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 5101:6-08. 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 5101:6-08.

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: 2/17/22

Implemented: 11/04

Board Approval: 11/04, 5/18/17, 5/16/19, 5/20/21, 2/17/22

Revised: 2/21/08, 5/19/11, 5/18/17, 5/14/19, 5/20/21, 2/17/22

Reviewed: 7/26/16, 5/18/17, 5/14/19, 5/20/21, 2/17/22

Cross Reference: Ohio Administrative Code (OAC): 5101:6-1-01, 5101:6-2-01 to 5101:6-2-08, 5101:6-3-02, 5101:6-4-01; 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 A*dministrative Resolution of Complaints for Individuals* policy, individuals who are receiving or requesting a 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 5101:6-2-08.

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 Service and Support Administrator (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 the form titled Notice of Your Rights to Medicaid Due Process. (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, the form titled Notice of Your Rights to Medicaid Due Process.(See Attached)

C. When an individual plan is approved or there is an approval of an increase in the Medicaid service, the form titled Notice of Your Rights to Medicaid Due Process.(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 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 Service and Support Administrator (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 the Notice of Your Rights to Medicaid Due Process form to make this notification. The notification may be sent electronically or 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, verbally, or electronically 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. Requests made electronically must be made through the individual's created SHARE (State Hearing Access to Records Electronically) account. 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 individual's 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 authorized 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.

Erie County Board of Developmental Disabilities

Notice of Your Rights to Medicaid Due Process
(Modification of JFS 07334, JFS 04065, JFS 04074)

NAME _____ MAILING DATE _____

ADDRESS _____ TYPE OF WAIVER Select One

CITY _____ STATE _____ ZIP CODE _____

This letter is to inform you of actions that have occurred or are being proposed:

APPROVED: EFFECTIVE DATE: _____

Name of Service(s): _____

DENIED: EFFECTIVE DATE: _____

Name of Service(s): _____

TERMINATION/REDUCTION:
A Medicaid/waiver service you currently have will be Select One Effective Date: _____

Name of Service(s): _____

☐ This service will be reduced from _____ to _____

If you do not agree and request a hearing within 15 days of the mailing date, this action will not occur until a hearing is held and a decision is made. For a full explanation of your rights, see page two of this notice.

WAITING LIST:

Select One Effective Date: _____

If you do not agree, you must request a hearing within 90 days of the mailing date of this notice. If the 90th day falls on a holiday or weekend, the deadline will be the next workday.

The reason for this proposed action:

_____

_____

The rule(s) that require this action are:

_____

_____