Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 27, 2023

The proposed policy is an Emergency Rule. The proposed policy was presented at the September 6, 2022 and January 3, 2023 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on March 2, 2023 and the OHCA Board of Directors on March 22, 2023.

SUMMARY:
Transition to SoonerSelect - As directed by the Legislature, the Oklahoma Health Care Authority will transition to a new health care program, called SoonerSelect. The proposed policy changes will comply with Senate Bill 1337 (SB1337) and Senate Bill 1396 (SB 1396), by addressing the specific delivery reform requirements, defining terms and required notices, grievances and appeals processes and regulations outlined throughout the bills and the published Request for Proposal (RFP)/Model Contract, respectively. Other revisions will make other grammatical and formatting changes as needed.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Title 56 of the Oklahoma Statutes, Sections 4002-4004; Title 42 of the Code of Federal Regulations, Part 438

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 23-06A

A. Brief description of the purpose of the rule:

As directed by the Legislature, the Oklahoma Health Care Authority (OHCA) will transition to a new health care program, called SoonerSelect. The proposed policy changes will comply with Senate Bill 1337 (SB1337) and Senate Bill 1396 (SB 1396), by addressing the specific delivery reform requirements, defining terms, and required notices, grievances and appeals processes and regulations outlined throughout the bills and the published Request for Proposal (RFP)/Model Contract, respectively. Other revisions will make other grammatical and formatting changes as needed.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost

impacts received by the Agency from any private or public entities:

Certain SoonerCare members and providers, who will be involved in the SoonerSelect program, will be affected by the proposed rule. This rule should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule will benefit SoonerSelect members by ensuring they have access to a grievance and appeals system that fairly and efficiently reviews, and resolves identified issues.

The proposed rule will benefit SoonerSelect providers by ensuring providers have access to a provider complaint and appeals system that fairly and efficiently reviews, and resolves identified issues.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rule changes upon any classes of persons or political.

E. The probable costs and benefits to the Agency and to any other Agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The OHCA Board approved expenditure authority for the SoonerSelect RFP at the January 18, 2023 meeting. The goal of the SoonerSelect delivery model over the term of the contracts (first year, plus 5 renewal years) is budget neutrality.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact or require the cooperation of any political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule changes will not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act at this time.

H. An explanation of the measures the Agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The Agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule at this time. Measure included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should have a positive effect on the public health, safety, and environment. If OHCA enters into a contract(s) with contracted entities and/or dental benefits managers, SoonerCare members will have access to additional services like enhanced care management and other value-added benefits offered by the contracted entities and/or dental benefits managers.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented:

The Agency has determined that the proposed rule changes will not have a detrimental effect on the public health, safety, and environment; however, if the rules are not implemented, the Agency will be out of compliance with Title 56 of the Oklahoma Statutes, Sections 4002-4004.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: January 11, 2023
Modified: January 23, 2023

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

SUBCHAPTER 1. ADMINISTRATIVE APPEALS

317:2-1-2. Appeals

(a) **Request for appeals.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an ~~agency~~Agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the ~~agency~~Agency receives it.

(b) **Member process overview.**

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or

discrimination complaints.
(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the ~~agency~~Agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.
(3) If the LD-1 form is not received timely, the OHCA administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.
(4) If the LD-1 form is not completely filled out or if necessary, documentation is not included, then the appeal will not be heard.
(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.
(6) Upon receipt of the member's appeal, a fair hearing before the OHCA ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member, and/or his/her designated authorized ~~representive~~representative, must appear at the hearing, either in person or telephonically. The preferred method for a hearing is telephonically, requests for an in-person hearing must be received in writing on OHCA's Form LD-4 (Request for In-Person Hearing) no later than ten (10) calendar days prior to the scheduled hearing date.
(7) The hearing shall be conducted according to OAC 317:2-1-5. The OHCA ALJ's decision may in certain instances be appealed to the CEO of the OHCA, or his or her designated independent ALJ, which is a record review at which the parties do not appear (OAC 317:2-1-13).
(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:
(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;
(B) The OHCA cannot reach a decision because the appellant requests a delay or fails to take a required action, as reflected in the record;
(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record; or
(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.
(9) Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision is normally rendered by the OHCA ALJ within twenty (20) days of the hearing.

(c) **Provider process overview.**
(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(d)(2).
(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).
(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.
(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not

received timely, the OHCA ALJ will cause a letter to be issued stating that the appeal will not be heard.

(C) A decision ordinarily will be issued by the OHCA ALJ within forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the OHCA ALJ's decision is appealable to OHCA's CEO, or his or her designated independent ALJ.

(d) **OHCA ALJ jurisdiction.** The OHCA ALJ has jurisdiction of the following matters:

(1) **Member appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare ~~Program~~program;

(C) Fee-for-service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision will be rendered by the OHCA ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the OHCA ALJ. A decision by the OHCA ALJ will ordinarily be rendered within twenty (20) days of the hearing. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8;

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310; and

(I) Requests for ~~State~~state fair hearing arising from a member's appeal of a ~~managed care~~CE or DBM adverse benefit determination.

