CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Managed Care 2014 Five Year Rule Review

Rule Number(s): 5160-26-02, 5160-26-06, 5160-26-07, 5160-26-07.1, 5160-26-08, 5160-26-08.1, 5160-26-08.2, 5160-26-08.3, 5160-26-08.4, 5160-26-08.5, 5160-26-09, 5160-26-11, 5160-26-12

Date: August 13, 2014

Rule Type:

New	X 5 Year Review
X Amended	X Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

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Rule 5160-26-02, entitled Managed health care programs: eligibility, membership, and automatic renewal of membership is being proposed for amendment due to five year rule review. The rule describes the managed care enrollment process and the categories of individuals who are eligible for enrollment in MCPs. Changes to the rule add modified adjusted gross income (MAGI)-based Medicaid eligibles to the list of groups eligible for Medicaid managed care. (MAGI)-based eligibility applies to the Covered Families and Children eligibility category. Other amendments to the rule clarify that this rule does not apply to MyCare Ohio plans, clarify the managed care mandatory and voluntary enrollment criteria, and update language regarding the coverage of newborns. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-06, entitled Managed health care programs: program integrity – fraud and abuse, audits, reporting and record retention, is being proposed for amendment due to five year rule review. The rule sets forth provisions for Medicaid MCP program integrity, including specific requirements on MCPs to guard against fraud and abuse, audits, the submission of reports, and record retention. Changes to the rule clarify language for the annual fraud and abuse report and record retention requirements. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-07, entitled Managed health care programs: annual external quality review, is being proposed for rescission to update policy relating to administration of the Medicaid program. The rule describes the federal requirement requiring states to complete external quality reviews for MCPs.

Rule 5160-26-07.1, entitled Managed health care programs: Quality assessment and performance improvement program (QAPI), is being proposed for rescission due to five year rule review. The rule sets forth the federal quality assessment and performance improvement program (QAPI) requirements for MCPs.

Rule 5160-26-08, entitled Managed health care programs: marketing, is being proposed for amendment due to five year rule review. The rule sets forth marketing requirements for MCPs. Changes to the rule clarify language regarding marketing activities and materials. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-08.1, entitled Managed health care programs: information and enrollment services, is being proposed for rescission due to five year rule review. The rule describes contracts with enrollment services entities for Medicaid managed care.

Rule 5160-26-08.2, entitled Managed health care programs: member services, is being proposed for amendment due to five year rule review. The rule sets forth requirements for MCPs regarding services and materials. Changes to the rule clarify language regarding member services and member materials that MCPs must provide to its members. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-08.3, entitled Managed health care programs: member rights, is being proposed for amendment to update policy relating to the administration of the Medicaid program. The rule sets forth requirements regarding the rights of members in MCPs. Changes to this rule modify language regarding the MCP members' ability to participate in their health care decisions. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-08.4, entitled Managed health care programs: MCP grievance system is being proposed for amendment due to five year rule review. The rule sets forth requirements for the MCP grievances and appeals and describes three avenues allowing a member to challenge certain actions taken by the MCP: (1) a grievance process, (2) an appeal to the MCP, and (3) a process allowing members to access the State's hearing system through the Ohio Department of Job and Family Services (ODJFS). Changes to the rule update and reorganize language regarding the obligations of the MCPs with respect to the grievance and appeals process and the processes for members to access the three avenues available to them. Additional amendments to the rule clarify that this rule does not apply to MyCare Ohio plans, and update legal citations and cross-references.

Rule 5160-26-08.5, entitled Managed health care programs: responsibilities for state hearings is being proposed for rescission due to five year rule review. The rule sets forth the obligations of the MCPs regarding compliance with state hearing decisions. The contents of the rescinded rule have been moved to OAC rule 5160-26-08.4.

