CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Job and Family Services

Regulation/Package Title: BSH MCP Hearings

Rule Number(s): 5101:6-4-01, 5101:6-5-01, 5101:6-6-01 and 5101:6-7-03

Date: September 25, 2017

Rule Type:

- ☐ New
- X Amended
- X 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- X Rescinded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.

These four rules are being filed in conjunction and coordination with the Department of Medicaid's updated new rules (5160-26-08.4 and 5160-58-08.4) outlining the Managed Care (MCP) and MyCare Ohio (MCOP) appeal and grievance rights, at the managed care level, prior to coming to the Department of Job and Family Services, Bureau of State Hearings. The need for rule changes are driven by Federal requirements found at 42 CFR 438, Subpart F.

Regulatory Intent

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

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

5101:6-4-01 *State Hearings: Continuation of Benefits When a State Hearing is Requested* - This rules describes the manner in which the continuation of benefits occurs and deadlines associated with receiving continued benefits. Changes include: adding a definition to "Prior Notice Period" to mean the timeframe from the adverse benefit determination appeal resolution decision date or the notice mail date to the state hearing request receive date, which is ten (10) calendar days for Medicaid, including managed care plans and "My Care Ohio" plans, and fifteen (15) days for all other programs; adding "MyCare Ohio" as a managed care plan for purposes of a hearing request involving an adverse benefit determination appeal resolution.

5101:6-5-01 *State Hearings: Procedures Prior to the State Hearing* – This rule describes the process for submitting state hearing requests to the Bureau of State Hearings, completing appeal summaries, performing county conferences, and other legal obligations of the parties. Changes to this rule include: 1) adding managed care plans (MCPs) and "MyCare Ohio" (MCOPs) plans as local agency entities who shall follow the procedures for requesting a state hearing; and 2) deleting a form and outdated language that references Medicaid managed care plans.

5101:6-6-01 *State Hearings: Scheduling and Attendance* – This rule describes the process for scheduling state hearings and outlines who is considered a party to the state hearing. Minor language changes were made for clarity regarding the inclusion of managed care plans in the scheduling process for state hearings.

5101:6-7-03 *State Hearings: Implementation of the Hearing Decision* – This rule describes the process for implementing a state hearing decision and outlines obligations for local agencies with respect to compliance, overpayments, or underpayments. Updates have been made to terminology such as adding the "MyCare Ohio" plan language and deleting "bureau of managed care" as an obsoleted reference.

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

5101:6-4-01 – 5101.35

5101:6-5-01 – 3125.25, 5101.35

5101:6-6-01 – 3125.25, 5101.35

5101:6-7-03 – 3125.25, 5101.35

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. Federal requirements are contained in 42 CFR 438, Subpart F related to the MCP appeals and grievance process including: timelines for a member to request an appeal or grievance, MCP appeal or grievance resolution timeframes, and the process for a member to request and be granted a state hearing.

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

   These regulations do not exceed federal regulations.

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 public purpose is to follow federal regulations in regards to allowing for an appeals process in which cases may be reviewed and where parties may request a formal change to an official decision. Appeals function as a process for error correction as well as a process for clarifying and interpreting law.

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

   To remain in compliance by following federal requirements with established standards as determined by monitoring and oversight through the state hearing process.

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.

   Ohio Department of Medicaid, Aetna, Buckeye Health Plan, CareSource, Molina Healthcare of Ohio, Paramount Advantage, and United Healthcare 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?**

   These rules are currently undergoing the Clearance process--submitted for public comment 9/21/2017 through 9/26/2017. No comments have been received as of the posting of these rules to CSIO. The Department met 9/25/2017 with stakeholders and managed care plans and Medicaid to review rules and process changes needed to support the Federal regulations. All parties were in consensus with the necessary changes.

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.

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?**

    No alternative regulations were considered as the Department followed the directives and guidelines of the Code of Federal regulations as outlined by the Department of Medicaid's new rules.

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

    No, rules were promulgated to follow federal directives.

