

OHIO DEPARTMENT OF MEDICAID

To: ALL CLEARANCE REVIEWERS
From: Ryver Penix, Office of Managed Care
Date: TBD
Subject: Updates to MyCare Ohio Rules

Attached for your review and comment are proposed Ohio Administrative Code (OAC) rules found in Ohio Administrative Code (OAC) Chapter 5160-58 governing the Ohio Department of Medicaid (ODM) MyCare Ohio program. The OAC Chapter 5160-58 rules below are being proposed for amendment or as new to implement managed care procurement, five year rule review, new types of managed care entities including the single pharmacy benefit manager (SPBM) and the Ohio Resilience through Integrated Systems and Excellence (OhioRISE) plan, and to update policy related to the administration of the MyCare Ohio program.

Ohio Administrative Code (OAC) rule 5160-58-01, entitled “MyCare Ohio plans: definitions,” sets forth the definitions used throughout Chapter 5160-58 of the Administrative Code regarding the MyCare Ohio managed care program. The definitions in this rule apply to MyCare Ohio Plans (MCOPs). The rule is being proposed for amendment to update policy related to the administration of the MyCare Ohio program and for five-year rule review. Changes to this rule include: revision of the definition of "MyCare Ohio Plan" in paragraph (B)(9), updated United States Code (U.S.C) and Code of Federal Regulations (C.F.R) references; and general edits for grammar, alphabetizing and formatting.

Ohio Administrative Code (OAC) rule 5160-58-01.1, entitled “MyCare Ohio plans: application of general managed care rules,” sets forth the applicability of general managed care rules used throughout Chapter 5160-58 of the Administrative Code. The rule is being proposed for amendment to update policy related to the administration of the MyCare Ohio program and for five-year rule review. Changes to the rule include: Revised MCP to MCO and added reference to Managed Care entity (MCE) in paragraph A, removed reference to OAC 5160-26-09 due to rescission, removed paragraph (B) due to creation of new OAC rule 5160-58-03.1, added clarification that cross-references to rule 5160-26-03.1 of the Administrative Code are replaced by cross-references to rule 5160-58-03.1 of the Administrative Code, added that rule 5160-26-03.1 does not apply to MyCare Ohio as we created its own corresponding MyCare rule 5160-58-03.1 and added reference to OhioRISE in paragraph D.

OAC rule 5160-58-02, entitled “MyCare Ohio plans: eligibility and enrollment”, sets forth the eligibility criteria for individuals to be enrolled in a MyCare Ohio plan and the enrollment process. The rule is being proposed for amendment to update policy related to the administration of the MyCare Ohio program and for five-year rule review. Changes to the rule include: CFR and USC dated references, revised "plan" to MCOP for consistency throughout MyCare Ohio program rules, replaced reference to rule 5123:2-8-01 with reference to rule 5123-8-01, added "gender identity" to the nondiscrimination section for consistency with the provider agreement and OAC rules, rescinded unnecessary language as needed and added a reference to managed care organization (MCO).

OAC rule 5160-58-02.1, entitled “MyCare Ohio plans: termination of enrollment”, sets forth the reasons why an individual’s enrollment in a MyCare Ohio plan may be terminated and the process for enrollment termination. The rule is being proposed for amendment to update policy related to the administration of the MyCare Ohio program and for five-year rule review. Changes to the rule include: Updated CFR dated

references, revised the use of the word "plan" to "MCOP" for consistency throughout managed care rules, clarified when termination of MyCare Ohio plan enrollment occurs when a third-party payer has been identified excluding Medicare, and rescinded unnecessary language as needed.

OAC rule 5160-58-03, entitled "MyCare Ohio plans: covered services", sets forth the services that must be covered by MyCare Ohio plans (MCOPs) and addresses exclusions and limitations for those services. Changes to the rule include: revised "panel" to "network" for consistency across ODM rules, revised some "musts" to "will" to maintain compliance with HB 166, added an MCOP service exclusions section, moved reference to MCOPs not being responsible for payment of services provided through the Medicaid schools program, coverage of services provided outside the U.S and IMD payment under MCO service exclusions and added reference to OhioRISE and rule 5160-59-03.

