continued until one of the following occurs:

(a) The member withdraws the appeal or the state hearing request;

(b) Fifteen calendar days pass following the mailing date of the MCOP's notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing and therefore the benefits shall be continued as specified in division 5101:6 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) If the final resolution of the appeal or state hearing upholds an MCOP's original adverse benefit determination, at the discretion of ODM, the MCOP may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

(J) Other duties of an MCOP regarding appeals and grievances.

(1) An MCOP shall give members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:

(a) Explaining the MCOP'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) An MCOP shall ensure the individuals who make decisions on appeals and grievances are individuals who:

(a) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 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 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 involving clinical issues.

(3) In reaching an appeal resolution, the MCOP shall take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

5160-20-01 **Coordinated services program.**

(A) Definitions.

(1) "Coordinated services program" (CSP) means a program that requires an individual to obtain certain services from a designated provider.

(2) "Department" means the Ohio department of medicaid (ODM) or its designee.

(3) "Designated provider" means a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified single provider or provider entity that is authorized to and is not excluded from receiving reimbursement for health care services rendered to an individual. The designated provider is selected in accordance with paragraph (E) of this rule to serve as the primary provider of non-emergency services for an individual enrolled in CSP.

(4) "Individual" is defined in rule 5160:1-1-01 of the Administrative Code.

(5) "Managed care plan" (MCP) is defined in rule 5160-26-01 of the Administrative Code.

(6) "Medical necessity" is defined in rule 5160-1-01 of the Administrative Code.

(B) CSP provides continuity of medical care and protection of health and safety to individuals by avoiding duplication of services, inappropriate or unnecessary utilization of medical services, and excessive utilization of prescription medications. An individual may be enrolled in CSP if a review of his or her utilization demonstrates a pattern of receiving services at a frequency or in an amount that exceeds medical necessity.

(C) An individual enrolled in CSP is eligible for all medically necessary services covered by medicaid. An individual enrolled in CSP must obtain medically necessary medicaid covered services from designated providers related to the reason for enrollment, as indicated by benefit utilization patterns.

(D) Initial enrollment, continued enrollment and disenrollment procedures.

(1) Initial enrollment.

(a) An individual proposed for enrollment in CSP will receive the "Notice of Proposed Enrollment in the Coordinated Services Program (CSP)" (ODM 01717, 7/2014)~~a notice of enrollment~~, including the effective date

of enrollment, from the department in accordance with ~~rule~~division 5101:6~~-2-40~~ of the Administrative Code.

(b) Initial CSP enrollment will be for twenty-four months from the effective date of enrollment.

(c) If an individual enrolled in CSP becomes ineligible for medicaid, then resumes eligibility for medicaid within the initial enrollment period, the individual will be reinstated into CSP until the initial enrollment period is exhausted.

(2) Continued enrollment.

(a) If after the initial enrollment period the department determines an individual's service utilization still supports the reasons for enrollment described in paragraph (B) of this rule, the individual will continue to be enrolled in CSP for up to an additional twenty-four month period.

(b) The department will notify the individual of the continued enrollment by issuing the "Notice of Continued Enrollment in the Coordinated Services Program (CSP)" (ODM 01705, 7/2014) in accordance with ~~rule~~ division 5101:6~~-2-40~~ of the Administrative Code.

(c) If an individual enrolled in CSP becomes ineligible for medicaid, then resumes eligibility for medicaid within a continued enrollment period, the individual will be reinstated into CSP until the continued enrollment period is exhausted.

(3) Disenrollment.

(a) If the department determines an individual's service utilization no longer supports the reasons for enrollment described in paragraph (B) of this rule, the individual will be disenrolled.

(b) If an individual enrolled in CSP enters a long-term care facility or hospice program, the individual will be disenrolled from CSP. If the individual is subsequently discharged from the long-term care facility or hospice program during the CSP enrollment period, the department may reinstate the individual into CSP.

(E) Initial assignment or changing a designated provider.

(1) Initial assignment.

(a) An individual enrolled in CSP may request a designated provider within thirty days of the mailing date on the initial enrollment notification. If approved by the department, this provider will serve as the individual's designated provider. The designated provider must be contracted with the department, unless otherwise permitted by the department.

(b) The department will select a designated provider for the individual for any of the following reasons:

(i) The individual does not select a designated provider within thirty days of the mailing date on the initial enrollment notification;

(ii) The individual's selected designated provider is denied by the department; or

(iii) The selected designated provider is unwilling or unable to accept the individual.

(2) Changing a designated provider.

(a) An individual may request to change, or the department may require an alternative selection of a designated provider under the following circumstances:

(i) The designated provider's office is no longer accessible to the individual because:

(a) Of relocation or closing of the designated provider's office;

(b) Of relocation or incapacity of an individual;

(c) The designated provider is no longer an eligible provider;

(d) The designated provider chooses to not, or no longer, provide services to the individual; or

(e) The individual transfers from the fee-for-service program to an MCP, from an MCP to the fee-for-service program or from one MCP to another.

(ii) The medical needs of the individual require a designated provider with a different specialty.

(b) If the department denies the individual's request to change the designated provider, the department shall notify the individual by issuing the "Notice of Denial of Designated Provider or Pharmacy in the Coordinated Services Program (CSP)" (ODM 01718, 7/2014) in accordance with ~~rule~~ division 5101:6~~-2-40~~ of the Administrative Code.

Effective:

Five Year Review (FYR) Dates: 1/1/2020

_____

Certification

_____

Date

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