DUE PROCESS FOR MEDICAID COVERED SERVICES POLICY

This policy establishes the Erie County Board of Developmental Disabilities (Board) to provide Due Process procedures for individuals who are requesting or receiving Medicaid covered services from the Erie County Board of Developmental Disabilities (Board) in accordance with Ohio Administrative Code (OAC) 5101:6-01 to 5101:6-09. This policy is in addition to the existing *Administrative Resolution of Complaints for Individuals* policy of the Board. It is established in accordance with section 5101.35 of the Ohio Revised Code (ORC) and as specified in OAC 5101:6-01 to 5101:6-09.

The Superintendent shall establish, revise, and keep current the procedures to be utilized in the implementation of this policy. The Superintendent/ designee shall ensure compliance with these procedures. All revisions and changes will be shared with the Board when made.

Superintendent Signature: Carrie Beier Date: 5/16/19

Implemented: 11/04

Board Approval: 11/04, 5/18/17, 5/16/19

Revised: 2/21/08, 5/19/11, 5/18/17, 5/14/19

Reviewed: 7/26/16, 5/18/17, 5/14/19

Cross Reference: Ohio Administrative Code (OAC): 5101:6-1-01, 5101:6-2-01 to 5101:6-2-09, 5101:6-3-02, 5101:6-4-01, 5101:6-5-3, 5123:2-1-12 Ohio Revised Code (ORC): 5101.35; Administrative Resolution of Complaints for Individuals Policy

ERIE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
DUE PROCESS FOR MEDICAID COVERED SERVICES PROCEDURE

I. APPLICATION

A. In addition to the Board *Administrative Resolution of Complaints for Individuals* policy, individuals who are receiving or requesting Medicaid covered service are afforded due process protections when services are proposed to be increased, denied, reduced, or terminated by the Board.

B. Although this procedure outlines a formalized process to resolve complaints, all individuals are encouraged to discuss concerns with involved parties to resolve issues as quickly as possible.

C. The provisions of this procedure shall apply to an individual applying for or enrolled in services provided pursuant to the Medicaid Home and Community Based Services (HCBS) Waiver (Individual Options, Level 1 and SELF). All such appeals of decisions of the Board shall be made to the Ohio Department of Job and Family Services (ODJFS) in accordance with applicable rules for appeals disseminated by ODJFS under OAC Rules 5101:6-2-01 to 5101:6-2-09.

D. Such individuals may appeal other decisions of the Board related to services or administrative practices of the Board other than HCBS waiver services using the applicable process (*Administrative Resolution of Complaints for Individuals* policy).

E. Medicaid services are to be based upon an assessed and medically related need for the service. The type, frequency, and implementation of the needed service are to be reflected in the service recipient's Individual Service Plan. This plan is developed and implemented upon written acceptance by the Medicaid eligible individual or his/her authorized representative. The plan development process allows for specific services to be identified and be adjusted as needs change. Adverse actions to increase, deny, reduce, or terminate specific services may be the result of assessment outcomes, professional opinion, and/or the service recipient request.

F. When Medicaid funded services are increased, denied, reduced, or terminated, the affected Medicaid eligible individual has the right to a state hearing if he/she wishes to appeal the decision. This right to a state hearing regarding the adverse action is guaranteed in the federal statutes that govern all Medicaid funded services. If the individual or his/her authorized representative does not provide written authorization for the change in services, notification must be sent prior to reducing services. There are exceptions to the requirement for prior notice of proposed adverse action. (See OAC Rule 5101:6-2-05.)

G. The individual or his/her authorized representative has ninety (90) calendar days from the mailing or delivery date of the notice in which to file an appeal. No reduction or termination of the service or service frequency or duration may occur without giving notice to the individual or his/her authorized representative no less than fifteen (15) calendar days prior to the effective date of the proposed action.

   1. The individual's assigned SSA shall be responsible to notify the affected individual of their due process. A copy of the notice will be maintained in the individual's file.
   2. Payment to the provider will continue if an appeal is received within fifteen (15) days. If no appeal is received, services will be denied, reduced, or terminated and payment will stop or be reduced in accordance with the proposed change. Payment will not be reinstated unless overturned in the appeal process in accordance with the Reinstatement of Services section of this policy. (See OAC Rule 5101:6-4-01.)

II. NOTIFICATION FORMS

A. When a request for an initial Medicaid covered service or a request to increase the frequency/duration of an existing Medicaid service is denied, the individual or his/her authorized representative must be given a ODJFS Form 7334, *Notice of Denial of Your Application For Assistance*. (See Attached)

B. When a decision has been made to suspend, reduce, or terminate a service being received or to reduce or change the frequency and/or duration of the service, an ODJFS Form 4065, *Prior Notice of Right to A State Hearing* must be issued. (See Attached)

C. When an individual plan is approved or there is an approval of an increase in the Medicaid service, ODJFS Form 4074, *Notice of Approval of Your Application for Assistance* must be issued. (See Attached)

D. Notification forms shall be provided to the individual or his/her authorized representative by the staff performing the Service and Support Administration (SSA) function for the Board.