(2) **Provider appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;

(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees, or penalties as specifically provided in OAC 317:2-1-15; and

(I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to

OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.

~~(J) Request for a State fair hearing arising from provider's appeal of managed care audit findings, for cause or immediate termination of the provider's managed care contract, or managed care claims denial.~~

317:2-1-2.6. Continuation of benefits or services pending appeal

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an ~~Appellant~~appellant submits a written request for a hearing within ~~ten (10)~~sixty (60) days of the notice of the adverse ~~agency~~Agency action, the ~~Appellant~~appellant may also request that existing benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, ~~Appellant's~~appellant's withdrawal of the appeal, or an initial hearing decision adverse to the ~~Appellant~~appellant.

(b) If the ~~Appellant~~appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ~~ten (10)~~sixty (60) days of the notice of the adverse ~~agency~~Agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;

(2) When a request for a prior authorization is denied for a prescription drug. However:

(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;

(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;

(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;

(4) When coverage for a prescription drug is denied because the ~~enrollee~~Enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or

(5) When a physician or other licensed health care practitioner has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the ~~Appellant's~~appellant's favor, OHCA may seek to recover reimbursement of all services received pending the hearing decision.

SUBCHAPTER 3. MEMBER GRIEVANCES AND APPEALS, PROVIDER COMPLAINTS, AND STATE FAIR HEARINGS IN ~~MANAGED CARE~~SOONERSELECT

317:2-3-1. Definitions

The following words or terms used in the Subchapter shall have the following meaning, unless the context clearly indicates otherwise:

"**Adverse benefit determination"** means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided,

does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated and in accordance with Title 36 of Oklahoma Statute (O.S.) § 6475.3.

"**Appeal**" means a review of an adverse benefit determination performed by a ~~managed care entity~~CE or DBM or according to managed care law, regulations, and contracts.

"**C.F.R.**" means the Code of Federal Regulations.

"Contracted entity" or **"CE"** means an organization or entity that enters into or will enter into a capitated contract with the Oklahoma Health Care Authority (OHCA) for the delivery of services that will assume financial risk, operational accountability, and state-wide or regional functionality in this act in managing comprehensive health outcomes of Medicaid members. This includes an accountable care organization, a provider-led entity, a commercial plan, a dental benefit manager, or any other entity as determined by the OHCA.

"Dental benefits manager" or **"DBM"** means an entity that meets the definition of a Prepaid Ambulatory Health Plan (PAHP) as per 42 C.F.R. § 438.2 and is under contract with the OHCA to manage and deliver all services described in this SoonerSelect Dental Contract and who handles claims payment and prior authorizations and coordinates dental care with participating providers and Enrollees. Also referred to as a "Contractor".

"**Exigent circumstances**" means a situation in which a reasonable person applying the appropriate standard would consider a member's health condition to be urgent with identifiable harm that could reasonably be expected to occur if the requested health care service is not provided promptly. The appropriate standard requires the assessment of a member's health condition through application, at minimum, of established, accepted standards of medical practice. Evidence of the member's condition may be demonstrated by indications from the treating provider or from the member's medical record, including but not limited to such information as the member's diagnosis, symptoms, or test results.

"**Grievance**" means a member's expression of dissatisfaction about any ~~managed care program~~ matter other than an adverse benefit determination and may include, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a ~~managed care~~contracted entity employee or contracted provider, or failure to respect the ~~member's~~Enrollee's rights regardless of whether remedial action is requested. A grievance includes a ~~member's~~Enrollee's right to dispute an extension of time to make an authorization decision when proposed by the ~~managed care entity~~Contractor.

"**Health plan**" means any person or entity that is licensed as a health maintenance organization (HMO) by the State of Oklahoma to provide or arrange for the delivery of basic health care services to ~~enrollees~~Enrollees on a prepaid basis, except for copayments or deductibles for which ~~enrollee~~Enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma State Medicaid Plan and that contracts with the ~~State~~state to provide services to ~~enrollees~~Enrollees. "Health plan" is synonymous with "health carrier".

~~"**Managed care entity**" or "**MCE**" means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).~~

~~"**Managed care organization**" or "**MCO**" means the same in these rules as defined at 42 Code of Federal Regulations (C.F.R.) § 438.2.~~

~~"**Managed care program**" or "**managed care**" or "**MCP**" means a health care delivery system~~

~~organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.~~

"**Member**" means an individual eligible for Medicaid in the State of Oklahoma, eligible for a managed care program, and enrolled in a ~~managed care entity~~CE or DBM. "Member" is synonymous with "~~health plan enrollee~~Enrollee".

"OAC" means the Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"O.S." means the Oklahoma Statutes.

"**Prepaid ambulatory health plan**" or "**PAHP**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"**Prepaid inpatient health plan**" or "**PIHP**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"**Primary care case management**" or "**PCCM**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"**Primary care case management entity**" or "**PCCM entity**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prior authorization ~~(PA)~~" or **"PA"** means a requirement that a member, through a provider, obtain the ~~managed care entity's~~CE or DBM approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim. For purposes of these rules, "prior authorization" is included as a determination of health care services within the term "adverse benefit determination".

"Provider" means a health care or dental provider licensed or certified in this state.

