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): MyCare Ohio Rules – Revisions to align with MyCare Ohio policy.

Rule Number(s):

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

Informational Only: 5160-58-01, 5160-58-02.2, 5160-58-03.2, 5160-58-04

Date of Submission for CSI Review: 11/21/2023

Public Comment Period End Date: 11/28/2023

Rule Type/Number of Rules:

New/ rule — **No Change/____ rules (FYR? ___)**

Amended/ 1 rules (FYR? Yes) — **Rescinded/ rules (FYR? Yes)**

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 (i.e., members receive both Medicaid and Medicare services).

OAC rule 5160-58-08.4, entitled "Appeals and grievances for "MyCare Ohio."" This rule establishes the appeals and grievance processes for the MyCare Ohio program. Minor updates are being proposed to clarify MyCare Ohio Plan requirements regarding grievance and appeal resolution extensions.

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.**

Revised Code Sections 5164.02, 5166.02, and 5167.02 authorize ODM to adopt these rules, and 5164.02, 5164.91, 5166.02, 5166.16, and 5167.02 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 CFR Part 438 imposes comprehensive requirements on the state regarding Medicaid managed care programs, however the proposed changes to the rule are not related to changes to federal regulation. 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 implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

Federal regulations do not impose requirements directly on MCOs; instead they require state Medicaid agencies to ensure MCO compliance with federal standards. The rules ensure MCO compliance with federal regulation and 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)?**

OAC rule 5160-58-08.4 is necessary for various reasons. Federal regulations require state Medicaid agencies to ensure MCO compliance with federal standards, therefore this rule ensures ODM compliance with federal regulations governing Medicaid managed care programs. The public purpose of this regulation is to:

- Ensure the provision of medically necessary services, preventative care, emergency services, and post stabilization services to promote the best outcomes for individuals enrolled in the Medicaid managed care program by requiring MCOPs to follow established guidelines and to ensure providers are paid appropriately for services delivered; and
- Ensure members' rights and protections.

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.

The MCOPs listed below were provided the draft rules electronically on 8/28/2023. These MCOPs were provided with updated versions of the draft rules electronically on 9/22/2023.
- UnitedHealthcare Community Plan of Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- CareSource Ohio, Inc.
- Aetna Better Health Ohio, Inc.
- Buckeye Community Health Plan

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

ODM did not receive any feedback from the stakeholders listed above.

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 these rules or the measurable outcomes of the rules.

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? *Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.***

No alternative regulations were discussed during the updating of OAC rule 5160-58-08.4. The regulations in OAC rule 5160-58-08.4 are necessary to ensure that the MyCare program's appeals and grievance resources are accessible to members and to enforce MCOP compliance with ODM appeals and grievance processes. The amendments to be proposed for OAC rule 5160-58-08.4 implement minor changes to MCOP notice requirements.

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

All Medicaid regulations governing managed care organizations are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the

Medicaid managed care program. ODM has reviewed its rules and regulations in the Ohio Revised Code and Ohio Administrative Code, and confirmed that the requirements found in 5160-58-08.4 are not duplicated elsewhere.

14. **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, BIAs, and filings affecting managed care program requirements with the Joint Committee on Agency Rule Review including RuleWatch Ohio and the CSIO eNotification System. ODM will ensure MCOPs are made aware of any future rule changes via established communication processes.

Adverse Impact to Business

15. **Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:**

    a. Identify the scope of the impacted business community, and

    This rule impacts the MyCare Ohio plans in the State of Ohio (Aetna Better Health Ohio, Buckeye Community Health Plan, CareSource Ohio, Molina Healthcare of Ohio, and UnitedHealthcare Community Plan of Ohio).

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

    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.

OAC rule 5160-58-08.4 establishes the appeals and grievance processes for the MyCare Ohio program. This rule requires MCOPs to report information as a condition of compliance, including the following items:

- Providing members with a Notice of Action (NOA) when there is an adverse benefit determination;
- Acknowledging receipt of member grievances and notifying members of grievance resolutions;
- Acknowledging receipt of member NOA appeals and notifying members of appeal resolutions;

- Notifying members of their right to request a state hearing; Notifying members of expedited appeal denials;
- Notifying members of grievance and appeal resolution extensions;
- Completing required forms related to grievances, appeals, or state hearings, when applicable.

