Ohio | Common Sense Initiative

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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

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Regulation/Package Title (a general description of the rules' substantive content): Appeals and Grievances for "MyCare Ohio"

Rule Number(s): 5160-58-08.4

Date of Submission for CSI Review: 7/26/2022

Public Comment Period End Date: 08/03/2022

Rule Type/Number of Rules:

New/___ rules

Amended/_X_ rules (FYR? _X_)

No Change/____ rules (FYR? ___)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **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 90% of Medicaid recipients receive their Medicaid services through the managed care delivery system. Managed care organizations (MCOs) are health insurance companies 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. MyCare Ohio plans (MCOPs) are considered MCOs per federal definitions. The rules in Ohio Administrative Code (OAC) Chapter 5160-58 govern the MyCare Ohio program. There are five MCOPs in Ohio, each with a network of health care professionals. MyCare Ohio is a managed care program aimed at providing integrated care for individuals who are dually eligible (e.g. members receive both Medicaid and Medicare services).

   OAC Rule 5160-58-08.4 sets forth MyCare Ohio plan (MCOP) appeal and grievance rights. Several changes to this rule are being made to align rule 5160-58-08.4 with updates to federal regulations in the Code of Federal Regulations (CFR) and updates to the Ohio Department of Medicaid's (ODM) applicable agency policy and procedure. Specifically, date references to CFR citations are being updated. Date references and names of ODM internal forms are also being updated within the rule. The time to request a state hearing is being shortened from one hundred twenty days to ninety days

from the date of adverse appeal resolution in order to align rule 5160-58-08.4 with recent changes to 5160-26-08.4 of the Ohio Administrative Code.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Ohio Revised Code Section 5167.02 authorizes ODM to adopt the rule, and Sections 5164.02 and 5166.02 amplify that authority.

4. **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 organizations. Additionally, ODM has entered into a three-way contract with the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services and each MCOP to implement the MyCare Ohio demonstration program.

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

   The current regulation does not exceed federal requirements. Federal regulations do not impose requirements directly on MCOs; instead, they require state Medicaid agencies to ensure MCO compliance with federal standards. The rules are consistent with federal managed care requirements outlined in 42 CFR Part 438 that require the state to implement policies and regulations as the state deems necessary and appropriate.

6. **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 organization (MCO) and MyCare Ohio plan (MCOP) compliance with federal regulations related to the member's right to grieve an MCO issue or appeal an adverse benefit determination made by an MCO.

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

   ODM monitors compliance with the regulation through reporting requirements established within the MyCare Ohio provider agreement. Successful outcomes are measured through a finding of compliance with these standards as determined by monitoring and oversight.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. 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.

A draft version of the amended OAC Chapter 5160-58.08.4 rule was electronically provided to the MCOPs, listed below, for comment on 6/17/2022. The MCOPs were given until 7/1/2022 to comment on the draft rule.

- Aetna Better Health Ohio, Inc.
- Buckeye Community Health Plan
- CareSource Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- UnitedHealthcare Community Plan of Ohio

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

No comments were received from the aforementioned stakeholders.

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

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

12. 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?

No alternative regulations were discussed during the rule amendment process. The amendments to the rule include general updates to keep the rule current and to reflect changes to the managed care program resulting from managed care procurement, implementation of centralized credentialing, and the implementation of the SPBM and the OhioRISE program.

13. 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 because ODM is required to comply with detailed federal requirements set forth in 42 CFR Part 438. MCOP performance requirements are outlined in the MCOP provider agreement available on the ODM website: https://medicaid.ohio.gov/.

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

All Medicaid regulations governing Medicaid MCOs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid managed care program, and the rules and regulations found in the rules in Chapter 5160-58 are not duplicated elsewhere in Ohio code.

15. 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 MCOPs of the final rule changes via email notification. Additionally, per the MCOP provider agreement, MCOPs are required to subscribe to the appropriate distribution lists for notification of all OAC rule clearances and final published rules including RuleWatch Ohio and the Common Sense Initiative Office (CSIO) eNotification system. ODM will ensure MCOPs are made aware of any future rule changes via established communication processes.

Adverse Impact to Business

16. 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; and

This rule impacts MCOPs in the State of Ohio (this includes: Aetna Better Health Ohio, Buckeye Community Health Plan, CareSource Ohio, Molina Healthcare of Ohio, and UnitedHealthcare Community Plan of Ohio).

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

This rule contains requirements for the 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 and cause the adverse impacts listed below.

-MCOPs must provide a written notice to members of an adverse benefit determination;

-MCOPs must acknowledge receipt of an appeal or grievance with the member or authorized representative;

-MCOPs must provide the member or authorized representative written notice of the resolution;

-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.