317:2-3-2. Timeframes

(a) For the purpose of calculating a timeframe in this Subchapter, the date on the written notice is not included. The last day of the timeframe is included, unless the last day is a legal holiday, as defined by 25 ~~Oklahoma Statutes (O.S.)~~O.S. § 82.1, or any other day OHCA is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(b) A grievance or appeal a member sends via mail is deemed filed on the date the ~~M~~CE receives request.

(c) A request for reconsideration or appeal a provider sends via mail is deemed filed on the date the ~~M~~CE receives the request.

(d) A request for ~~State~~state fair hearing by a member or provider is deemed filed on the date the OHCA receives the request.

317:2-3-3. Grievance and appeals system

In accordance with state and federal law, including but not limited to 63 ~~Oklahoma Statutes (O.S.)~~O.S. § 7310 and 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. §§ 438.210, 431.213-14, 438.402, 438.404, 438.408, and 438.410, each ~~M~~CE and DBM will have an established grievance and appeals system by which to receive, process, and resolve grievances and appeals, including requests for extensions of relevant timeframes, and by which to afford parties proper notice.

317:2-3-4. Member grievances

(a) **Filing**.

(1) **Filing with ~~managed care entity~~a CE or DBM**. Except as described in this ~~section~~Section, when the member is enrolled in a managed care program, the member initially files a grievance

with the ~~managed care entity~~CE or DBM in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a ~~managed care~~SoonerSelect program and the grievance deals with direct interaction with OHCA or its employees or officers, the member first files the grievance with OHCA as an administrative appeal pursuant to applicable rules set forth at ~~Oklahoma Administrative Code (OAC)~~OAC 317:2-1-2 et seq.

(b) **Timing.** A member may file a grievance, orally or in writing, at any time.

(c) **Provider's and authorized representative's right to file a grievance.** A provider or an authorized representative may file a grievance on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the ~~litigation~~resolution of a grievance, as applicable.

(d) **Clinical expertise in a grievance decision.** When a grievance involves clinical issues or is related to a denial of an expedited resolution of an appeal, the decision maker(s) of such a grievance will have clinical expertise as discussed at OAC 317:2-3-6.

(e) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(f) **OHCA-established timeframes for grievance decisions.** A grievance related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. § 438.408, the standard resolution of a grievance will occur within ninety (90) calendar days after the ~~managed care entity~~CE or DBM receives the grievance. The OHCA may choose to adopt a shorter timeframe for the grievance resolution. The CE and DBM must adhere to such timeframes that are described within the Contract.

~~(2) OHCA sets the standard resolution of a grievance to occur within sixty (60) calendar days, inclusive of any extensions, after the MCE receives the grievance.~~

~~(3)~~(2) The ~~M~~CE and DBM may extend the timeframe ~~in (f)(2)~~ up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The ~~M~~CE and DBM shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

~~(4)~~(3) If the ~~M~~CE and DBM extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay; and

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform ~~the enrollee~~Enrollee of the right to file a grievance if he or she disagrees with that decision; and

~~(5)~~(4) The ~~M~~CE and DBM will adhere to all OHCA rules related to grievances, including but not limited to:

(A) Observing the timeframe for standard resolution of a grievance;

(B) Sending acknowledgement of receiving the grievance in writing to the member or the member's authorized representative within ten (10) calendar days of receipt; and

(C) Sending written notice conforming with this ~~subchapter~~Subchapter to the affected parties within three (3) calendar days following resolution of the grievance.

317:2-3-5. Member appeals

(a) **Filing**.

(1) **Filing with ~~managed care entity~~a CE or DBM.** Except as described in this Section, when the member is enrolled in a managed care program, the member initially files an appeal with the ~~managed care entity~~CE or DBM in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a ~~managed care~~SoonerSelect program, the member initially files administrative appeals with OHCA and follows the appeals rules set forth at ~~Oklahoma Administrative Code (OAC)~~OAC 317:2-1-2 et seq. whenever the appeal concerns a decision the ~~Oklahoma Health Care Authority (OHCA)~~OHCA made regarding:

(A) Eligibility for Oklahoma Medicaid;

(B) Eligibility for a ~~managed care~~SoonerSelect program;

(C) Enrollment into Oklahoma Medicaid;

(D) Enrollment, including use of an auto-assignment algorithm, into a ~~managed care entity~~CE or DBM;

(E) Disenrollment from a ~~managed care entity~~CE or DBM; or

(F) Any other matter, so long as OHCA made the decision in the matter.

(b) **Timing.** ~~A member may file an appeal, orally or in writing, at any time. An administrative appeal or State fair hearing request made to OHCA shall conform with the requirements of OAC 317:2-1-2 et seq. in terms of the manner and timing of any such filing.~~

(1) Per OAC 317:2-3-4(b), a member may file a grievance at any time. If the grievance decision is adverse to the member, the member may file an appeal. The member has sixty (60) days from the adverse decision notice to file an appeal.

(2) An administrative appeal or state-fair hearing request made to OHCA shall conform with the requirements of OAC 317:2-1-2 et seq. in terms of the manner and timing of any such filing.