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

    There is no duplication as no other state agencies impose state hearing requirements except ODJFS Bureau of State Hearings.

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.**

    ODJFS will notify Medicaid, the managed care plans, and the MyCare Ohio plans of the final rules via email notification. The changes to the rules will not impact current business processes.

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;**

    In Ohio, approximately 86% of Medicaid recipients receive their Medicaid services through a Managed Care Plan (MCP) or MyCare Ohio Plan (MCOP). These rules impact MCPs and MCOPs in the State including: Aetna, Buckeye, CareSource, Molina, Paramount Advantage, and United Healthcare.

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

These rules speak to Managed Care Plans and MyCare Ohio plans that are contracted under the Ohio Department of Medicaid and subject to provider agreement contracting.

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.

All costs are initiated through the Department of Medicaid, through Ohio Medicaid's payment of the capitation rates/per member, per month.

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

Per federal requirements.

Regulatory Flexibility

16. **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 MCP or MCOP 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?**

This rule imposes no sanctions.

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 MCPs or MCOPs may contact ODM directly through their assigned Contract Administrator.

The ODJFS Bureau of State Hearings contact is: Sandra Richendollar (614) 644-6909.

5101:6-4-01 **State hearings: continuation of benefits when a state hearing is requested.**

(A) "Prior notice period" means the timeframe from the adverse benefit determiniation appeal resolution decision date or the notice mail date to the state hearing request receive date, which is ten calendar days for Medicaid, including managed care plans and "MyCare Ohio" plans, and fifteen days for all other programs.When a request for a state hearing is received by either the state or local agency within the ~~fifteen day~~ prior notice period, benefits shall not be reduced, suspended, or terminated until a state hearing decision is rendered unless one of the following occurs:

(1) A determination is made at the hearing that the sole issue is one of state or federal law, and not one of fact or judgment.

(2) The appeal is withdrawn or abandoned pursuant to rule 5101:6-5-03 of the Administrative Code.

(3) A change affecting the assistance group's eligibility or level of benefits occurs while the decision is pending and the assistance group fails to timely request a hearing upon receipt of the subsequent notice of adverse action.

(4) A mass change that adversely affects an assistance group's eligibility for food assistance or basis of issuance occurs while the hearing decision is pending.

(5) The assistance group specifically waives continuation of food assistance benefits.

The section for requesting a state hearing on the prior notice contains a space for the assistance group to indicate whether it desires to waive continued food assistance benefits. If the assistance group does not positively indicate that it waives continued benefits, the local agency shall assume that continued benefits are desired.

(6) The assistance group's food assistance certification period expires. Further entitlement to food assistance benefits cannot be established without recertification based upon a new application as provided in rule 5101:4-7-07 of the Administrative Code.

(7) The assistance group's learning earning and parenting (LEAP) supportive services, and support services provided to participants in a work activity under the Ohio works first (OWF) program, or the food assistance employment and training program are being reduced or terminated.

(8) The managed care plan continues the provision of medical services and the member receives the services previously requested by the provider and authorized by the managed care plan before the hearing decision is rendered. Further entitlement to medical services cannot be established without a provider requesting additional services and the managed care plan making a medical necessity determination.

(B) When benefits are reduced, suspended, or terminated in violation of the provisions of paragraph (A) of this rule, benefits shall be reinstated to the previous level.

(C) When the request for a state hearing is received by the state or local agency within ten calendar days after the effective date of the adverse action (the ten-day time limit does not apply in the food assistance program), and when good cause is shown for the delay in making the request, benefits shall be reinstated to the previous level. "Reinstatement of benefits to the previous level" means that benefits shall be reinstated retroactive to the date the benefits were reduced, suspended, or terminated.

(1) "Good cause" is defined as death in the immediate family, sudden illness, or injury of the individual or a member of the individual's immediate family, or other circumstances that reasonably prevented requesting a hearing within the timely notice period.

(2) Food assistance benefits shall not be reinstated when the assistance group has specifically waived continuation of benefits, or when the certification period has expired.