III. REINSTATEMENT OF SERVICES

A. Rule 5101:6-4-01, paragraph C, of the Ohio Administrative Code provides that when the request for a state hearing is received by the state or local agency within ten (10) calendar days after the effective date of the adverse action, 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.

B. Determination of 'good cause' is the responsibility of the ODJFS hearing authority, which is the hearing supervisor in the ODJFS district office with jurisdiction over the county in which the individual lives. If good cause is found, the hearing authority will issue an order that services are to be reinstated. It is then the responsibility of ODJFS to assure that the service is reinstated and continued until the hearing decision is made. Service invoices would be submitted by the Medicaid provider to the Office of Medicaid Payment and Supports to recover costs related to the provision of the reinstated service.

C. The individual's assigned SSA shall be responsible to assure required forms are completed and delivered.

IV. GENERAL APPEAL PROCESS

A. Rule 5101:6-2-04 of Ohio Administrative Code requires that individuals currently receiving Medicaid covered services be given written notice of any proposed increase, denial, reduction, or termination of their services. Written prior notification of a proposed action must be made no less than fifteen (15) calendar days prior to the effective date of the adverse action. The Board will use ODJFS Forms 4065, 7334, and/or 4074 to make this notification. The notification may be sent electronically, by regular mail, or be hand delivered. The notice shall contain a clear and understandable statement of the action the Board intends to take, cite the applicable regulations, explain the individual's right to and the method of obtaining a county conference and a state hearing, explain the circumstances under which a timely hearing request will result in continued benefits, and contain a telephone number to call about free legal services.

B. The individual may request the hearing in writing or verbally to ODJFS. If the request is made verbally, the request shall be transcribed in written format by

the person whom the request is made. Requests made by telephone must be made by the individual. The individual has ninety (90) days to make the request.

C. The individual may also request a county conference in which the Director of Individual and Family Supports or designee and the individual and/or authorized representative discusses the compliant or issue and attempts a resolution.

D. Any action cannot be implemented until the hearing decision is issued if the affected individual requests a hearing within fifteen (15) calendar days from the mailing date (or receipt date if the prior notice is hand delivered) of the action notification.

E. ODJFS is responsible for coordinating all aspects of the hearing. In cases where the Board's decision is being appealed, the Board shall be responsible for the preparation of the 'Appeals Summary' and defending the decision in the hearing. The Director of Individual and Family Supports or designee will coordinate the defense of the Boards decision. A copy of the summary and all related material (inclusive of the certified letter receipt) is to be kept on file as part of the individuals record/file.

1. The 'Appeals Summary' shall be forwarded to ODJFS before the scheduled date of the hearing. The actual hearing is typically held via telephone conferencing. The appellant or designated representative is typically present with the local ODJFS caseworker and the other relevant parties participate in the conference call. The appellant presents the basis of the appeal during the hearing and the Board presents its justification or defense of its decision/action. The hearing decision is typically not made during the hearing. The decision shall be made known in a written document to all relevant parties at a later date.

V. AUTHORIZED REPRESENTATIVE

Rule 5101:6-1-01 of Ohio Administrative Code makes provision for a Medicaid recipient's case to be presented by the recipient, their legal or natural guardian or by an authorized representative, such as legal counsel, relative, friend, or other spokesperson. Rule 5101:6-3-02 of Ohio Administrative Code states that written authorization must accompany all requests made on an individual's behalf by an authorized representative. Attorneys may make a written hearing request on an individual's behalf without written authorization.

VI. ANNUAL NOTIFICATION

The Board shall give annual notification of the availability of the Administrative Resolution of Complaints Procedures to individuals and any entity in the county that serves persons or provides or desires to provide other goods or services under a contract with the county board. The Board shall post the toll-free number for the department and Ohio legal rights service in a visible place. The Board shall inform the individual that a representative of the Board is available to assist the individual with the administrative resolution procedures outlined in this procedure.

VII. CONFIDENTIALITY

The Board shall at all times maintain confidentiality concerning the identity of individuals, complainants, witnesses, and other involved parties who provide information unless the individual, in writing, authorizes the release of information.

Ohio Department of Job and Family Services

NOTICE OF DENIAL OF YOUR APPLICATION FOR ASSISTANCE

(Do not use to deny food assistance benefits, or to terminate cash or medical assistance)

Name	Assistance Group	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

We denied your _____ application dated _____

The people affected by this action are _____

The reason for this action is _____

The rules that require this action are _____

Caseworker	Worker I.D.	Telephone Number ( )

Your Right to a State Hearing

This notice tells you what we are doing on your case. Contact your caseworker if you do not understand this notice. We can explain it. We also may be able to change what we are doing.