(c) **Levels of appeals.** The ~~managed care entity~~CE or DBM will use only one (1) level of ~~appeals~~appeal, in accordance with 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. § 438.402.

(d) **Provider's and authorized representative's right to file an appeal.** A provider or an authorized representative may file an appeal on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of an appeal, as applicable.

(e) **Clinical expertise in an appeal decision.** When an appeal involves clinical issues or is related to a denial based on lack of medical necessity, the decision maker(s) of such an appeal will have clinical expertise as discussed at OAC 317:2-3-6.

(f) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(g) **OHCA-established timeframes for appeals decisions.** An appeal related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

~~(1) Per 42 C.F.R. § 438.408, the standard resolution of an appeal will occur within thirty (30) calendar days after the managed care entity receives the appeal.~~

~~(2)~~ (1) Per 42 C.F.R. § 438.408, the OHCA establishes the following timeframes for appeals:

(A) Standard resolution of an appeal will occur within thirty (30) calendar days, excluding any extensions, after the ~~managed care entity~~CE or DBM receives the appeal;

(B) ~~Expedited resolution of an appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal;~~The CE and DBM will be responsible for expedited

resolutions.

(i) An expedited appeal resolution should occur if the standard resolution timeframe could jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

(ii) Per 42 C.F.R. § 438.408(b)(2), if the CE or DBM denies a request for expedited appeal resolution, the CE or DBM must transfer the appeal to the standard appeal resolution timeframe.

(C) In exigent circumstances, resolution of a step therapy request appeal will occur within twenty-four (24) clock-hours after the ~~M~~CE receives the appeal; and

(D) In all other circumstances, resolution of a step therapy request appeal will occur within seventy-two (72) clock-hours after the ~~M~~CE receives the appeal.

(3) The ~~M~~CE and DBM may extend the timeframes in (g)~~(2)~~(1)(A) or (B) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The ~~M~~CE and DBM shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

(4) If the ~~M~~CE and DBM extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform ~~the enrollee~~Enrollee of the right to file a grievance if he or she disagrees with that decision; and

(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(5) The ~~M~~CE and DBM will adhere to all OHCA policies related to appeals, including but not limited to:

(A) Observing the timeframes for resolving appeals, including standard resolution, expedited resolution, and resolution of step therapy appeals (in both exigent and other circumstances);

(B) Sending acknowledgement of receiving the appeal in writing to the member or the member's authorized representative within five (5) calendar days of receipt;

(C) Sending written notice conforming with this ~~subchapter~~Subchapter to the affected parties within three (3) calendar days following resolution of the appeal; and

(D) Sending documentation, in conformance with OAC 317:2-3-12(d) and any established OHCA forms or processes, to OHCA within fifteen (15) calendar days after a request for ~~State~~state fair hearing.

317:2-3-5.1. Continuation of benefits pending appeal and state fair hearing

(a) Per OAC 317:2-1-2.6 and 42 C.F.R. § 438.420, the CE or DBM shall continue a member's benefits under the plan when all of the following occur:

(1) The member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii):

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The member timely files for continuation of benefits, meaning on or before the later of the following:

(A) Within ten (10) calendar days of the CE or DBM sending the notice of adverse benefit determination; or

(B) The intended effective date of the CE or DBM's proposed adverse benefit determination.

(b) If the member fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within sixty (60) calendar days of the adverse benefit determination, services shall be continued or reinstated. Notwithstanding the foregoing, continuation or reinstatement of benefits shall not occur under the following circumstances:

(1) The member has exceeded the limit applicable to the services; or

(2) When a provider has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) The CE or DBM shall continue or reinstate benefits if the member:

(1) Files a request for a state fair hearing within one hundred twenty (120) days of the adverse resolution notice; and

(2) Files a request for continuation of benefits within thirty (30) calendar days of the adverse resolution notice.

(d) If the CE or DBM continues or reinstates the member's benefits at the member's request while the appeal or state fair hearing is pending, the benefits must be continued until one (1) of the following occurs:

(1) The member withdraws the appeal or request for state fair hearing;

(2) The member fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the CE or DBM sends the notice of an adverse resolution to the member's appeal under 42 C.F.R. §§ 438.420 (c)(2) and 438.408 (d)(2); or

(3) A state fair hearing officer issues a hearing decision adverse to the member.

317:2-3-6. External medical review and clinical expertise

(a) ~~**No external**~~**External medical review.** The ~~Oklahoma Health Care Authority (OHCA)~~OHCA will not offer an external medical review for the purposes of grievances or appeals.

(b) **Clinical expertise standards.** Individuals making the decision for a grievance or appeal regarding an adverse benefit determination will be unbiased with appropriate clinical expertise in treating the member's condition or disease.

(1) Medical review staff of the ~~M~~CE and DBM will be licensed or credentialed health care clinicians with relevant clinical training and/or experience.

(2) All ~~M~~CE and DBM will use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.

(3) Bias is deemed to exist if an individual making a decision on a grievance or appeal was involved in, or a subordinate of any individual involved in, any previous level of review or decision regarding the subject matter of the grievance or appeal.