(D) When an adverse action was taken without prior notice, pursuant to paragraph (A) of rule 5101:6-2-05 of the Administrative Code, and when the hearing request is received by either the state or local agency within fifteen calendar days from the mailing date of the notice of adverse action, benefits shall be reinstated to the previous level.

(E) When food assistance benefits are reduced or terminated because of a mass change, and when the assistance group's hearing request is received by either the state or local agency within fifteen calendar days from the mailing date of the mass change notice, food assistance benefits shall be reinstated to the previous level if the following conditions are met:

(1) The reason for the assistance group's appeal is an erroneous application of the mass change to the individual case.

(2) The assistance group does not specifically waive its right to continuation of benefits.

(3) The food assistance certification period has not expired.

(F) If the need for reinstatement is discovered by the local agency, the local agency shall authorize reinstatement within one work day of the date of discovery. If the need for reinstatement is discovered by the bureau of state hearings, the bureau shall immediately order the responsible agency to reinstate benefits. All reinstatement orders shall be in writing. The agency shall respond to reinstatement orders by authorizing benefits within one work day of receipt of the order. Benefits so reinstated shall continue until the state hearing decision is rendered unless one of the conditions in paragraph (A) of this rule is met.

(G) Managed care plan or "MyCare Ohio" issues

(1) When a hearing request involves an adverse benefit determination appeal resolution ~~When a hearing request involving a medicaid managed care plan's proposed reduction, suspension, or termination of a managed care plan authorized service is received by the state or local agency within the prior notice period~~, the managed care plan shall be responsible for assuring that assistance is continued at or reinstated to the previous level until the services that were authorized by the managed care plan are received or until the state hearing decision is issued, whichever date comes first.

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

(3) Nothing in this rule shall require an individual physician to continue a service for an enrollee if that physician believes that to do so would violate the provisions of section 4731.22 of the Revised Code.

(4) When a hearing request involving a managed care plan's proposed enrollment in the coordinated services program (CSP), defined in rule 5160-20-01 of the Administrative Code, is received by the state or local agency within the prior notice period, the managed care plan will not enroll the member in the CSP until the state hearing decision is issued.

(5) Managed care plans will not be required to provide continuation of benefits except for the reasons outlined in paragraphs (G)(1) and (G)(4) of this rule.

(H) The denial or delay of replacement food assistance benefits, under the provisions of rule 5101:4-7-11 of the Administrative Code and paragraph (A)(1)(a) of rule 5101:6-5-02 of the Administrative Code, shall remain in effect pending the state hearing decision.

When a nonadverse action is required, the agency shall proceed with that action. In the child support program, the child support enforcement agency (CSEA) shall continue to provide services, as otherwise appropriate, without regard to any hearing requests that have been made.

(I) When a hearing request involving ODJFS's proposed enrollment in the CSP, defined in rule 5160-20-01 of the Administrative Code, is received by the state or local agency within the prior notice period, ODJFS will not enroll the individual in the CSP until the state hearing decision is issued.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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5101:6-5-01 **State hearings: procedures prior to the state hearing.**

(A) The bureau of state hearings shall handle the receipt and processing of the request for a state hearing. When the hearing request is made to the local agency, managed care plan (MCP), or "MyCare Ohio" plan, ~~the local agency~~ each shall date stamp the request, retain a copy, and mail or transmit the request to "ODJFS, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825," or fax to 614-728-9574 or email to bsh@jfs.ohio.gov, within one business day from the date of receipt. MCPs or MCOPs shall notify the bureau of state hearings within three calendar days of forwarding of receiving the state hearing request when the individual has not exhausted the grievance and appeal process described in rules 5160-26-08.4 or 5160-58-08.4 of the Administrative Code.

(B) The local agency proposing the action about which the individual requested the state hearing shall complete an appeal summary. The summary consists of a prescribed form (the JFS 04067 "Appeal Summary" (rev. 5/2001), ~~or for a medicaid managed care plan the JFS 01959 "Appeal Summary for Managed Care Plans" (rev. 6/2003))~~ and attachments, and is intended to provide a summary of all facts and documents relevant to the issue under appeal sufficient to demonstrate the basis for the local agency's action.