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 capitation rates for the MCOs and MCOPs 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 2021, the administrative component of the managed care capitation rate varies by program/population and ranges from 3.0% to 6.0% for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates.

16. **Are there any proposed changes to the rules that will <u>reduce</u> a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).***
    Not Applicable.

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

MCOPs are aware of federal requirements for covered services prior to seeking and signing contracts with the state. More importantly, without the requirements outlined in OAC rule, the State would be out of compliance with federal regulations.

<u>Regulatory Flexibility</u>

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 negatively impacted by these rules, MCOPs may contact ODM directly through their assigned Contract Administrator.

DRAFT - NOT FOR FILING

5160-58-01 MyCare Ohio plans: definitions.

(A) The definitions set forth in rule 5160-26-01 of the Administrative Code apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code.

(B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code, the following definitions apply to Chapter 5160-58 of the Administrative Code:

(1) "Assessment" means a comprehensive evaluation of an individual's medical, behavioral health, long-term services and supports, and social needs. Results of the assessment process are used to develop the integrated, individualized care plan, inclusive of the waiver services plan.

(2) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (October 1,2021).

(3) "Dual benefits member" or "opt-in member" means a member for whom a MyCare Ohio plan is responsible for the coordination and payment of both medicare and medicaid benefits.

(4) "Financial management service (FMS)" means a support that is provided to waiver participants who direct some or all of their waiver services. When used in conjunction with the employer authority, this support includes, but is not limited to, operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes, but is not limited to, paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.

(5) "Health and welfare" means a requirement that necessary safeguards are taken to protect the health and welfare of individuals enrolled in a home and community-based services (HCBS) waiver. It includes the following:

(a) Risk and safety planning and evaluations;

(b) Critical incident management;

(c) Housing and environmental safety evaluations;

(d) Behavioral interventions;

(e) Medication management; and

(f) Natural disaster and public emergency response planning.

(6) "Home and community-based services (HCBS)" means services available to individuals to help maintain their health and safety in a community setting in lieu of institutional care as described in 42 C.F.R. 440 subpart A (October 1, 2021).

(7) "Individual care plan" means an integrated, individualized, person-centered care plan developed by the member and his or her MyCare Ohio plan's trans-disciplinary care management team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.

(8) "Medicaid only member" or "opt-out member" means a member for whom a MyCare Ohio plan is responsible for coordination and payment of medicaid ~~benefits.~~benefits, and, upon request, responsible

to assist with coordination of medicare benefits.

(9) "MyCare Ohio plan (MCOP)" means a health insuring corporation (HIC) contracted to comprehensively manage medicaid benefits for medicare and medicaid eligible members, including HCBS. An MCOP is also a managed care organization as defined in rule 5160-26-01 of the Administrative Code. For the purpose of this chapter, an MCOP does not include entities approved to operate as a program for the all-inclusive care of the elderly (PACE) site as defined in rule 5160-36-01 of the Administrative Code.

(10) "Nursing facility-based level of care" means the intermediate and skilled levels of care, as described in rule 5160-3-08 of the Administrative Code.

(11) "Participant direction" means the opportunity for a MyCare Ohio waiver member to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

(12) "Significant change event" is a change experienced by a member that warrants further evaluation. Significant changes include, but are not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective service agency; institutionalization; and when the waiver-enrolled individual has not received MyCare Ohio waiver services for ninety calendar days.

(13) "Trans-disciplinary care management team" means a team of appropriately qualified individuals comprised of the member, the member's family/caregiver, the MyCare Ohio plan manager, the waiver service coordinator, if appropriate, the primary care provider, specialists, and other providers, as applicable, that is designed to effectively meet the enrollee's needs.