IF YOU DISAGREE WITH THIS DECISION, ASK FOR A STATE HEARING

Ask for a State Hearing: You can ask for a state hearing, if you disagree with the County Department of Job and Family Services' (CDJFS) action or think the CDJFS may have made a mistake. If you want a hearing, the Ohio Department of Job and Family Services (ODJFS) must receive your request 90 days from the date this notice was mailed to you. If 90th day falls on a holiday or weekend, the deadline will be the next work day.

You can ask your local Legal Aid program for free help with your case. Contact your local Legal Aid office by phoning 1-866-LAW-OHIO (1-866-529-6446) or by searching the Legal Aid directory at http://www.ohiolegalservices.org/programs on the internet.

If someone is helping you with your case, ODJFS will need a signed "authorized representative" notice from you saying it's okay for that person to represent you for the hearing process.

AG Name	Case Number	Mailing Date

Step 1: Read, sign, date, and fill in your telephone number. Another person may sign this for you, if they send us your signed "authorized representative" notice.

Sign Here	Date	Telephone Number
		( )

Step 2: What is your hearing for? *(Check all that apply.)*

- ☐ OWF (cash assistance)
- ☐ Medicaid
- ☐ Medicaid Waiver Services
- ☐ Medicaid – Prior Authorization
- ☐ Disability Financial Assistance
- ☐ Child Care (Title XX)
- ☐ Medicaid – Disability Determination
- ☐ Provision, Retention, Contingency (PRC)
- ☐ Child Support (Title IV-D)
- ☐ Medicaid – Managed Care

Step 3: Fill out the information, as it applies to your situation.

- ☐ I want to do my hearing by telephone.
- ☐ I need an interpreter at my state hearing.
- ☐ My preferred days/times for a hearing are: _____
  (Please note: ODJFS may not be able to give you the preferred date.)
- ☐ I want a County Conference. (This is a meeting to discuss your case with your local agency.)
- ☐ This person has agreed to help me with my state hearing (my "authorized representative")

Name	Telephone Number
	( )
Address	Fax
	( )
City, State, Zip	Email

Step 4: ODJFS must receive your request 90 days from the date this notice was mailed to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us.

Please only submit your hearing request one time.

Email – Email the ODJFS Bureau of State Hearings at bsh@jfs.ohio.gov. In the subject, put "State Hearing Request". In the message, put all of the information from the boxes at the top of this page and from Steps 1, 2, and 3; or
Phone – Phone the ODJFS Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice; or
Fax – Fax both pages of this notice to the ODJFS Bureau of State Hearings at (614) 728-9574; or
Mail – Mail all pages of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.
Contact your caseworker – It is better to send this request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.

On the Day of the State Hearing: You, or someone else helping you with your case, can explain the reason(s) why you don't think the decision is right. ODJFS will explain its reasons. Then, an ODJFS hearing officer will make a decision after the hearing.

Ohio Department of Job and Family Services

PRIOR NOTICE OF RIGHT TO A STATE HEARING

Name	Case Name	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

We are proposing to make the following changes in your assistance. If you do not agree with this proposal and request a hearing by _____ this action will not be taken until the state hearing is decided. (For a full explanation of your hearing rights, see the back of this notice.)

Termination of Benefits:

☐The following benefits will be stopped:

☐Your _____ check will stop on _____.

☐Your Food Stamps will stop on _____.

☐Your _____ health card will stop on _____.

☐The following services will stop on _____.

Services:

Reduction of Benefits:

☐The following benefits will be reduced:

☐Your _____ check will be reduced from $_____ to $_____ on _____.

☐Your Food Stamps will be reduced from $_____ to $_____ on _____.

☐The following services will be reduced from _____ to _____ on _____.

Services:

☐The _____ allowance will be reduced from $_____ to $_____ on _____.

Suspension or Change in Benefits:

☐The following action will be taken:

☐Your Medicaid spend-down liability will be increased from $_____ to $_____ on _____.

☐Your Medicaid card will stop on _____ unless you continue to be eligible for a Medicaid card as a spend-down recipient. If you can prove to the county department of job and family services that you have $_____ of medical expenses each month, your card will be released to you.

☐Your _____ check for the month of _____ will be held and not mailed.

☐Your Medicaid card for the month of _____ will be held and not mailed.

☐Your _____ check will be suspended effective _____.

☐Your Medicaid card will be suspended effective _____.

☐Other (explain):

Keep Reading >>>>>>>>>>>>>>>>

Reason and Regulations Supporting this Action:

The reasons for this proposed action are:

The rules which require this action are:

If you do not understand this proposed action or you want to talk to your caseworker about it, you may call:

Caseworker	District/ID	Telephone Number

Your Right to a State Hearing

This notice is to tell you about action we are taking on your case. If you do not understand this action, you should contact your caseworker. After discussing the reasons for the action with your caseworker, it is possible that we will change our decision or that you will agree with the action.

