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

(A) A member will be terminated from enrollment in a MyCare Ohio plan ("plan") 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 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 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 notifies ODM this has occurred, termination of plan 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.

(6) The provider agreement between ODM and the plan is terminated or not renewed. The effective date of termination shall be the last day of the month of the provider agreement termination or nonrenewal.

(7) The member is not eligible for enrollment in a plan 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) Such terminations may occur either in a mandatory or voluntary service area;

(2) All such terminations occur at the individual level;

(3) Such terminations do not require completion of a consumer contact record (CCR);

(4) If ODM fails to notify the plan of a member's termination from the plan, ODM shall continue to pay the plan the applicable monthly premium rate for the member. The plan shall remain liable for the provision of covered services as set forth in rule 5160-58-03 of the Administrative Code, until ODM provides the plan with documentation of the member's termination.; and

(5) ODM shall recover from the plan 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 and transfer between plans on a month-to-month basis any time during the year. Plan coverage continues until the end of the month of disenrollment.

(2) A medicaid-only member may request a different plan 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 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 ~~either~~ requests a different plan in a mandatory service area:~~, requests disenrollment in a voluntary service area, or qualifies as voluntary population as set forth in rule 5160-58-02 of the Administrative Code:~~

(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 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 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 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, ~~2017~~2019), a change or termination of plan enrollment may be permitted for any of the following just cause reasons:

(i) The member moves out of the plan'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 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 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 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 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 would be harmful to the interests of the member.

(f) The following provisions apply when a member seeks a change or termination in plan enrollment for just cause:

(i) The member or an authorized representative must contact the plan 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. 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.

(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 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) is precluded from changing plans.

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

(1) A plan 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 ability to provide services to either the member or other plan members.

(2) The plan 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 must provide covered services to a terminated member through the last day of the month in which the plan enrollment is terminated.

(4) If ODM approves the plan's request for termination, ODM shall notify in writing the member, the authorized representative, the medicaid consumer hotline and the plan.

(E) Open enrollment

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 a plan and will explain how the individual can obtain further information.

Effective:

Five Year Review (FYR) Dates: 1/1/2025

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Certification

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Date

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