(14) "Waiver services plan" is a component of the care plan that identifies specific goals, objectives and measurable outcomes for a waiver-enrolled member's health and functioning expected as a result of HCBS provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the individual. At a minimum, the waiver services plan shall include:

(a) Essential information needed to provide care to the member that assures the member's health and welfare;

(b) Signatures indicating the member's acceptance or rejection of the waiver services plan. If the member is unable to provide the signature when the services plan is initially developed, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the case manager; and

(c) Information that the waiver services plan is not the same as the physician's plan of care.

DRAFT - NOT FOR FILING

5160-58-02.2 MyCare Ohio waiver: eligibility and enrollment.

(A) To be eligible for enrollment in the MyCare Ohio waiver, a member must meet all of the following requirements:

(1) Be enrolled in the MyCare Ohio demonstration at the time of application for the MyCare Ohio waiver;

(2) Be determined to have a nursing facility-based level of care (i.e., intermediate or skilled) in accordance with rule 5160-3-08 or 5160-3-09 of the Administrative Code;

(3) In the absence of the MyCare Ohio waiver, require hospitalization or institutionalization in a nursing facility to meet his or her needs;

(4) ~~Be determined to require at least one waiver service monthly that is otherwise unavailable through another source (including the medicaid state plan) and in an amount sufficient to meet the member's assessed needs;~~The member:

(a) Has at least monthly monitoring of the member's health and welfare through a combination of telephonic and in-person contacts with the case manager as identified in the person-centered services plan, and

(b) Has at least one waiver service annually.

(5) Reside in a setting that possesses the home and community-based setting characteristics set forth in rule 5160-44-01 of the Administrative Code, and is not a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (October 1, 2020), residential care facility (except an assisted living facility as described in rule 173-39-02.16 of the Administrative Code), adult foster home or another group living arrangement subject to state licensure or certification.

(6) Sign an agreement prior to waiver enrollment confirming that the member has been informed of service alternatives, choice of qualified providers available in the MyCare Ohio plan's provider panel and the options of institutional and community-based care, and he or she elects to receive MyCare Ohio waiver services. If the individual is unable to sign the agreement prior to waiver enrollment, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the case manager; and

(7) Be able to have waiver services that can be identified in a person-centered services plan as described in rule 5160-44-02 of the Administrative Code that will safely meet his or her assessed needs.

(B) To be enrolled, and maintain enrollment in the MyCare Ohio waiver, a member must be determined by the MyCare Ohio plan to meet all of the following requirements:

(1) Be determined eligible for the MyCare Ohio waiver in accordance with paragraph (A) of this rule;

(2) Be able to have his or her health and welfare ensured through the waiver;

(3) Participate in the development and implementation of an integrated, individualized care plan that includes a person-centered services plan in accordance with the process and requirements set forth in rule 5160-44-02 of the Administrative Code, and sign and date the plan as a condition of its acceptance. If the individual is unable to sign the plan when initially developed, the individual will submit an

electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the case manager;

(4) Agree to receive waiver service coordination from the MyCare Ohio plan or its designee; and

(5) Agree to participate in quality management and evaluation activities during his or her enrollment on the MyCare Ohio waiver.

(C) If a member fails to meet any of the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, the member shall be denied enrollment on the MyCare Ohio waiver.

(D) Once enrolled in the MyCare Ohio waiver, a member's level of care shall be reassessed at least annually, and more frequently if there is a significant change in the member's situation that may impact his or her health and ~~welfare.~~welfare, including when the member is admitted to a hospital for inpatient services. If the reassessment determines the member no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, he or she shall be disenrolled from the MyCare Ohio waiver.

(E) If a member enrolled in the MyCare Ohio waiver who requires monthly waiver service does not receive at least one waiver service for ninety consecutive days, the MyCare Ohio plan shall, within ten days of the ninetieth day, reassess the member's need for waiver services. If it is determined the member no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, he or she shall be disenrolled from the MyCare Ohio waiver.