The local agency shall file its appeal summary with the bureau of state hearings at least three business days prior to the scheduled hearing date, and also make it available to the individual or authorized representative at least three days prior to the hearing for inspection. Failure to do so may be considered good cause for postponing or continuing the hearing if the individual has been materially disadvantaged by the failure.

(C) County conferences

(1) In order to avoid unnecessary state hearings, the local agency shall provide an opportunity for the individual to discuss and/or resolve disagreements with the local agency's actions or inaction. ~~For a medicaid managed care plan, the plan's appeal or grievance process substitutes for the county conference requirement.~~

(2) When an individual requests a county conference, the local agency shall convene a conference presided over by the local agency's director or a designee. Both the local agency and the individual may bring whomever each reasonably wants to be at the conference. The issue to be decided by the presiding person shall be whether the local agency can show, by a preponderance of the evidence, that its action or inaction was in accordance with applicable regulations. If not,

the presiding person shall retract the notice of adverse action and/or decide the question of the individual's entitlement to benefits, or arrange to make that determination as quickly as possible. The outcome of the county conference shall be recorded, in writing, in the case record.

(3) The individual need not have a county conference in order to have a state hearing, nor does the holding of a county conference, or the individual's failure to appear for one, diminish the right to a state hearing. A state hearing must still be held unless a resolution is reached at the county conference and the individual withdraws the hearing request in writing. Any such withdrawal shall be signed and dated by both the individual and the local agency representative, shall clearly set forth the resolution upon which the withdrawal is based, and shall be forwarded to the assigned hearings section within two business days. The local agency shall give one copy of the withdrawal to the individual and retain one copy in the case file.

(4) The local agency shall schedule a county conference for assistance groups contesting a denial of expedited food assistance within two business days, unless the assistance group requests that the county conference be scheduled later or states that it does not wish to have a county conference.

(D) Legal representation

Both the individual and the local agency have the right to be represented by legal counsel at the state hearing. The local agency shall provide the individual with information regarding free legal services in the community, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code and upon request from the appellant, via the JFS 04059 "Explanation of State Hearing Procedures" (rev. ~~10/2008~~1/2015). The local agency may provide legal services through a social services contract.

(E) Access to documents and regulations

(1) The individual and authorized representative shall be provided reasonable time before the date of the hearing, as well as during the hearing, to examine the contents of the case file, as well as all records and documents to be used by the local agency at the hearing, except for confidential information protected from release.

(2) If the individual or authorized representative requests case record documents that are relevant to the issue under appeal, the local agency shall provide one copy of each such document at no cost. The authorized representative must provide the individual's signed authorization to the local agency before obtaining a copy of case record material.

(3) Current program manuals shall be made available to the individual or authorized representative for review at the local agency.

(4) The local agency's failure to provide or allow access to the information, at least three days prior to scheduled hearing, as required by this paragraph, may be the basis for postponing or continuing the hearing.

(5) Confidential material protected from release, and other documents or records that the individual will not have an opportunity to contest or challenge, shall not be presented at the hearing nor affect the hearing officer's decision.

(6) When the hearing involves work registration or employment and training, the individual shall also be allowed to examine the employment and training component case file, except for confidential information (which may include test results) that the agency determines should be protected from release.

(7) When the hearing involves ~~action or lack of action by~~ a managed care plan, the provisions of paragraphs (E)(1), (E)(2), (E)(4), and (E)(5) of this rule shall apply to the managed care plan, its subcontracting providers, and all relevant records.

(F) Subpoenas

(1) Both the local agency and the individual or authorized representative may request in writing, at least five calendar days prior to the date of the state hearing, that ODJFS issue a subpoena to compel the presence of documents and witnesses that would not otherwise be available and that are essential to the requesting party's case.

(2) The hearing authority shall make the determination as to whether such subpoenas shall be issued and whether subpoenaed individuals shall participate in person or by telephone. If a subpoena request is denied, the reason for denial shall be clearly explained in the state hearing decision.