OAC rule 5160-58-03.1, entitled "MyCare Ohio plans: primary care and utilization management", sets forth the requirements for MyCare Ohio Plans (MCOPs) related to member primary care provider (PCP) assignment and utilization management. These requirements are currently established in OAC rule 5160-26-03.1 but are being moved to the MyCare Ohio Rule Chapter due to changes in OAC 5160-26 to implement the single pharmacy benefit manager (SPBM). The new rule is specific to MyCare Ohio plans only and removes pharmacy-related language because Medicare pays primary for MyCare Ohio beneficiaries.

Thank you in advance for your comments.

Attachments

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5160-58-01 MyCare Ohio plans: definitions.

- (A) The definitions set forth in rule 5160-26-01 of the Administrative Code apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code.
- (B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code, the following definitions apply to Chapter 5160-58 of the Administrative Code:
- (1) "Assessment" means a comprehensive evaluation of an individual's medical, behavioral health, long-term services and supports, and social needs. Results of the assessment process are used to develop the integrated, individualized care plan, inclusive of the waiver services plan.
 - (2) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (October 1, ~~2020~~2021).
 - (3) "Dual benefits member" or "opt-in member" means a member for whom a MyCare Ohio plan is responsible for the coordination and payment of both medicare and medicaid benefits.
 - (4) "Financial management service (FMS)" means a support that is provided to waiver participants who direct some or all of their waiver services. When used in conjunction with the employer authority, this support includes, but is not limited to, operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes, but is not limited to, paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.
 - (5) "Health and welfare" means a requirement that necessary safeguards are taken to protect the health and welfare of individuals enrolled in a home and community-based services (HCBS) waiver. It includes the following:
 - (a) Risk and safety planning and evaluations;
 - (b) Critical incident management;
 - (c) Housing and environmental safety evaluations;
 - (d) Behavioral interventions;
 - (e) Medication management; and
 - (f) Natural disaster and public emergency response planning.
 - (6) "Home and community-based services (HCBS)" means services available to individuals to help maintain their health and safety in a community setting in lieu of institutional care as described in 42 C.F.R. 440 subpart A (October 1, ~~2020~~2021).
 - (7) "Individual care plan" means an integrated, individualized, person-centered care plan developed by the member and his or her MyCare Ohio plan's trans-disciplinary care management team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.
 - (8) "Medicaid only member" or "opt-out member" means a member for whom a MyCare Ohio plan is

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responsible for coordination and payment of medicaid benefits.

- (9) "MyCare Ohio plan (MCOP)" means a health insuring corporation (HIC) contracted to comprehensively manage medicaid benefits for medicare and medicaid eligible members, including HCBS. ~~MCOPs are~~ An MCOP is also managed care ~~plans~~ organization as defined in ~~accordance with~~ rule 5160-26-01 of the Administrative Code. For the purpose of this chapter, an MCOP does not include entities approved to operate as a program for the all-inclusive care of the elderly (PACE) site as defined in rule 5160-36-01 of the Administrative Code.
- (10) "Nursing facility-based level of care" means the intermediate and skilled levels of care, as described in rule 5160-3-08 of the Administrative Code.
- (11) "Participant direction" means the opportunity for a MyCare Ohio waiver member to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.
- (12) "Significant change event" is a change experienced by a member that warrants further evaluation. Significant changes include, but are not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective service agency; institutionalization; and when the waiver-enrolled individual has not received MyCare Ohio waiver services for ninety calendar days.
- (13) "Trans-disciplinary care management team" means a team of appropriately qualified individuals comprised of the member, the member's family/caregiver, the MyCare Ohio plan manager, the waiver service coordinator, if appropriate, the primary care provider, specialists, and other providers, as applicable, that is designed to effectively meet the enrollee's needs.
- (14) "Waiver services plan" is a component of the care plan that identifies specific goals, objectives and measurable outcomes for a waiver-enrolled member's health and functioning expected as a result of HCBS provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the individual. At a minimum, the waiver services plan shall include:
 - (a) Essential information needed to provide care to the member that assures the member's health and welfare;
 - (b) Signatures indicating the member's acceptance or rejection of the waiver services plan. If the member is unable to provide the signature when the services plan is initially developed, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the case manager; and
 - (c) Information that the waiver services plan is not the same as the physician's plan of care.

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5160-58-01.1 MyCare Ohio plans: application of general managed care rules.