(4) Clinical expertise is deemed necessary for decisions makers whenever:

(A) The denial is based on a lack of medical necessity;

(B) The grievance is regarding a denial of an expedited resolution an appeal; and

(C) The grievance or appeal involves clinical issues.

317:2-3-7. Obligation to pay costs of services

(a) In accordance with 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. § 438.420(d), the ~~M~~CE and

DBM may recover from the member the costs of services provided to the member while an appeal or ~~State~~state fair hearing is pending:

(1) To the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420 or 431.230(b); and

(2) The final resolution of the appeal or ~~State~~state fair hearing upholds the ~~M~~CE or DBM's adverse benefit determination.

(b) If OHCA or the ~~M~~CE or DBM reverses a decision to deny, limit, or delay services and these services were not furnished while the appeal or ~~State~~state fair hearing was pending, the ~~M~~CE or DBM will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(c) If OHCA or the ~~M~~CE or DBM reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal or ~~State~~state fair hearing was pending, the ~~M~~CE or DBM will pay for these services.

317:2-3-8. Grievances and appeals notice

(a) The ~~M~~CE or DBM will provide timely written notices per OAC 317:2-3-4 and 317:2-3-5.

(b) Each notice will conform to the provisions of 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. § 438.10 related to information provided from an ~~M~~CE or DBM to a member.

(c) At minimum, each notice will:

(1) Be written in a manner and format, as outlined in the Contract, that may be easily understood and is readily accessible by members;

(2) Use OHCA-developed definitions for terms as those terms are defined in the ~~Model Member~~Enrollee Handbook related to the ~~contract~~Contract;

(3) Use a font size no smaller than twelve-point (12-point);

(4) Be made available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members with disabilities or limited English proficiency; and

(5) Include a large-print tagline, in minimum eighteen-point (18-point) font, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

(d) Per the delegation choice of 42 C.F.R. § 438.228, OHCA does not delegate responsibility to the ~~M~~CE or DBM for timely notices of action under 42 C.F.R. Part 431, Subpart E.

(1) OHCA retains all responsibility for timely notices of action under 42 C.F.R. Part 431, Subpart E, including:

(A) A termination, suspension of, or reduction in covered benefits or services, when termination, suspension, or reduction is determined by OHCA;

(B) A termination, suspension of, or reduction in Medicaid eligibility, when termination, suspension, or reduction is determined by OHCA; and

(C) An increase in beneficiary liability, including determination that a beneficiary will incur a greater amount of medical expenses in order to establish income eligibility or is subject to an increase in premiums or cost sharing charges, when such increase is determined by OHCA.

(2) The foregoing (d)(1) does not apply to:

(A) Any grievance notice required to be sent by the ~~M~~CE or DBM by ~~contract~~Contract or 42 C.F.R. § 438.408;

(B) Any adverse benefit determination notice based on the termination, suspension, or reduction of authorized covered services, payment denial, or standard, expedited, or

untimely service authorization denial or limitation as required to be sent by the ~~M~~CE or DBM by contract or 42 C.F.R. § 438.404;

(C) Any appeal resolution notice required to be sent by the ~~M~~CE or DBM by contract or 42 C.F.R. § 438.404 or 438.408; or

(D) Any other notice required to be sent by the ~~M~~CE or DBM by ~~contract~~Contract or any state or federal law or regulation.

(3) OHCA's decision not to delegate the notices of action required by 42 C.F.R. Part 431 Subpart E applies to any ~~managed care entity~~CE or DBM under ~~any managed care contract~~Contract for professional services unless and until this ~~section~~Section is revoked.

(4) The random review system required of a state by 42 C.F.R. § 438.228 does not apply to OHCA, because OHCA has not delegated responsibility for the relevant notices of action.

(5) For any notices of action for which OHCA retains responsibility under this ~~section~~Section, OHCA will ensure the notice conforms to federal regulations at 42 C.F.R. Part 431, Subpart E, and any applicable requirements under 42 C.F.R. § 438.228. OHCA will send such notices of action by electronic or postal means at least ten (10) days before the date of action, except as permitted when:

(A) OHCA has factual information confirming the death of a beneficiary;

(B) OHCA receives a clear written statement signed by a member that they no longer wish to receive services or that gives information that requires termination or reduction of services and indicates that the member understands that supplying the information will result in termination or reduction of services;

(C) The member has been admitted to an institution where they are ineligible for further services;

(D) The member's whereabouts are unknown and the post office returns, indicating no forwarding address, OHCA mail sent directly to the member; ~~and~~or

(E) The ~~M~~CE or DBM establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

(6) For any notices of action for which OHCA retains responsibility under this Section, OHCA will ensure the notice contains:

(A) A statement of the action OHCA intends to take and the effective date of such action;

(B) A clear statement of the specific reasons supporting the intended action, the specific regulations that support or require the action, and an explanation of the member's rights to request a hearing; and

(C) An explanation of the circumstances under which benefits continue if a hearing is requested.

(7) For any notices of action for which OHCA retains responsibility under this ~~section~~Section, OHCA will allow the member a reasonable time, not to exceed ninety (90) days from the date the notice is mailed, to request a ~~State~~state fair hearing.