(F) If, at any other time, it is determined that a member enrolled in the MyCare Ohio waiver no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, or fails to meet the member responsibilities set forth in rule 5160-58-03.2 of the Administrative Code, he or she shall be disenrolled from the MyCare Ohio waiver.

(G) If a member is denied enrollment in the MyCare Ohio waiver pursuant to paragraph (C) of this rule, or is disenrolled from the waiver pursuant to paragraph (D), (E) or (F) of this rule, the member will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

TO BE RESCINDED

5160-58-03.2 **MyCare Ohio waiver: member choice, control, responsibilities and participant direction.**

A member and/or an authorized representative who is acting on behalf of a member (hereinafter "member") who is enrolled in the MyCare Ohio waiver in accordance with rule 5160-58-02.2 of the Administrative Code has choice and control over the arrangement and provision of home and community-based services (HCBS). Members also have choice over the selection and control over the direction of approved waiver service providers.

(A) A member may choose to receive MyCare Ohio waiver services from any combination of providers on the provider panel of the MyCare Ohio plan selected by the member pursuant to paragraph (B) of rule 5160-58-04 of the Administrative Code.

(B) A member receiving waiver services from any MyCare Ohio waiver provider shall:

(1) Participate with the waiver service coordinator in the development of the person-centered services plan as defined in rule 5160-44-02 of the Administrative Code.

(2) Decide who from their trans-disciplinary care management team will participate in the face-to-face development of the person-centered services plan.

(3) Communicate to the service provider and, as appropriate, the provider's management staff, personal preferences about the manner in which duties, tasks and procedures are to be performed.

(4) Work with the waiver service coordinator and the provider to identify and secure additional service provider orientation, training and/or continuing education within the provider's scope of practice in order to meet the member's specific needs.

(5) Not direct the provider to act in a manner that is contrary to any relevant MyCare Ohio waiver requirements, medicaid rules and regulations, or the provider's policies and procedures.

(6) Understand the incident management and reporting responsibilities of the member as set forth in rule 5160-58-05.3 or 5160-44-05 of the Administrative Code.

(7) Communicate to the waiver service coordinator and/or MyCare Ohio plan care manager any significant changes, as defined in rule 5160-58-01 of the

Administrative Code, that may affect the provision of services or result in a need for more or fewer hours of service.

(8) Sign a complete and accurate timesheet or other documentation, as appropriate, to verify services have been furnished. The member shall never approve blank timesheets, or timesheets that have been completed before services have been furnished. Verification may be written or electronic at the discretion of the MyCare Ohio plan, unless otherwise required by rule 5160-1-40 of the Administrative Code. If the individual is unable to provide the signature required to verify a service at the time of the service, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the provider.

(9) Participate in the recruitment, selection and dismissal of providers in collaboration with the trans-disciplinary care management team.

(10) In the manner specified by the waiver service coordinator, notify the provider if the member is going to miss a scheduled visit.

(11) Notify the waiver service coordinator if the assigned provider misses a scheduled visit.

(12) Notify the waiver service coordinator when any change in provider is necessary. Notification shall include the desired end date of the current provider.

(13) Participate in the monitoring of the performance of the provider.

(C) If a member chooses to receive waiver services from any non-agency provider, or is exercising participant-direction over the services in paragraph (F) of rule 5160-58-04 of the Administrative Code using one or more participant-directed individual providers or participant-directed personal care providers, the following additional requirements shall apply as appropriate to the service being furnished:

(1) In accordance with paragraph (B)(9) of this rule, members shall take a proactive role in the delivery of their MyCare Ohio waiver services. This includes identifying prospective providers, recruiting and training MyCare Ohio providers to furnish tasks in accordance with the member's needs and preferences, and working with the MyCare Ohio care manager or waiver service coordinator to schedule and manage the delivery of authorized MyCare Ohio waiver services.

(2) The member shall designate a location in their home in which the member and, as appropriate, the provider can safely store a copy of the member's records in

a manner that protects the confidentiality of the records, and for the purpose of contributing to the continuity of the member's care.