(A) MyCare Ohio plans must comply with all of the requirements applicable to managed care ~~plans (MCPs)~~ organizations (MCOs) and managed care entities (MCEs) in the following rules:

- (1) Rule 5160-26-05 of the Administrative Code;
- (2) Rule 5160-26-05.1 of the Administrative Code;
- (3) Rule 5160-26-06 of the Administrative Code;
- (4) Rule 5160-26-08.3 of the Administrative Code;
- ~~(5) (5) Rule 5160-26-09 of the Administrative Code;~~
- ~~(6) (5) Rule 5160-26-09.1 of the Administrative Code;~~
- ~~(7) (6) Rule 5160-26-10 of the Administrative Code; and~~
- ~~(8) (7) Rule 5160-26-11 of the Administrative Code.~~

~~(B) (B) MyCare Ohio plans must comply with all of the requirements applicable to MCPs in rule 5160-26-03.1 of the Administrative Code, however, the following language replaces all of paragraph (B)(3)(h) for MyCare Ohio plans: "Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect January 1, 2017) must be made within the timeframes specified in 42 C.F.R. 423.568(b) (October 1, 2017) for standard decisions and 42 C.F.R. 423.572(a) (October 1, 2017) for expedited decisions. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the plan is unable to obtain the information needed to make the prior authorization decision within seventy-two hours, the decision timeframe has expired and the MCP must give notice to the member as specified in rule 5160-58-08.4 of the Administrative Code."~~

~~(C) (B) For all rules listed in paragraphs paragraph (A) and (B) of this rule, the following provisions apply to the MyCare Ohio program described in Chapter 5160-58 of the Administrative Code:~~

- (1) All cross-references to rule 5160-26-01 of the Administrative Code are replaced by cross-references to rule 5160-58-01 of the Administrative Code.
- (2) All cross-references to rule 5160-26-02 of the Administrative Code are replaced by cross-references to rule 5160-58-02 of the Administrative Code.
- (3) All cross-references to rule 5160-26-02.1 of the Administrative Code are replaced by cross-references to rule 5160-58-02.1 of the Administrative Code.
- (4) All cross-references to rule 5160-26-03 of the Administrative Code are replaced by cross-references to rule 5160-58-03 of the Administrative Code.
- (5) All cross-references to rule 5160-26-03.1 of the Administrative Code are replaced by cross-references to rule 5160-58-03.1 of the Administrative Code.
- ~~(5) (6) All cross-references to rule 5160-26-08.4 of the Administrative Code are replaced by cross-references to rule 5160-58-08.4 of the Administrative Code.~~

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~~(D)~~(C) The following rules in Chapter 5160-26 of the Administrative Code do not apply to MyCare Ohio, as they are replaced by corresponding rules in Chapter 5160-58 of the Administrative Code:

- (1) Rule 5160-26-02 of the Administrative Code,
- (2) Rule 5160-26-02.1 of the Administrative Code,
- (3) Rule 5160-26-03 of the Administrative Code, ~~and~~
- (4) Rule 5160-26-03.1 of the Administrative Code, and
- ~~(4)~~(5) Rule 5160-26-08.4 of the Administrative Code.

~~(E)~~(D) When an ~~MCP~~MCO holds provider agreements with the Ohio department of medicaid (ODM) for the MyCare Ohio and medicaid managed care programs or OhioRISE program, ODM may apply all of the applicable provisions in Chapter 5160-26 of the Administrative Code separately to each of the contracts.

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5160-58-02 MyCare Ohio plans: eligibility and enrollment.

(A) Eligibility.

- (1) Except as specified in paragraph (A)(2) of this rule, in mandatory service areas as permitted by 42 C.F.R. 438.52 (October 1, ~~2016~~2021), an individual must be enrolled in a MyCare Ohio plan (~~also known as "plan"~~)(MCOP) if he or she meets all of the following criteria:
 - (a) Age eighteen or older at the time of enrollment in the ~~plan~~ MCOP;
 - (b) Eligible for medicare parts A, B and D, and full benefits under the medicaid program; and
 - (c) Reside in a plan demonstration county in Ohio. A list of demonstration counties, and the ~~plans~~ MCOPs available in those counties, is available at <http://medicaid.ohio.gov>.
- (2) Indians who are members of federally recognized tribes may voluntarily choose to enroll in a ~~plan~~ an MCOP.
- (3) The following individuals are not eligible for enrollment in a ~~plan~~ an MCOP:
 - (a) Individuals enrolled in the program of all-inclusive care for the elderly (PACE);
 - (b) Individuals who have other third party creditable health care coverage, except medicare coverage as authorized by 42 U.S.C. 1395 (January 1, ~~2017~~2022);
 - (c) Individuals who are inmates of public institutions as defined in 42 C.F.R. 435.1010 (October 1, ~~2016~~2021);
 - (d) Individuals with intellectual disabilities who have a level of care that meets the criteria specified in rule ~~5123:2-8-01~~5123-8-01 of the Administrative Code and receive services through a home and community-based services (HCBS) waiver administered by the Ohio department of developmental disabilities (DODD); and
 - (e) Individuals with intellectual disabilities who receive services through an intermediate care facility for individuals with intellectual disabilities (ICF-IID).
- (4) Individuals are eligible for ~~plan~~ MCOP enrollment ~~in the manner prescribed in this rule~~ if the Ohio department of medicaid (ODM) has a provider agreement with the ~~plan~~ MCOP applicable to the eligible individual's county of residence.
- (5) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for medicare or other non-medicaid benefits to which he or she may be entitled.

