TO BE RESCINDED

5160-26-02 **Managed health care programs: eligibility, membership, and automatic renewal of membership.**

(A) This rule does not apply to "MyCare Ohio" plans as defined in rule 5160-58-01 of the Administrative Code. The eligibility, membership, and automatic renewal provisions for "MyCare Ohio" plans are described in rule 5160-58-02 of the Administrative Code.

(B) Eligibility.

(1) In mandatory service areas as permitted by 42 CFR 438.52 (October 1, 2013), an individual must be enrolled in an MCP if he or she meets the following criteria and paragraphs (B)(2) to (B)(5) of this rule do not apply:

(a) Eligible for covered families and children (CFC) medicaid in accordance with Chapter 5160:1-4 of the Administrative Code or modified adjusted gross income (MAGI)-based medicaid eligibility in accordance with division 5160:1 of the Administrative Code; or

(b) Eligible for aged, blind, or disabled (ABD) medicaid in accordance with Chapter 5160:1-3 of the Administrative Code.

(2) Individuals who are dually eligible under both the medicaid and medicare programs are excluded from medicaid MCP membership.

(3) The following individuals are not required to enroll in an MCP:

(a) Children under nineteen years of age and receiving Title IV-E federal foster care maintenance through an agreement between the local children services board and the foster care provider;

(b) Children under nineteen years of age and receiving Title IV-E adoption assistance through an agreement between the local children services board and the adoptive parent;

(c) Children under nineteen years of age and in foster care or other out-of-home placement;

(d) Children under nineteen years of age and receiving services through the Ohio department of health's bureau for children with medical handicaps (BCMH) or any other family-centered, community-based, coordinated

care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act, 42 U.S.C. 701(a)(1)(D) (as in effect December 1, 2014) and is defined by the state in terms of either program participation or special health care needs; and

(e) Indians who are members of federally recognized tribes.

(4) Eligible individuals for ABD described in paragraph (B)(1)(b) of this rule are excluded from MCP membership if they are:

(a) Institutionalized;

(b) Eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements; or

(c) Individuals receiving medicaid services through a medicaid waiver component, as defined in section 5166.02 of the Revised Code.

(5) Individuals are excluded from MCP membership when excluded under a federally approved state plan or state law from MCP enrollment.

(6) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for other non-medicaid benefits to which he or she may be entitled.

(C) Enrollment.

(1) The following applies to enrollment in an MCP:

(a) The MCP must accept eligible individuals without regard to race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services. The MCP will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.6(d) (October 1, 2013).

(b) The MCP must accept eligible individuals who request MCP membership without restriction.

(c) The MCP must accept PCP(s) selected by the member when available, except as otherwise provided in this rule.

(d) In the event that an MCP member loses medicaid eligibility and is automatically terminated from the MCP, but regains medicaid eligibility within a period of sixty days or less, his or her membership in the same MCP shall automatically be re-instated.

(e) ODM shall confirm the eligible individual's MCP membership to the MCP via an ODM-produced roster of new members, continuing members, and terminating members.

(f) The MCP shall not be required to provide coverage until MCP membership is confirmed via an ODM-produced roster except as provided in paragraph (C)(3) of this rule or upon mutual agreement between ODM and the MCP.

(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 (B)(1) of this rule, ODM shall confirm the eligibility of each eligible individual as prescribed in paragraph (C)(1)(e) of this rule. Upon the confirmation of eligibility:

(i) Eligible individuals residing in the service area who are currently MCP members are deemed participants in the mandatory program; and

(ii) All other eligible individuals residing in the mandatory service area may request MCP membership at any time but must select an MCP following receipt of a notification of mandatory selection (NMS) issued by ODM.

(b) MCP membership selection procedures for the mandatory program:

(i) An individual that does not make a choice following issuance of an NMS by ODM and one additional notice will be assigned to an MCP by ODM, the medicaid consumer hotline, or other ODM-approved entity.

(ii) ODM or the medicaid consumer hotline shall assign the individual to an MCP based on prior medicaid fee-for-service or MCP membership history, whenever available, or at the discretion of

ODM.

(3) Newborn notification and membership.

(a) The MCP must notify ODM, or its designee, as directed by ODM of the birth of any newborn whose mother is enrolled in an MCP.