(3) Subpoenas shall be served by mail. The payment of witness fees for attendance and travel is not required.

(4) When the hearing involves ~~action or lack of action by~~ a managed care plan, the managed care plan shall have the same subpoena rights as the local agency.

(G) Transportation

The local agency may provide transportation to the individual through a social services contract where a valid need for transportation exists.

(H) Translations of hearing decisions

If an individual or authorized representative requests that a hearing decision be translated, the bureau of state hearings shall provide a translation in accordance with the "Ohio Department of Job and Family Services Language Access Policy" (rev. 4/3/2008) at http://jfs.ohio.gov/civilrights/pdf/LEP_Policy_12.pdf.

(I) Interpreters for hearings

If an individual or authorized representative has limited proficiency in English or communicates using sign language, the local agency shall provide an interpreter for the individual or authorized representative, at the request of the individual, authorized representative, or hearing authority. The bureau of state hearings will work with all local agencies to insure interpreter services at a reasonable cost to the local agencies when it comes necessary to utilize such services.

(J) Group hearings

(1) The bureau of state hearings may respond to a series of individual state hearing requests by scheduling a single group hearing. Requests may be consolidated only when individual issues of fact are not disputed and where related issues of state or federal law are the sole issues being raised.

(2) In all group hearings, the rules governing individual hearings must be followed. Each individual shall be permitted to present his or her own case or have his or her case presented by an authorized representative.

(3) Individuals scheduled for a group hearing shall be notified of the group hearing procedures via the JFS 04059, along with the scheduling notice.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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5101:6-6-01 **State hearings:- scheduling and attendance.**

(A) Time and place of the hearing

(1) The hearing shall be conducted at a reasonable time, date, and place. The hearing will usually be conducted at the local agency, since it is usually most convenient to the individual. However, there may be circumstances which warrant conducting the hearing at another time, date, or place. In these cases, efforts shall be made to schedule the hearing at a time, date, and place convenient to all parties involved.

(a) The bureau of state hearings may elect to have the hearing officer participate via video conference, with the appellant and the county representatives participating at the local agency.

(b) Documents shall be provided to the hearing officer for inclusion in the record in accordance to the requirements for telephone hearings as set forth in rule 5101:6-6-04 of the Administrative Code.

(c) State hearings conducted via video conference shall be considered face to face hearings.

(2) When a hearing request can be identified as involving a prevention retention and contingency (PRC) program issue, dealing with an emergent need, or a denial of expedited food assistance, the hearing shall be scheduled and conducted more quickly than other requests, if necessary, so that the decision can be issued within the thirty-day period specified in rule 5101:6-7-01 of the Administrative Code.

(3) The hearings section shall expedite food assistance hearing requests from assistance groups, such as migrant farm workers, that plan to move from the county before the hearing decision would normally be issued.

(a) Hearing requests from these assistance groups shall be scheduled and conducted more quickly than other requests, if necessary, to enable them to receive a decision, and a restoration of benefits if appropriate, before they leave the county.

(b) To qualify, the assistance group must submit, in writing if possible, its planned date of move. When this information is provided in an oral request, the local agency shall put the information in writing and forward

it to the district hearings section with the hearing request, if possible, or immediately upon receipt.

(4) Hearings involving the determination of the community spouse resource allowance shall be conducted within thirty days of the date of the hearing request. This requirement shall not prevent the granting of otherwise appropriate postponements and continuances.

(5) When the hearing is conducted at the local agency, the local agency shall provide adequate accommodations where the hearing can be conducted in privacy, with the proper decorum, and with a minimum of distractions.

(B) The bureau of state hearings shall send written notice of the time, date, and place of the hearing to the individual and authorized representative, to the local agency, and to the medical determination units identified in paragraph (C)(1) of this rule, who may be participating, via use of a notice describing the date, place, and time of the state hearing.

(1) A copy of the scheduling notice shall be retained and included in the hearing record.