(B) MyCare Ohio plan enrollment.

- (1) The following applies to ~~plan~~ MCOP enrollment:
 - (a) The ~~plan~~ MCOP must accept eligible individuals without regard to race, color, religion, gender,

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gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. The ~~plan~~-MCOP will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.3(d) (October 1, ~~2016~~2021).

- (b) The ~~plan~~-MCOP must accept eligible individuals who request ~~plan~~-MCOP membership without restriction.
- (c) If a ~~plan~~-an MCOP member loses managed care eligibility and is disenrolled from the ~~plan~~-MCOP, and subsequently regains eligibility, his or her membership in the same ~~plan~~-MCOP shall be re-instated back to the date eligibility was regained in accordance with procedures established by ODM.
- (d) The ~~plan~~-MCOP must cover all members designated by ODM in an ODM-produced Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 834 daily or monthly enrollment file of new members, continuing members, and terminating members.
- (e) The ~~plan~~-MCOP shall not be required to provide medicaid coverage to an individual until the individual's membership in the ~~plan~~-MCOP is confirmed via an ODM-produced HIPAA compliant 834 daily or monthly enrollment file or upon mutual agreement between ODM and the ~~plan~~-MCOP.

(2) Should a service area change from voluntary to mandatory, the notice rights in this rule must be followed.

- (a) When a service area is initially designated by ODM as mandatory for eligible individuals specified in paragraph (A)(1) of this rule, ODM shall confirm the eligibility of each individual as prescribed in paragraph (A)(1) of this rule. Upon the confirmation of eligibility:
 - (i) Eligible individuals residing in the service area who are currently ~~plan~~-MCOP members are deemed participants in the mandatory program; and
 - (ii) All other eligible individuals residing in the mandatory service area may request ~~plan~~-MCOP membership at any time but must select a ~~plan~~-MCOP following receipt of a notification of mandatory enrollment (NME) issued by ODM.
- (b) MyCare Ohio plan membership selection procedures for the mandatory program:
 - (i) A newly eligible individual who does not make a choice following issuance of a NME by ODM and one additional notice, will be assigned to a ~~plan~~-MCOP by ODM, the medicaid consumer hotline, or other ODM-approved entity.
 - (ii) ODM or the medicaid consumer hotline shall assign the individual to a ~~plan~~-MCOP based on prior medicaid fee-for-service, managed care organization, or ~~plan~~-MCOP membership history, whenever available, or at the discretion of ODM.

(C) Commencement of coverage.

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Coverage of ~~plan~~[MCOP](#) members will be effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily or monthly enrollment file to the ~~plan~~[MCOP](#).

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5160-58-02.1 MyCare Ohio plans: termination of enrollment.