(b) Newborns born to mothers enrolled in an MCP are enrolled in an MCP from their date of birth through the end of the month of the child's first birthday, in accordance with the enrollment and disenrollment criteria specified in Chapter 5160-26 of the Administrative Code.

(D) Commencement of coverage.

(1) Coverage of MCP members will be effective at the beginning of the first day of the calendar month following the confirmation of the eligible individual's effective date of MCP membership via an ODM-produced roster to the MCP, except as identified in paragraph (C)(3) of this rule.

(2) The following coverage responsibilities shall apply for a new member admitted to an inpatient facility prior to the effective date of managed care coverage who remains an inpatient on the effective date of coverage in accordance with the following:

(a) The new member must be enrolling in the MCP from medicaid fee-for-service. In the event the member is transferring membership from one MCP to another, the provisions of paragraphs (D)(3) and (D)(4) of this rule apply.

(b) The MCP shall assume responsibility for all medically necessary medicaid covered services including professional and ancillary services related to the inpatient stay beginning with the effective date of membership in the MCP, except for the inpatient facility charges. Medicaid fee-for-service shall remain responsible for the inpatient facility charges through the date of discharge pursuant to rule 5160-2-07.11 of the Administrative Code.

(3) The coverage responsibilities listed in paragraph (D)(4) of this rule shall apply to a member who meets the following criteria:

(a) The member's current MCP membership is changed or terminated for any reason, including, but not limited to, any of the reasons set forth in rule

5160-26-02.1 of the Administrative Code, except if the member becomes ineligible for medicaid; and

(b) The member is admitted to an inpatient facility prior to the effective date of the MCP change or termination; and

(c) The member remains an inpatient in an inpatient facility after the date that membership in the current MCP ends.

(4) The following coverage responsibilities shall apply to a member who meets the criteria listed in paragraph (D)(3) of this rule:

(a) The disenrolling MCP shall remain responsible for providing all medically necessary medicaid covered services through the last day of the month in which the membership is changed or terminated, and shall remain responsible for all inpatient facility charges through the date of discharge. For retroactive disenrollments authorized by ODM, where the date of inpatient admission is prior to the last day of MCP coverage, the disenrolling MCP is responsible for inpatient facility charges through the date of discharge.

(b) The disenrolling MCP shall receive capitation through the end of the month in which membership is changed or terminated regardless of the length of the inpatient stay. Additional capitation payments will not be made by ODM regardless of the length of the inpatient stay.

(c) If the member will be enrolling in a new MCP, the disenrolling MCP shall notify the enrolling MCP of the inpatient status of the member following verification of the change or termination by the medicaid consumer hotline via the consumer contact record and the disenrollment by ODM via the monthly member roster.

(d) The disenrolling MCP shall notify the inpatient facility of the change or termination in MCP enrollment including the name of the enrolling MCP, if applicable, following verification of the disenrollment by ODM via the monthly membership roster, but advise the inpatient facility that the disenrolling MCP shall remain responsible for the inpatient facility charges through the date of discharge.

(e) If the member will be enrolling in a new MCP, the enrolling MCP shall assume responsibility for all medically necessary medicaid covered services including professional and ancillary services related to the

inpatient stay beginning with the effective date of membership in the MCP, except for the inpatient facility charges.

(f) If the member will be enrolling in a new MCP, the enrolling MCP shall receive capitation beginning with the effective date of MCP membership.

(g) If the member will be enrolling in a new MCP, then upon notification of the inpatient status of the new member as specified in paragraph (D)(4)(c) of this rule, the enrolling MCP shall contact the inpatient facility to verify responsibility for all services following discharge for the member, and to assure that discharge plans are arranged through the MCP's panel. The enrolling MCP shall also verify the MCP's responsibility for all professional and ancillary charges related to the inpatient stay beginning with the effective date of MCP membership.

(h) If the member will be enrolling in a new MCP, and if the enrolling MCP fails to contact the inpatient facility prior to discharge, the enrolling MCP must honor discharge arrangements until such time that the MCP can transition the member to the MCP's participating providers.

Replaces: 5160-26-02

Effective:

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Certification

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Date

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