If you do not agree with this action, you have a right to a state hearing. A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against the action. We will also attend or be represented at the hearing to present our reasons. A hearing officer from the Ohio Department of Job and Family Services will decide who is right.

If you want a hearing we must receive your hearing request within 90 days of the mailing date of this notice. You do not need to return this form if you agree with the action.

If we receive your request by , the action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay back benefits that your were not eligible to receive.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone.

If you want information on free legal services, but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

If you want a hearing, sign your name, and send this form to the Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

☐ I want a county conference and a state hearing on this action.

☐ I want a state hearing only.

Waiver of Continuing Benefits (Food Stamps Only)

☐ I agree to let the county department of job and family services go ahead with the food stamp action(s) now, even though I have requested a hearing.

I want a hearing.

Signature	Date	Telephone Number

Distribution: Original to client; one copy to case record

Ohio Department of Job and Family Services

NOTICE OF APPROVAL OF YOUR APPLICATION FOR ASSISTANCE

(Do not use to approve food stamp benefits)

Name	Assistance Group	
Street Address	Case Number	Program
City, State, and Zip Code	County	Mailing Date

We approved your _____ Application dated _____

Starting _____ you will get _____

The people affected by this action are _____

The reason for this action is _____

The rules that require this action are _____

Caseworker	Worker I.D.	Telephone Number

Your Right to a State Hearing

This notice tells you what we are doing on your case.

Contact your caseworker if you do not understand this notice. We can explain it. We also may be able to change what we are doing.

Ask for a State Hearing if you want to appeal

Ask for a State Hearing if you disagree with what we are doing or think we are making a mistake. At the state hearing, you can explain your reasons. We will explain our reasons. A hearing officer from the Ohio Department of Job and Family Services will make a decision after the hearing.

We must <u>receive</u> your request for a State hearing by this deadline _____ .

(Note: The deadline is 90 days after the Mailing Date at the top of this page. If a deadline falls on a Saturday, Sunday, or state or federal legal holiday, then the deadline is extended to the next workday.)

Follow the instructions on page 2 of this notice if you want to ask for a State Hearing.

Someone else may help you (a lawyer, social worker, friend, relative, etc.). They may ask for a hearing and go to the hearing for you if they send us your signed authorization.

You can ask your local Legal Aid program for free help with your case. Call the Ohio State Legal Services Association at 1-800-589-5888 (a free call) if you need your local phone number.

AG Name	Case Number	Mailing Date

State Hearing Request

If you disagree with what we are doing or think we are making a mistake, you may use this form to ask for a State Hearing.

Step 1 **If you would like to ask for a State Hearing, read, sign, date and fill in your phone number. Another person may sign this for you if they send us your signed authorization.**

I want a State Hearing because I disagree with what you are doing or think you are making a mistake on my case.

Sign	Date	Phone

Step 2 **Optional -- You may check boxes and fill in blanks to help us schedule your State Hearing.**

☐ I want a State Hearing about:

☐ Checks or cash assistance *(OWF, DFA, RSS, Refugee Cash Assistance, etc.)*

☐ Medical coverage *(Medicaid, Disability Medical, Alien Emergency Medical, Refugee Medical, etc.)*

☐ Other benefits *(PRC, Child Care, Child Support, Work Allowance, etc.)* _____

☐ I want a State Hearing because _____

☐ I need an interpreter, a signer, or other assistance, at my State hearing *(explain)* _____

☐ The days/times I cannot come to a State Hearing are _____

☐ I also want a County Conference *(a meeting with County Department of Job & Family Services staff)*

☐ This person has agreed to help me with my State Hearing *(my "authorized representative")*:

Name	Phone
Address	Fax
City, State and Zip Code	E-mail

Step 3 **You must choose <u>one</u> of the following ways to send this State Hearing request to us. We must <u>receive</u> this request by the deadline on previous page of this notice. You should keep proof of when and how you sent this hearing request to us.**

- **Mail** -- Mail both pages of this notice to ODJFS Bureau of State hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.
- **Fax** -- Fax both pages of this to ODJFS Bureau of State Hearings at (614) 728-9574.
- **E-mail** -- E-mail the ODJFS Bureau of State Hearings at <bsh@jfs.ohio.gov>. In the subject, put "State Hearing Request." In the message, put all the information from the boxes at the top of this page and from Steps 1 and 2.
- **Phone** -- Phone the ODJFS Consumer Access Line at 1-866-635-3748. Follow the instructions for State Hearings. Mention this notice.
- **Contact your caseworker** -- It is better to send your request using one of the other methods above. But, you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.