- (A) A member will be terminated from enrollment in a MyCare Ohio plan (~~("plan")~~(MCOP)) for any of the following reasons:
- (1) The member becomes ineligible for full medicaid or medicare parts A or B or D. Termination of ~~plan-~~MCOP enrollment is effective the end of the last day of the month in which the member became ineligible.
 - (2) The member's permanent place of residence is moved outside the plan's service area. Termination of ~~plan-~~MCOP enrollment is effective the end of the last day of the month in which the member moved from the service area.
 - (3) The member dies, in which case plan enrollment ends on the date of death.
 - (4) The member is found by the Ohio department of medicaid (ODM), or their designee, to meet the criteria for the developmental disabilities (DD) level of care and has a stay in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or is enrolled in a DD waiver. After the ~~plan-~~MCOP notifies ODM this has occurred, termination of ~~plan-~~MCOP enrollment takes effect on the last day of the month preceding the ICF-IID facility stay or enrollment on the DD waiver.
 - (5) The member has third party coverage, excepting medicare coverage, ~~and ODM determines it is not in the best interest of the member to continue in the plan. The effective date of termination shall be determined by ODM but in no event shall the termination date be later than the last day of the month in which ODM approves the termination.~~ Termination of MCOP enrollment is effective the end of the last day of the month in which ODM identified the third party coverage.
 - (6) The provider agreement between ODM and the ~~plan-~~MCOP is terminated or not renewed. The effective date of termination shall be the date of ~~last day of the month of the~~ provider agreement termination or nonrenewal.
 - (7) The member is not eligible for enrollment in ~~a plan-~~an MCOP for one of the reasons set forth in rule 5160-58-02 of the Administrative Code.
- (B) All of the following apply when enrollment in a MyCare Ohio plan is terminated for any of the reasons set forth in paragraph (A) of this rule:
- (1) Terminations ~~Such terminations~~ may occur either in a mandatory or voluntary service area;
 - (2) All ~~such~~ terminations occur at the individual level;
 - (3) Terminations ~~Such terminations~~ do not require completion of a consumer contact record (CCR);
 - (4) If ODM fails to notify the ~~plan-~~MCOP of a member's termination from the plan, ODM shall continue to pay the ~~plan-~~MCOP the applicable monthly premium rate for the member. The ~~plan-~~MCOP shall remain liable for the provision of covered services as set forth in rule 5160-58-03 of the Administrative Code,

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until ODM provides the ~~plan~~ MCOP with documentation of the member's termination.; and

- (5) ODM shall recover from the ~~plan~~ MCOP any premium paid for retroactive enrollment termination occurring as a result of paragraph (A) of this rule.

(C) Member-initiated terminations.

- (1) A dual-benefits member may request disenrollment from the ~~plan~~ MCOP and transfer between plans on a month-to-month basis any time during the year. ~~Plan~~ MCOP coverage continues until the end of the month of disenrollment.
- (2) A medicaid-only member may request a different ~~plan~~ MCOP in a mandatory service area as follows:
- (a) From the date of initial enrollment through the first three months of plan enrollment, whether the first three months of enrollment are dual-benefits or medicaid-only enrollment periods;
 - (b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or
 - (c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.
- (3) A medicaid-only member may request a different ~~plan~~ MCOP if available or be returned to medicaid fee-for-service in a voluntary service area as follows:
- (a) From the date of enrollment through the initial three months of plan enrollment;
 - (b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or
 - (c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.
- (4) The following provisions apply when a member requests a different ~~plan~~ MCOP in a mandatory service area:
- (a) The request may be made by the member, or by the member's authorized representative.
 - (b) All member-initiated changes or terminations must be voluntary. ~~Plans~~ MCOPs are not permitted to encourage members to change or terminate enrollment due to a member's race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. ~~Plans~~ MCOPs may not use a policy or practice that has the effect of discrimination on the basis of the above criteria.
 - (c) If a member requests disenrollment because he or she meets any of the requirements in rule 5160-58-02 of the Administrative Code, the member will be disenrolled after the member notifies

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the consumer hotline.

- (d) Disenrollment will take effect on the last day of the calendar month as specified by an ODM-produced HIPAA compliant 834 daily or monthly file sent to the plan.
- (e) In accordance with 42 C.F.R. 438.56 (October 1, ~~2019~~2021), a change or termination of ~~plan~~-MCOP enrollment may be permitted for any of the following just cause reasons:
 - (i) The member moves out of the ~~plan's~~-MCOP's service area and a non-emergency service must be provided out of the service area before the effective date of a termination that occurs for one of the reasons set forth in paragraph (A) of this rule;
 - (ii) The ~~plan~~-MCOP does not, for moral or religious objections, cover the service the member seeks;
 - (iii) The member needs related services to be performed at the same time in a coordinated manner; however, not all related services are available within the ~~plan~~-MCOP network, and the member's primary care provider (PCP) or another provider determines that receiving services separately would subject the member to unnecessary risk;
 - (iv) The member has experienced poor quality of care and the services are not available from another provider within the ~~plan's~~MCOP's network;
 - (v) The member receiving long-term services and supports would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to and out-of-network provider with the ~~plan~~-MCOP and, as a result, would experience a disruption in their residence or employment;
 - (vi) The member cannot access medically necessary medicaid-covered services or cannot access the type of providers experienced in dealing with the member's health care needs;
 - (vii) ODM determines that continued enrollment in the ~~plan~~-MCOP would be harmful to the interests of the member.
- (f) The following provisions apply when a member seeks a change or termination in ~~plan~~-MCOP enrollment for just cause:
 - (i) The member or an authorized representative must contact the ~~plan~~-MCOP to identify providers of services before seeking a determination of just cause from ODM.
 - (ii) The member may make the request for just cause directly to ODM or an ODM-approved entity, either orally or in writing.
 - (iii) ODM shall review all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the member and the ~~plan~~MCOP. ODM shall make a decision within ten working days of receipt of all necessary documentation, or forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.