(2) This notice shall be mailed at least ten calendar days prior to the date of the hearing, unless the appellant or authorized representative requests less advance notice in order to expedite scheduling. Expedited hearings may be granted at the discretion of the hearing authority.

(3) When the hearing request involves ~~action or lack of action by~~ a managed care plan, copies of the scheduling notice shall be sent to the managed care plan and upon request to the Ohio department of medicaid, ~~bureau of managed care.~~

(4) The scheduling notice shall:

(a) Provide the name, address and telephone number of the person to notify if the individual cannot attend the hearing.

(b) Explain that the hearing request will be dismissed if the appellant or authorized representative fails, without good cause, to appear for the hearing.

(c) Explain state hearing procedures and provide other information necessary for the individual's understanding of the proceedings and the effective presentation of his or her case.

(d) Explain that the appellant or representative may examine the case file prior to the hearing.

(C) Attendance

(1) Attendance at the hearing is limited to the following:

(a) The agency representative.

(b) The individual and/or authorized representative.

(c) Legal representation for the individual and for the agency.

(d) Witnesses called by the individual and the agency to present relevant testimony.

(e) Other persons, only if the individual agrees and if their attendance does not interfere with the orderly conduct of the hearing.

(2) When the hearing involves one of the medical determination issues listed in this paragraph, the agency representative shall be an employee of the medical determination unit or agency, or an agent of that office.

(a) Medical determination issues include the following:

(i) Prior authorization for medical services.

(ii) Need for long-term care.

(iii) Determination of disability and incapacity.

(iv) Precertification of hospital admissions and medical procedures.

(v) Preadmission screening and resident review (PASRR) determinations made by the Ohio department of mental health and addiction services and the Ohio department of developmental disabilities.

(vi) Coordinated services program (CSP) issues, including enrollment, continued enrollment, denial of a requested designated provider change, and denial of payment for services by a nondesignated provider.

(vii) Home and community-based services (HCBS) waiver determinations.

(viii) County board of developmental disabilities actions.

(b) The medical determination unit shall participate in the hearing, either in person or by telephone.

(c) If the medical determination unit is to participate in the hearing by telephone, such participation shall be as described in rule 5101:6-6-04 of the Administrative Code.

(3) When the hearing involves ~~action or lack of action by~~ a managed care plan, a representative of the managed care plan shall participate in the hearing as the agency representative.

The managed care plan representative shall participate in the hearing either in person or by telephone.

If the managed care plan representative is to participate in the hearing by telephone, such participation shall be as described in rule 5101:6-6-04 of the Administrative Code.

(4) Any disputes regarding attendance shall be resolved by the hearing officer prior to the hearing.

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Five Year Review (FYR) Dates:

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5101:6-7-03 **State hearings: implementation of the hearing decision.**

(A) Responsibility

(1) When the hearing decision orders action to be taken by the agency, the agency that is ordered to take the action is responsible for promptly and fully implementing the decision.

(2) State hearings is responsible for monitoring timely compliance with decisions.

(3) When the hearing decision orders action to be taken by a managed care plan, the managed care plan is responsible for promptly and fully implementing the decision.

The ~~bureau of managed care~~, Ohio department of medicaid (ODM)~~,~~ is responsible for timely compliance with decisions involving compliance by a managed care plan.

(B) Promptness

(1) Decisions that order action favorable to the individual

(a) For decisions involving public assistance, social services or child support services, compliance shall be achieved within fifteen calendar days from the date the decision is issued, but in no event later than ninety calendar days from the date of the hearing request.

(b) For decisions involving food assistance, any increase in benefits must be reflected in the food assistance allotment within ten calendar days of receipt of the decision, even if the local agency must provide a supplement, outside the normal issuance cycle.

The local agency may take longer than ten days if it elects to make the decision effective in the assistance group's normal issuance cycle, provided that issuance will occur within sixty calendar days of the date of the hearing request. If the local agency elects to follow this procedure, the benefit increase may be reflected in the normal issuance cycle or with a supplementary issuance.