(3) The member or, as appropriate, the provider shall make the member's records available upon request by the MyCare Ohio plan, the Ohio department of medicaid (ODM) and/or ODM's designee.

(4) The member shall not aid the provider in furnishing a service in a manner that does not comply with any rule or law that regulates the provider.

(5) Members who exercise participant-direction of providers under the MyCare Ohio waiver shall work with ODM's designated financial management service.

(D) If the member elects to receive services from a participant-directed provider, the waiver service coordinator shall assess the member's strengths and weaknesses (and if the member has an authorized representative, the authorized representative's strengths and weaknesses) and ability to direct a provider. The waiver service coordinator shall allow the member to direct a provider if the waiver service coordinator determines that the member demonstrates the following:

(1) An understanding of the elements of the service the provider shall furnish;

(2) An understanding of how to direct the provider; and

(3) An ability to perform the responsibilities of an employer, including:

(a) Completion of any training required by ODM or the MyCare Ohio plan;

(b) Understanding which service activities are covered according to rule 5160-58-04 of the Administrative Code;

(c) Understanding the methods for selecting and dismissing participant-directed service providers including the requirements for providers to furnish services in the MyCare Ohio waiver;

(d) Understanding the methods for entering into written agreements with participant-directed service providers for specific activities;

(e) Understanding the methods for training participant-directed service providers to meet the member's specific needs;

(f) Understanding the methods for supervising and monitoring the participant-directed service provider's performance of specific activities, including written approval of the provider's time sheets;

(g) Development of a back-up plan if a provider is unable to furnish the agreed-upon service;

(h) Understanding the methods for filing grievances, including use of the regional and state long term care ombudsman;

(i) Familiarity with the MyCare Ohio plan grievance process and the state appeal and fair hearing request procedures;

(j) Understanding and compliance with the state's record-retention requirements; and

(k) An ability to manage the participant-directed service provider when he or she furnishes a service.

(E) If the waiver service coordinator determines that the member cannot meet the requirements set forth in paragraph (C) or (D) of this rule, as appropriate, the waiver service coordinator may require the member to appoint an authorized representative to assist the member with directing services.

(F) If the waiver service coordinator, in consultation with the trans-disciplinary care management team, determines that the member and/or the member's authorized representative cannot meet the requirements set forth in paragraph (C) or (D) of this rule, or the health and welfare of the member receiving services from a non-agency or participant-directed provider cannot be ensured, the waiver service coordinator may require the member to receive services from only agency providers. The member will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	null
Rule Amplifies:	null

DRAFT - NOT FOR FILING

5160-58-03.2 MyCare Ohio waiver: member choice, control, responsibilities and participant direction.

(A) A member may choose to receive MyCare Ohio waiver services from any combination of providers on the provider panel of the MyCare Ohio plan selected by the member pursuant to paragraph (B) of rule 5160-58-04 of the Administrative Code.

(B) A member receiving waiver services from any MyCare Ohio waiver provider will:

(1) Participate with the waiver service coordinator in the development of the person-centered services plan as defined in rule 5160-44-02 of the Administrative Code.

(2) Decide who from their trans-disciplinary care management team will participate in the development of the person-centered services plan.

(3) Communicate to the service provider and, as appropriate, the provider's management staff, personal preferences about the way duties, tasks and procedures are to be performed.

(4) Work with the waiver service coordinator and the provider to identify and secure additional service provider orientation, training and/or continuing education within the provider's scope of practice to meet the member's specific needs.

(5) Not direct the provider to act in a manner that is contrary to any relevant MyCare Ohio waiver requirements, medicaid rules and regulations, or the provider's policies and procedures.

(6) Understand the incident management and reporting responsibilities of the member as set forth in rule 5160-44-05 of the Administrative Code.

(7) Communicate to the waiver service coordinator and/or MyCare Ohio plan care manager any significant changes, as defined in rule 5160-58-01 of the Administrative Code, that may affect service provision or result in a need for more or fewer hours of service.