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- (iv) ODM may establish retroactive termination dates and/or recover premium payments as determined necessary and appropriate.
 - (v) Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member requests change or termination.
 - (vi) If the just cause request is not approved, ODM shall notify the member or the authorized representative of the member's right to a state hearing.
 - (vii) Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate.
 - (viii) If a member submits a request to change or terminate enrollment for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall assure that the member's ~~plan~~-MCOP enrollment is not automatically renewed if eligibility for medicaid is reauthorized.
- (g) A member who is in a medicare Part D drug management program and is in a potentially at-risk or at-risk status as defined in 42 C.F.R. 423.100 (October 1, ~~2019~~2021) is precluded from changing ~~plans~~MCOPs.

(D) The following provisions apply when a termination in ~~plan~~-MCOP enrollment is initiated by a ~~plan~~-MCOP for a medicaid-only member:

- (1) ~~A~~An ~~plan~~-MCOP may submit a request to ODM for the termination of a member for the following reasons:
 - (a) Fraudulent behavior by the member; or
 - (b) Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the extent that such behavior seriously impairs the ~~plan's~~MCOP's ability to provide services to either the member or other ~~plan~~-MCOP members.
- (2) The ~~plan~~-MCOP may not request termination due to a member's race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services.
- (3) The ~~plan~~-MCOP must provide covered services to a terminated member through the last day of the month in which the ~~plan~~-MCOP enrollment is terminated.
- (4) If ODM approves the ~~plan's~~MCOP's request for termination, ODM shall notify in writing the member, the authorized representative, the medicaid consumer hotline and the ~~plan~~MCOP.

(E) Open enrollment

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Open enrollment months will occur at least annually. At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals by mail of the opportunity to change or terminate enrollment in ~~aan plan~~ [MCOP](#) and will explain how the individual can obtain further information.

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5160-58-03 MyCare Ohio plans: covered services.

- (A) A MyCare Ohio plan (MCOP) must ensure members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based services (HCBS) covered by Ohio medicaid. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the MCOP ~~must~~ will ensure:
- (1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;
 - (2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;
 - (3) Prior authorization is available for services on which an MCOP has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary, unless the MCOP's limitation is also a limitation for fee-for-service medicaid coverage;
 - (4) Medicaid coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code; and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and
 - (5)) If a member is unable to obtain medically-necessary medicaid services from an MCOP ~~panel~~ network provider, the plan must adequately and timely cover the services out of ~~panel~~ network until the plan is able to provide the services from a ~~panel~~ network provider.
- (B) The MCOP may place appropriate limits on a service;
- (1) On the basis of medical necessity for the member's condition or diagnosis; ~~or;~~
 - (2) Except as otherwise specified in this rule, to available ~~panel~~ network providers; or
 - (3) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.
- (C) The MCOP must cover annual physical examinations for adults.
- (D) At the request of a member, an MCOP must provide for a second opinion from a qualified health care professional within the ~~panel~~ network. If a qualified health care professional is not available within the plan's ~~panel~~ network, the plan ~~must~~ will arrange for the member to obtain a second opinion outside the ~~panel~~ network, at no cost to the member.
- (E) The MCOP must ensure emergency services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:
- (1) The MCOP may not deny payment for treatment obtained when a member had an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.
 - (2) The MCOP cannot limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