~~(c) When the hearing has been requested in response to the simultaneous proposal of public assistance and food assistance adverse actions,~~

~~compliance shall be achieved according to public assistance timeliness standards.~~

~~(d)~~(c) Compliance shall be promptly reported to the bureau of state hearings, via a notice certifying the agency's compliance with the state hearing decision, and accompanied by appropriate documentation substantiating compliance is met.

When the hearing decision orders action to be taken by a managed care plan or a "MyCare Ohio" plan, ~~the managed care plan~~ each shall also send a copy of the notice certifying the agency's compliance with the state hearing decision, to ODM~~, bureau of managed care~~.

(2) Decisions that authorize action adverse to the individual

(a) The agency shall implement the decision promptly, if still appropriate.

(b) When the adverse action results in a decrease in the assistance group's food assistance benefits, the decrease shall be reflected in the next issuance cycle following receipt of the hearing decision.

(C) Date compliance is achieved

(1) For decisions involving public assistance, social services or child support services, compliance shall be considered achieved on the date eligibility, payment, or services are authorized or other action ordered by the hearing decision is taken.

(2) For decisions involving food assistance, compliance shall be considered achieved on the date the action is reflected in the assistance group's food assistance allotment.

(D) Underpayments/underissuances

(1) When the decision determines that the individual has been improperly denied benefits or has received fewer benefits than were due, any underpayments must be corrected in accordance with rules 5101:1-23-60, 5101:1-5-50 and/or 5101:4-8-03 of the Administrative Code.

(2) The local agency shall restore food assistance benefits to assistance groups that are leaving the county before the departure whenever possible. If benefits are not restored prior to departure, the local agency shall forward an authorization of the benefits to the assistance group or to the new county if this information is known.

The new county shall accept an authorization and issue the appropriate benefits whether the notice is presented by the assistance group or received directly from another county.

(E) Overpayments/overissuances

(1) Overpayments related to the appeal are subject to collection in accordance with rule 5101:1-23-70 of the Administrative Code.

(2) When the appeal involves food assistance, a claim against the assistance group for any overissuance related to the appeal must be prepared in accordance with rule 5101:4-8-15 of the Administrative Code.

(F) Prior authorization issues

(1) When a hearing decision reverses a denial of prior authorization for medical service and authorizes the service, the approval unit shall approve the prior authorization, using the normal prior authorization procedure. The approval notification sent to the provider shall be accompanied by a copy of the hearing decision.

(2) When a hearing decision reverses a denial of prior authorization for additional therapeutic leave days for a medicaid recipient with a developmental disabilities (DD) level of care in a long-term care facility, the bureau of state hearings shall send a copy of the decision to the long-term care facility. The hearing decision constitutes authorization for the additional leave days.

(G) Precertification issues

When a hearing decision changes a review agency's decision on a request for precertification of a hospital admission or medical procedure, the bureau of state hearings shall send a copy of the decision and a notice certifying the agency's compliance with the state hearing decision to the review agency.

The review agency shall certify those hospital days or medical procedures authorized by the decision using the normal precertification procedure, complete the notice certifying the agency's compliance with the state hearing decision, and send it to state hearings.

(H) Coordinated services program (CSP) issues

When a hearing decision changes a decision by the recipient monitoring and review section concerning proposed or continued enrollment in the CSP or denial of a request for a change of designated provider, the bureau of state hearings shall send a copy of

the decision to the recipient monitoring and review section. The recipient monitoring and review section shall take the actions ordered by the decision, complete the notice certifying the agency's compliance with the state hearing decision, and send it to state hearings.

(I) Preadmission screening resident review (PASRR) issues

When a hearing decision changes a preadmission screening (PAS) or resident review (RR) determination made by the Ohio department of mental health and addiction services or the Ohio department of developmental disabilities, the hearing decision shall constitute the revised PAS or RR determination.

Effective:

Five Year Review (FYR) Dates:

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Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5101.35, 3125.25
Rule Amplifies:	3125.25, 5167.13, 5164.758, 5160.011, 5101.35
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