(8) Sign a complete and accurate timesheet or other documentation, as appropriate, to verify services have been furnished. The member will never approve blank timesheets, or timesheets that have been completed before services have been furnished. Verification may be written or electronic at the discretion of the MyCare Ohio plan, unless otherwise required by rule 5160-1-40 of the Administrative Code. If the individual is unable to provide the signature required to verify a service at the time of the service, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the provider.

(9) Participate in the recruitment, selection and dismissal of providers in collaboration with the trans-disciplinary care management team.

(10) In the manner specified by the waiver service coordinator, notify the provider if the member is going to miss a scheduled visit.

(11) Notify the waiver service coordinator if the assigned provider misses a scheduled visit.

(12) Notify the waiver service coordinator when any change in provider is necessary. Notification will include the desired end date of the current provider.

(13) Participate in the monitoring of the performance of the provider.

(14) Understand and abide by the rules governing the MyCare Ohio program.

(C) Members who choose to exercise participant-direction for their waiver services, as outlined in paragraph (F) of rule 5160-58-04 of the Administrative Code will have the following additional requirements as appropriate to the service being furnished:

(1) Take a proactive role in the delivery of their MyCare Ohio waiver services. This includes identifying and recruiting prospective providers, training on tasks to meet the member's needs and preferences, and scheduling and managing the delivery services.

(2) Designate a location in their home in which the member and, as appropriate, the provider can safely store a copy of the member's records in a manner that protects the confidentiality of the records, and for the purpose of contributing to the continuity of the member's care.

(3) Work with ODM's designated financial management service and the waiver service coordinator and/or MyCare Ohio care manager to coordinate the authorized service delivery.

(D) Members who elect participant-directed services will demonstrate the ability and willingness to:

(1) Understand the service elements the provider furnishes;

(2) Understand how to direct the provider; and

(3) Perform employer-related responsibilities, including:

(a) Completing required training;

(b) Select and dismiss participant-directed service providers;

(c) Enter into written agreements with participant-directed service providers for specific activities;

(d) Train participant-directed service providers to meet the member's specific needs;

(e) Supervise and monitor the participant-directed service provider's performance of specific activities, including written approval of the provider's time sheets;

(f) Manage the participant-directed service provider when they furnish a service.

(E) If the waiver service coordinator, in consultation with the trans-disciplinary care management team, determines that the member and/or the member's representative cannot meet the requirements set forth in paragraph (C) or (D) of this rule, or the health and welfare of the member cannot be ensured, the waiver service coordinator may require the member to receive services from agency or non-agency providers. The member will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-58-04 MyCare Ohio waiver: covered services and providers.

(A) The purpose of this rule is to establish both the services covered by the MyCare Ohio home and community based services (HCBS) waiver program and the providers eligible to furnish those services to members enrolled in the MyCare Ohio waiver.

(B) Providers seeking to furnish services in the MyCare Ohio waiver program shall meet the requirements in Chapter 173-39, 5160-45 or 5160-44 of the Administrative Code, as appropriate. Prior to furnishing services to MyCare Ohio waiver recipients, the services must be documented on the member's person-centered services plan as described in rule 5160-44-02 of the Administrative Code.

(C) MyCare Ohio waiver covered services are limited to the following and exclude any reimbursement provisions in the Ohio Administrative Code rules cited therein:

(1) Adult day health services as set forth in rule 173-39-02.1 or 5160-46-04 of the Administrative Code;

(2) Alternative meal services as set forth in rule 173-39-02.2 of the Administrative Code;

(3) Assisted living services as set forth in rule 173-39-02.16 of the Administrative Code;

(4) Choices home care attendant services as set forth in rule 173-39-02.4 of the Administrative Code except MyCare waiver providers are not required to submit task sheets to the Financial Management Service (FMS), as identified in rule 173-39-02.4 of the Administrative Code;

(5) Community integration services as set forth in rule 173-39-02.15 or 5160-44-14 of the Administrative Code;

(6) Community transition services as set forth in rule 173-39-02.17 or 5160-44-26 of the Administrative Code;

(7) Enhanced community living services as set forth in rule 173-39-02.20 of the Administrative Code.