317:2-3-9. Exhaustion of ~~managed care entity~~CE or DBM appeals

(a) **Deemed exhaustion of ~~M~~CE or DBM appeals.** If the ~~M~~CE or DBM fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the member is deemed to have exhausted the ~~M~~CE's or DBM's appeal process, and the member or the member's authorized representative may request a ~~State~~state fair hearing.

(b) **Actual exhaustion of ~~M~~CE or DBM appeals.** Except as allowed in (a), a member or the member's authorized representative may request a ~~State~~state fair hearing only after receiving notice from the ~~M~~CE or DBM upholding an adverse benefit determination and only within one hundred

twenty (120) days after the date of the notice of appeal resolution.

(c) **Exhaustion of ~~M~~CE or DBM appeals, determination.** OHCA has sole authority to decide whether ~~M~~CE or DBM appeals have been exhausted for any member. Documentation, as submitted to OHCA by the ~~M~~CE or DBM within fifteen (15) calendar days of the request for ~~State~~state fair hearing, will serve as evidence to deemed exhaustion, actual exhaustion, or no exhaustion of the ~~M~~CE or DBM appeals process.

317:2-3-10. Provider complaint system and appeal requests

(a) A participating provider or nonparticipating provider may file a complaint whenever:

(1) The provider is not satisfied with the ~~M~~CE or DBM's policies and procedures; or

(2) The provider is not satisfied with a decision made by the ~~M~~CE or DBM that does not impact the provision of services to members.

(b) The ~~M~~CE or DBM will establish and operate a provider complaint system. Such system will:

(1) Use written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving provider complaints;

(2) Track receipt and resolution of provider complaints, including requests for reconsideration or appeals;

(3) Demonstrate sufficient ability to receive provider complaints by telephone, in writing, or in person;

(4) Designate staff to receive, process, and resolve provider complaints;

(5) Thoroughly investigate each provider complaint;

(6) Ensure an escalation process for provider complaints;

(7) Furnish the provider timely written notification of resolution or results; and

(8) Maintain a tracking system capable of generating reports to OHCA on provider complaint volume and resolution.

(c) The ~~M~~CE or DBM will operate a reconsideration process whereby providers may request the ~~M~~CE or DBM reconsider a decision the ~~M~~CE or DBM has made or intends to make that is adverse to the provider, including, at minimum, reconsiderations of provider audit findings, reconsiderations of provider agreement termination, and reconsiderations of denied claims.

(1) **Request for reconsideration, denied claims.** The ~~M~~CE or DBM will ask that the provider submits a request for reconsideration of a denied claim within six (6) months after the provider receives notice of the denied claim.

(2) **Request for reconsideration, all other reasons**. The ~~M~~CE or DBM will ask that the provider submits a request for reconsideration within fifteen (15) days after the date the provider receives notice of audit findings, termination of provider agreement, or other actions the ~~M~~CE or DBM permits for reconsideration requests.

(3) **Desk review.** The ~~M~~CE or DBM will conduct the reconsideration through a desk review of the request and all related and available documents.

(4) **Reconsideration resolution.** The ~~M~~CE or DBM will resolve all requests for reconsideration within ~~twenty (20) calendar days of the date the MCE receives the request for reconsideration~~the timeframes established by the OHCA. The ~~M~~CE or DBM will send a reconsideration resolution notice to the provider within ~~three (3) days of the MCE finalizing the resolution~~five (5) calendar days of resolution of the consideration.

(5) **Notice of ~~Reconsideration Resolution~~reconsideration resolution**. The ~~M~~CE or DBM will send a reconsideration resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The action the ~~M~~CE has made or intends to make;

(C) The reasons for the action;
(D) The date the action was made or will be made;
(E) The citation to statute, regulation, policy, or procedure, if any, upon which the action was based;
(F) An explanation of the provider's ability to submit an appeal request to the ~~M~~CE or DBM within thirty (30) calendar days of the date recorded on the notice;
(G) The address and contact information for submitting an appeal;
(H) The procedures by which the provider may request an appeal regarding the ~~MCE's~~CE's or DBM's action;
(I) The specific change in federal or state law, if any, that requires the action;
(J) The provider's ability to submit a ~~State~~state fair hearing request following completion of the provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a ~~State~~state fair hearing will be granted; and
(K) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(d) The ~~M~~CE or DBM will operate an appeals process whereby a provider may request an appeal of a reconsideration resolution when the underlying matter is based on the ~~MCE's~~CE or DBM's provider audit findings~~,~~ or for-cause or immediate termination of the provider agreement~~, or a denied claim~~.

(1) **Request for appeal.** The ~~M~~CE or DBM will require the provider to submit a request for appeal in writing within thirty (30) calendar days after the provider receives notice reconsideration resolution.

(2) **Panel review.** The ~~M~~CE or DBM will conduct the appeal through a panel review including a hearing and review of the request, all related and available documents, and all documents created for or used in connection with the request for reconsideration.

(A) The panel will consist of three (3) or five (5) reviewers, who are employees or officers of the ~~M~~CE or DBM.

(B) Panel members will not have been directly involved with the reconsideration desk review and will not be a subordinate of someone involved directly with the reconsideration desk review.