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- (3) The MCOP must cover all emergency services without requiring prior authorization.
 - (4) The MCOP must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the ~~plan~~-MCOP including but not limited to the member's primary care provider (PCP) or the ~~plan's~~-MCOP's twenty-four-hour toll-free call-in-system.
 - (5) The MCOP cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.
 - (6) For the purposes of this rule, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCOP but provides emergency services to a ~~plan~~-an MCOP member, regardless of whether that provider has a medicaid provider agreement with ODM. The ~~plan~~-MCOP must cover emergency services as defined in rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services. Claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code. Such services must be reimbursed by the ~~plan~~-MCOP at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the ~~plan~~-MCOP is required to reimburse at this rate only until the member can be transferred to a provider designated by the ~~plan~~-MCOP.
 - (7) The MCOP must cover emergency services until the member is stabilized and can be safely discharged or transferred.
 - (8) The MCOP must adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The ~~plan~~-MCOP may establish arrangements with hospitals whereby the ~~plan~~-MCOP may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.
 - (9) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
- (F) The MCOP must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (E)(6) of this rule. These written policies and procedures must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. The ~~plan~~-MCOP may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.
- (G) The MCOP must ensure post-stabilization care services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week.

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- (1) The MCOP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day, seven days a week. The ~~plan-~~ MCOP must document the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The ~~plan-~~ MCOP must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the ~~plan-~~ MCOP communicated the decision in writing to the provider.
 - (2) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:
 - (a) The MCOP must cover services obtained within or outside the plan's ~~panel-~~ network that have not been pre-approved in writing by a ~~plan-an~~ MCOP provider or other ~~plan-~~ MCOP representative.
 - (b) If the MCOP does not respond within one hour of a provider's request for preapproval of further services administered to maintain the member's stabilized condition, the ~~plan-~~ MCOP must cover the services, whether or not they were provided within the ~~plan's~~ MCOP's ~~panel-~~ network.
 - (c) The MCOP must cover services obtained within or outside the ~~plan's~~ MCOP's ~~panel-~~ network that are not pre-approved by a ~~plan-an~~ MCOP provider or other ~~plan-~~ MCOP representative but are administered to maintain, improve or resolve the member's stabilized condition if:
 - (i) The MCOP fails to respond within one hour to a provider request for authorization to provide such services.
 - (ii) The MCOP cannot be contacted.
 - (iii) The MCOP's representative and treating provider cannot reach an agreement concerning the member's care and a ~~plan-~~ network provider is not available for consultation. In this situation, the ~~plan-~~ MCOP must give the treating provider the opportunity to consult with a ~~plan-~~ network provider and the treating provider may continue with care until a ~~plan-~~ network provider is reached or one of the criteria specified in paragraph (G)(3) of this rule is met.
 - (3) The MCOP's financial responsibility for post stabilization care services not pre-approved ends when:
 - (a) A ~~plan-~~ network provider with privileges at the treating hospital assumes responsibility for the member's care;
 - (b) A ~~plan-~~ network provider assumes responsibility for the member's care after the member is transferred to another facility;
 - (c) A ~~plan-~~ An MCOP representative and the treating provider reach an agreement concerning the member's care; or
 - (d) The member is discharged.
- (H) MCOP responsibilities for payment of other services.

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- (1) The MCOP must permit members to self-refer to Title X services provided by any qualified family planning provider (QFPP). The ~~plan~~-MCOP is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the ~~plan~~-MCOP at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges, in effect for the date of service.
- (2) The MCOP must permit members to self-refer to any women's health specialist within the ~~plan's~~MCOP's ~~panel~~-network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated primary care provider (PCP) if that PCP is not a women's health specialist.
- (3) The MCOP must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- (4) Where available, the MCOP must ensure access to covered services provided by a certified nurse practitioner.
- ~~(5)~~ ~~(5) The MCOP is not responsible for payment of services provided through the medicaid schools program pursuant to Chapter 5160-35 of the Administrative Code.~~
- ~~(6)~~ ~~(5) The MCOP must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with rule 5160-1-14 of the Administrative Code, to healthchek eligible members and ensure healthchek exams:~~
 - (a) Include the components specified in rule 5160-1-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual external quality review.
 - (b) Are completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.
- (6) The MCOP will ensure access to services described in rule 5160-59-03 of the Administrative Code for members who are not enrolled in the OhioRISE plan but require the OhioRISE services.

(I) MCOP service exclusions.