(8) Homemaker services as set forth in rule 173-39-02.8 of the Administrative Code;

(9) Home care attendant services as set forth in rule 173-39-02.24 or 5160-44-27 of the Administrative Code;

(10) Home delivered meal services as set forth in rule 173-39-02.14 or 5160-44-11 of the Administrative Code;

(11) Home maintenance and chore services as set forth in rule 173-39-02.5 or 5160-44-12 of the Administrative Code.

(12) Home medical equipment and supplemental adaptive and assistive devices services as set forth in rule 173-39-02.7 or 5160-46-04 of the Administrative Code;

(13) Home modification services as set forth in rule 173-39-02.9 or 5160-44-13 of the Administrative Code;

(14) Nutrition consultation services as set forth in rule 173-39-02.10 of the Administrative Code;

(15) Out-of- home respite services as set forth in rule 173-39-02.23 or 5160-44-17 of the Administrative Code;

(16) Personal care aide services as set forth in rule 173-39-02.11 or 5160-46-04 of the Administrative Code;

(17) Personal emergency response services as set forth in rule 173-39-02.6 or 5160-44-16 of the Administrative Code;

~~(18)~~ (18) ~~Pest control services as set forth in rule 173-39-02.3 of the Administrative Code;~~

~~(19)~~ (18) Social work counseling services as set forth in rule 173-39-02.12 of the Administrative Code;

~~(20)~~ (19) Waiver nursing services as set forth in rule 173-39-02.22 or 5160-44-22 of the Administrative Code; and

~~(21)~~ (20) Waiver transportation services as set forth in ~~rules 173-39-02.13 and~~ rule 173-39-02.18 or 5160-46-04 of the Administrative Code.

(D) If a member enrolled in the MyCare Ohio waiver is also a participant in the helping ohioans move, expanding (HOME) choice demonstration program pursuant to Chapter 5160-51 of the Administrative Code, the member may use the HOME choice community transitions service in lieu of, but not in addition to, the community transition service available through the MyCare Ohio waiver.

(E) If a member receives enhanced community living services, the member shall not also receive personal care or homemaker services available through the MyCare Ohio waiver.

(F) The following services may be participant-directed using budget and/or employer authority. To exercise these authorities, members must demonstrate the ability to direct providers in accordance with paragraph (D) of rule 5160-58-03.2 of the Administrative Code:

(1) Employer authority which includes, but is not limited to, the ability of the member to hire, fire, and train employees is available for the following services:

(a) Choices home care attendant services provided by a participant-directed individual provider; and

(b) Personal care services provided by a participant-directed personal care provider.

(2) Budget authority which includes the ability of the member to negotiate rates of reimbursement is available in the following services:

(a) Alternative meals;

(b) Choices home care attendant services;

(c) Home maintenance and chore services;

(d) Home modification services; and

(e) Home medical equipment and supplemental adaptive and assistive devices.

DRAFT - NOT FOR FILING

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

(A) Notice of action (NOA) by 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, 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.

(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.

(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.

(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; and

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

(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.

(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 extension, and include the following components in the notice: ~~reason for the extension and the date a decision shall be made.~~

~~-~~(i) The MCOP's reason for needing the extension;

~~-~~(ii) The date a decision will be made; and

~~-~~(iii) Inform the member of their right to file a grievance if the member disagrees with the extension.

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

(F) Access to state's hearing system.

(1) In accordance with 42 CFR 438.402 (October 1, 2022), 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 Entity" (ODM 04043).

(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 Entity" (ODM 04066).

(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 Entity" (ODM 04046).

(3) The member or the member's authorized representative may request a state hearing within 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 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 Entities" (ODM 01959) 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) 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). If the state hearing decision sustains the member's appeal, the MCOP shall submit the information required by the "Order of Compliance" (JFS 04068) 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.

(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.

(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.

DRAFT - NOT FOR FILING