(C) The panel review hearing will provide the provider or an authorized representative of the provider with a reasonable opportunity to be heard in person or by telecommunications.

(D) The review panel will accept and document any exhibit offered prior to the hearing or during the hearing, so long as the exhibit directly relates to the matter of the appeal.

(E) When the appeal is based on a claim denied on the basis of medical necessity, the following requirements apply:

(i) Medical or dental review staff of the ~~M~~CE or DBM will be licensed or credentialed health care clinicians with relevant clinical training or experience; and

(ii) All ~~M~~CEs or DBMs will use medical or dental review staff for such appeals and will not use any automated claim review software or other automated functionality for such appeals.

(3) **Appeal resolution.** The ~~M~~CE or DBM will resolve all appeals within ~~forty-five (45) calendar days of the date the MCE receives the request for appeal~~the timeframes established by the OHCA. The ~~M~~CE or DBM will send an appeal resolution notice to the provider within ~~three (3) business~~five (5) calendar days of the ~~M~~CE or DBM finalizing the resolution.

(4) **Notice of ~~Appeal Resolution~~appeal resolution.** The ~~M~~CE or DBM will send an appeal resolution notice that contains, at a minimum:

(A) The date of the notice;
(B) The date of the appeal resolution; and
(C) For decisions not wholly in the provider's favor:
~~(i) An explanation of the provider's ability to request a State fair hearing within thirty (30) calendar days of the date recorded on the notice;~~
~~(ii) How to request a State fair hearing, including the OHCA address and contact information for submitting a request;~~
~~(iii) Details on the right to be represented by counsel at the State fair hearing; and~~
~~(iv) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.~~
(i) An explanation of the provider's ability to request and OHCA administrative appeal within thirty (30) calendar days of the date recorded on the notice;
(ii) How to request an OHCA administrative appeal, including the OHCA address and contact information for submitting a request;
(iii) Details on the right to be represented by counsel at the OHCA administrative appeal.
(D) Any other information required by state or federal statute or regulation, by Contract, or by Contract-related manual.

(5) **Documentation.** The ~~M~~CE or DBM will furnish to OHCA documentation including all information specified ~~at OAC 317:2-3-13(c)(2)~~within the Contract within fifteen (15) calendar days of a provider's request for ~~a State fair hearing~~an OHCA administrative appeal.

(6) **State fair hearing for providers.** There are no state fair hearings provided for providers under a CE or DBM, per OAC 317:2-3-13.

317:2-3-11. Recordkeeping

In compliance with 42 C.F.R. § 438.3(h) and (u), the ~~M~~CE or DBM will maintain records of each grievance and appeal for ten (10) years after the later of the final date of the contract period or the date of completion of any ~~M~~CE or DBM audit by the State, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General, or the Comptroller General. Such records will be part of OHCA's ongoing monitoring and will be used to update and revise OHCA's ~~managed care~~SoonerSelect quality strategy. The record will conform with the content requirements at 42 C.F.R. § 438.416.

317:2-3-12. State fair hearing for members

(a) **Right to ~~State~~state fair hearing.** With regard to grievances or appeals first filed with the ~~M~~CE or DBM, a member may request a ~~State~~state fair hearing under 42 C.F.R. 431 Subpart E only after receiving notice from the ~~M~~CE or DBM upholding an adverse benefit determination. The member will have one-hundred twenty (120) days from the date of the adverse benefit determination notice to request a ~~State~~state fair hearing. Refer to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1).

(b) **~~M~~CE or DBM policies and procedures.** The ~~M~~CE or DBM will implement established policies and procedures that allow a member described in (a) to initiate a ~~State~~state fair hearing process after having exhausted the ~~MCE's~~CE or DBM's appeals process or after the member is deemed to have exhausted the process due to the ~~MCE's~~CE or DBM's failure to adhere to notice and timing requirements.

(c) **Member's request for a ~~State~~state fair hearing.** The ~~M~~CE or DBM will allow the member to request a ~~State~~state fair hearing either through an established ~~M~~CE or DBM process or through an established OHCA process. Any ~~M~~CE or DBM process will ensure that notice of the request for

~~State~~state fair hearing is communicated in writing to the OHCA contracting officer within twenty-four (24) clock-hours of receiving the request.

(d) **~~M~~CE or DBM documentation obligation.** The ~~M~~CE or DBM will provide documentation to the member, the member's authorized representative, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The ~~M~~CE or DBM will provide the ~~documentation~~support documentation (summary) described in this subsection~~:~~ within fifteen (15) calendar days after notification of the request for state fair hearing.