MCOPs are paid a per member per month amount. ODM must pay MCOPs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.4, 42 CFR 438.5, and CMS's Medicaid Managed Care Rate Development Guide. ODM's actuary will develop rates that 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 the MyCare Ohio provider agreement. Through the administrative component of the capitation rate paid to the MCOPs by ODM, MCOPs will be compensated for the cost of the reporting and notice requirements found in these rules. For CY 2022, the administrative component of the managed care capitation rate varies by program/population and ranges from 3.0% to 7.5% for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates.

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

The MCOPs were aware of the federal requirements for covered services prior to seeking and signing their contracts with the State. More importantly, without the requirement of certain covered health care services, the State would be out of compliance with federal regulations.

Regulatory Flexibility

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

The requirements of this rule must be applied uniformly and no exception is made based on an MCOP's size.

19. 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 do not impose any monetary fines or penalties for first-time paperwork violations for small businesses as outlined in ORC section 119.14.

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

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

DRAFT - NOT FOR FILING

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

~~(A)~~ (A) ~~Definitions.~~

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

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

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

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

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

~~(3)~~ (3) ~~"Grievance" is the member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCOP to make an authorization decision.~~

~~(4)~~ (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.~~

~~(B)~~ (A) ~~NOA~~Notice of action (NOA) by ~~an MCOP.~~a MyCare Ohio plan (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 process;

(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;

(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) It shall explain that oral interpretation is available for any language, written translation is available in prevalent non-English languages as applicable, and written alternative formats may be available as needed;

(c) It shall explain how to access the MCOP's interpretation and translation services as well as alternative formats that can be provided by the MCOP;

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

(e) 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 time frames:

(a) For a decision to deny or limit authorization of a requested 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 effective 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 effective date of the adverse benefit determination.

(ii) Under the circumstances set forth in 42 CFR 431.213 ~~(October 1, 2017)~~(October 1, 2022), the MCOP shall give notice on or before the effective 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 time frames 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 time frame expires.

~~(C)~~ (B) Grievances to an MCOP.

(1) A member may file a grievance with an MCOP orally or in writing at any time. 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 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 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 (G) of this rule, if the member has not previously been notified.

~~(D)~~ (C) 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 shall 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 time frame. Upon request, 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, 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 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 (F) 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.

~~(E)~~ (D) 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) Determine within one business day of the appeal request whether to expedite the appeal resolution;

(b) Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution;

(c) 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;

(d) 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 MCOP received the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule;

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

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

~~(g)~~ (g) ~~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 time frame of fifteen calendar days from the date the appeal was received unless the resolution time frame is extended as outlined in paragraph (F) 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.

~~(F)~~ (E) Grievance and appeal resolution extensions.

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

(2) An MCOP may request that the time frame to resolve a grievance or standard or expedited appeal 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 time frame;

(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.

~~(G)~~ (F) Access to state's hearing system.

(1) In accordance with 42 CFR 438.402 ~~(October 1, 2017)~~(October 1, 2021), 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.

(2) When required by paragraph (D)(8) of this rule, and in accordance with 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~~"Entity" ~~(ODM 04043, 1/2018)~~(ODM 04043, 7/2022).

(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~~"Entity" ~~(ODM 04066, 1/2018)~~(ODM 04066, 7/2022).

(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~~"Entity" ~~(ODM 04046, 1/2018)~~(ODM 04046, 7/2022).

(3) The member or the member's authorized representative may request a state hearing within ~~one hundred twenty~~ninety days from the date of an adverse appeal resolution by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS).

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

(5) 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~~"Entities" ~~(ODM 01959, 7/2014)~~(ODM

01959, 7/2022) 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;

(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) If benefits were continued through the appeal process in accordance with paragraph (H)(1) of this rule, continue or reinstate the benefit(s) if the MCOP is notified the member's state hearing request was received within fifteen days from the date of the appeal resolution.

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

(7) An MCOP shall comply with the state hearing decision provided to the MCOP via the "State Hearing Decision" (JFS 04005, 1/2015). If the state hearing decision sustains the member's appeal, the MCOP shall submit the information required by the "Order of 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.

~~(H)~~ (G) 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 requests an appeal within fifteen days of the MCOP issuing the NOA;

(b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized services;

(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) The member fails to request a state hearing within fifteen days after the MCOP issues an adverse appeal resolution; or

(c) The bureau of state hearings issues a state hearing decision upholding the reduction, suspension or termination of services.

(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.

~~(I)~~ (H) 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 interpretation 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.