- ~~(7)~~ ~~(1) An MCOP is not required to cover services provided to members outside the United States.~~
- ~~(8)~~ ~~(2) When a member is determined to be no longer eligible for enrollment in an MCOP during a stay in an institution for mental disease (IMD), the MCOP is not responsible for payment of that IMD stay after the date of disenrollment from the ~~plan~~MCOP.~~
- ~~(4)~~ ~~(3) The MCOP is not responsible for payment of services provided through the medicaid schools program pursuant to Chapter 5160-35 of the Administrative Code.~~

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5160-58-03.1 MyCare Ohio plans: primary care and utilization management.

(A) The MyCare Ohio plan (MCOP) will ensure each member has a primary care provider (PCP) who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member's needs.

(1) An MCOP will ensure PCPs are in compliance with the following triage requirements. Members with:

(a) Emergency care needs, triage and treatment occurs immediately on presentation at the PCP site;

(b) Persistent symptoms, treatment occurs no later than the end of the following working day after their initial contact with the PCP site; and

(c) Requests for routine care will be seen within six weeks.

(2) PCP care coordination responsibilities include the following:

(a) Assisting with coordination of the member's overall care, as appropriate for the member;

(b) Providing services which are medically necessary as described in rule 5160-1-01 of the Administrative Code;

(c) Serving as the ongoing source of primary and preventative care;

(d) Recommending referrals to specialists, as required; and

(e) Triageing members as described in paragraph (A)(1) of this rule.

(B) An MCOP will have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. An MCOP will ensure decisions rendered through the UM program are based on medical necessity.

(1) The UM program based on written policies and procedures will include, :

(a) The information sources used to make determinations of medical necessity;

(b) The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria;

(c) A specification that written UM criteria will be made available to both contracting and non-contracting providers; and

(d) A description of how the MCOP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(2) An MCOP's UM program will ensure and document the following:

(a) An annual review and update of the UM program.

(b) The involvement of a designated senior physician in the UM program.

(c) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions.

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- (d) The use of board-certified consultants to assist in making medical necessity determinations, as necessary.
 - (e) That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Administrative Code. An MCOP will not impose conditions on the coverage of a medically necessary medicaid-covered service unless they are supported by such clinical practice guidelines.
 - (f) The reason for each denial of a service, based on sound clinical evidence.
 - (g) That compensation by the MCOP to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member.
- (3) An MCOP will process requests for initial and continuing authorizations of services from their providers and members. An MCOP will have written policies and procedures to process requests and, upon request, the MCOP's policies and procedures will be made available for review by the Ohio department of medicaid (ODM). The MCOP's written policies and procedures for initial and continuing authorizations of services will also be made available to contracting and non-contracting providers upon request. The MCOP will ensure and document the following occurs when processing requests for initial and continuing authorizations of services:
- (a) Consistent application of review criteria for authorization decisions.
 - (b) Consultation with the requesting provider, when necessary.
 - (c) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, will be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.
 - (d) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member will meet the requirements of division 5101:6 and rule 5160-26-08.4 of the Administrative Code.
 - (e) For standard authorization decisions, the MCOP will provide notice to the provider and member as expeditiously as the member's health condition requires but no later than ten calendar days following receipt of the request for service, except as specified in paragraph (B)(3)(g) of this rule. If requested by the member, provider, or MCOP, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCOP, the MCOP will submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCOP's extension request, the MCOP will give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCOP will carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
 - (f) If a provider indicates or the MCOP determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCOP will make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than forty-eight hours after receipt of the request for service. If requested by the member or MCOP, expedited authorization decisions may be extended up to fourteen additional calendar days. If

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requested by the MCOP, the MCOP will submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCOP's extension request, the MCOP will give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCOP will carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(g) Service authorization decisions not reached within the timeframes specified in paragraphs (B)(3)(e) and (B)(3)(f) of this rule constitute a denial, and the MCOPs will give notice to the member as specified in rule 5160-58-08.4 of the Administrative Code.

(h) Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect January 1, 2022) will be made within the timeframes specified in 42 C.F.R. 423.568(b) (October 1, 2021) for standard decisions and 42 C.F.R. 423.572(a) (October 1, 2021) for expedited decisions. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed will be authorized. If the MCOP is unable to obtain the information needed to make the prior authorization decision within seventy-two hours, the decision timeframe has expired and the MCOP will give notice to the member as specified in rule 5160-58-08.4 of the Administrative Code.

(i) MCOPs will maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. MCOP records will include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

~~(6)~~ (4) An MCOP may develop other UM programs subject to ODM prior approval.