~~(A) Within twenty-four (24) clock-hours after receiving notification of the request for State fair hearing relating to a step therapy request; or~~

~~(B) Within fifteen (15) calendar days after notification of the request for State fair hearing in all other circumstances.~~

(2) **Information.** ~~Documentation~~Support documentation (summary) will include, at minimum, the following information:

(A) The name and address of the member and, if applicable, the member's authorized representative;

(B) A summary statement concerning why the member has filed a request for ~~State~~state fair hearing;

(C) A brief chronological summary of the ~~MCE's~~CE or DBM's action in relationship to the matter underlying the member's request for ~~State~~state fair hearing;

(D) The member's appeal request, along with any supporting documentation, if received by the ~~M~~CE or DBM;

(E) Any applicable correspondence between the ~~M~~CE or DBM and the member, including system notes entered by one (1) or more ~~M~~CE or DBM employees based on one (1) or more telephone conversations with the member;

(F) All exhibits offered at any hearing held with the ~~M~~CE or DBM;

(G) All documents the ~~M~~CE or DBM used to reach its decision;

(H) A statement of the legal basis for the ~~MCE's~~CE or DBM's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the ~~M~~CE or DBM in making its decision;

(J) A copy of the notice which notified the member of the decision in question;

(K) The names and titles of any ~~M~~CE or DBM employees who will serve as witnesses at the ~~State~~state fair hearing; and

(L) Any other information requested by the member, the member's authorized representative, OHCA, or the Office of Administrative Hearings when the information relates to the ~~State~~state fair hearing or any matter giving rise to the ~~State~~state fair hearing.

(e) **~~M~~CE or DBM staffing.** The ~~M~~CE or DBM will maintain a sufficient level of staffing to competently perform the functions, requirements, roles, and duties involved in ~~State~~state fair hearing support, including but not limited to documentation, summarization of the arguments presented, and ensuring timely notice and delivery of documents to all parties.

(f) **Performance targets**. OHCA may set performance targets related to ~~State~~state fair hearing requests that are resolved upholding the ~~MCE's~~CE or DBM's original determination when and as OHCA deems necessary or appropriate.

(g) **Post-transition obligations**. After termination or expiration of the ~~managed care contract~~Contract, the ~~M~~CE or DBM will remain responsible for ~~State~~state fair hearings related to dates of service prior to the ~~contract~~Contract termination or expiration, including but not limited to

the provision of records and representation at ~~State~~state fair hearings.
(h) **Cost of services.** If the ~~State~~state fair hearing officer reverses the ~~MCE's~~CE or DBM's decision to deny authorization of services and the member received the disputed services while the ~~State~~state fair hearing was pending, the ~~M~~CE or DBM will pay for those disputed services.

317:2-3-13. State fair hearing for providers

~~(a) **Right to State fair hearing.** With regard to provider audit findings, for-cause and immediate termination of the provider's agreement, and claims denial, a provider may request a State fair hearing within thirty (30) calendar days of the MCE's notice of appeal resolution when that resolution does not favor the provider.~~

~~(b) **Information for providers.** As a part of the MCE's provider complaint system, the MCE will provide information to providers on how to request a State fair hearing via filing the appropriate form with the OHCA Docket Clerk.~~

~~(c) **MCE documentation obligation.** The MCE will provide documentation to the provider, OHCA, and the Office of Administrative Hearings.~~

~~(1) **Timing.** The MCE will provide the documentation described in this subsection within fifteen (15) calendar days after notification of the request for State fair hearing.~~

~~(2) **Information.** Documentation will include, at minimum, the following information:~~

~~(A) The name and address of the provider;~~

~~(B) A summary statement concerning why the provider has filed a request for State fair hearing;~~

~~(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the provider's request for State fair hearing;~~

~~(D) The provider's appeal request, along with any supporting documentation, if received by the MCE;~~

~~(E) Any applicable correspondence between the MCE and the provider, including system notes entered by one or more MCE employees based on one or more telephone conversations with the provider;~~

~~(F) All exhibits offered at any hearing held with the MCE;~~

~~(G) All documents the MCE used to reach its decision;~~

~~(H) A statement of the legal basis for the MCE's decision;~~

~~(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;~~

~~(J) A copy of the notice which notified the provider of the decision in question;~~

~~(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and~~

~~(L) Any other information requested by the provider, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.~~

(a) There are no state fair hearings provided for providers under a CE or DBM. The CE or DBM shall provide the following:

(1) A provider complaint system;

(2) A provider reconsideration system whereby providers may request the CE or DBM to reconsider the decision the CE or DBM has made or intends to make that is adverse to the provider. This shall include, at minimum, reconsiderations for Program Integrity provider audit findings and provider agreement termination.

(3) Provider appeal to the CE or DBM:

(A) The CE or DBM shall implement and operate a system for provider appeals of the CE or DBM's audit findings related to Program Integrity efforts and for cause and immediate provider agreement termination.

(B) The CE or DBM shall operate a process whereby providers may appeal a decision the CE or DBM has made or intends to make that is adverse to the provider.

(b) For decisions not wholly in the provider's favor an OHCA administrative appeal will be provided, per OAC 317:2-3-10 (d)(4)(C).

317:2-3-14. Administrative Law Judge (ALJ) jurisdiction

The ALJ has jurisdiction of the following matters:

(1) **Member ~~State~~state fair hearing.** The ALJ has jurisdiction to hear any ~~State~~state fair hearing arising from a member's ~~MCE~~CE or DBM appeal of an adverse benefit determination.

(2) ~~**Provider State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a provider's appeal of audit findings, for cause or immediate termination of the provider's contract with the MCE, or claims denial.~~ **Provider OHCA administrative appeal.** The ALJ has jurisdiction to hear any OHCA administrative appeal arising from a decision that was not wholly in the provider's favor.