Rule 5160-26-09, entitled Managed health care programs: reimbursement and financial responsibility is being proposed for amendment due to five year rule review. The rule describes ODM's payments to MCPs and the obligations of the MCPs with respect to financial reporting and reinsurance. Changes to the rule update language regarding the frequency of actuarial review and MCPs' responsibilities for cost reports and reinsurance requirements. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-11, entitled Managed health care programs: managed care plan non-contracting providers, is being proposed for amendment to update policy relating to the administration of the Medicaid program. The rule sets forth requirements for providers that do not contract with Medicaid MCPs. Changes to the rule add clarifying language from state law which specifies that the compensation for inpatient hospital capital costs for emergency services provided by non-contracting hospitals shall not exceed the maximum amount established by the department. Other amendments clarify the activities related to external quality reviews and update the timeframe for record retention by non-contracting providers, consistent with the provisions of OAC rule 5160-26-06. Additional amendments to the rule update legal citations and cross-references.

Rule 5160-26-12, entitled Managed health care programs: member co-payments, is being proposed for amendment to update policy relating to the administration of the Medicaid program. The rule sets forth requirements for MCPs when they elect to implement a co-payment program. Changes to the rule simplify and clarify language regarding co-payments and update legal citations and cross-references.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Ohio Revised Code Section 5167.02.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program? If yes, please briefly explain the source and substance of the federal requirement.**

   Yes. 42 C.F.R. Part 438 imposes comprehensive requirements on Medicaid managed care plans. For example, Section 438.56 imposes requirements for disenrollment of members from plans, and Section 438.114 addresses the requirement to provide emergency and post-stabilization services even when they are rendered by providers who do not have contracts with managed care plans. Subpart C of the regulations imposes requirements for enrollee protections and marketing activities. Subpart F of these regulations (42 C.F.R. 438.400 - 438.424) imposes detailed requirements requiring each Medicaid managed care plan to have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system. Other rules in this Subpart address the requirements for a notice of action that the plan intends to take, the handling of grievances and appeals, and the resolution of appeals and grievances.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   Although the federal regulations do not impose requirements directly on managed care plans, they do require state Medicaid agencies to ensure managed care plan compliance with federal standards.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   These rules perform several functions. They ensure compliance with federal regulations governing Medicaid managed care. They ensure that information maintained by managed care plans is readily available for the State, and if requested, for the Centers for Medicare and Medicaid Services (CMS).

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   Through the review of reports, the Agency verifies that plans are complying with federal standards. With five plans in the state, all will be expected to provide similar information, making missing information more obvious, measuring the success of the regulation.

   The managed care plans must demonstrate compliance with several performance measures that gauge the performance of plans. Successful health outcomes are measured through a finding of compliance with these standards.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**

   Medicaid managed care plans and stakeholders such as the Ohio Hospital Association and Voices for Ohio's Children have been involved in the initial review of the draft regulations.

   The MCPs that applied for a request for applications (RFA) in 2012 were aware of the expectations and requirements they would be held to if they were to become a Medicaid MCP for the state of Ohio. Since the regulations were in place prior to the RFA process, these plans were already aware of the reporting requirements. The MCPs selected are Buckeye, CareSource, Molina, Paramount and UnitedHealthCare.

   Stakeholders have provided informal input that has been the basis for the draft regulations. Additionally, stakeholders provided formal input when the rule was distributed to stakeholders during the department's clearance process from May 7 to May 20, 2014.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   The Department received comments from four stakeholders, specifically, Buckeye, Molina, Paramount and Marion County Department of Job and Family Services (CDJFS). The comments from Buckeye, Molina, and Paramount pertained to the clarification of revisions to the primary care provider and subcontract definitions. Paramount also requested clarification on an operational issue regarding newborn enrollment. Marion CDJFS requested clarification regarding transportation issues which were not related to the rule revisions. The Department provided the necessary clarifications to the stakeholders. All comments received to date have been considered in developing the draft regulations.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   No scientific data was used; however, the requirements in these rules are based on federal regulations as mentioned above.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    The Agency considered performing periodic audits; however, reports provide more real-time feedback to assure timely access to needed services for Medicaid beneficiaries.

11. **Did the Agency specifically consider a performance-based regulation? Please explain. *Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    A performance-based regulation would not comply with the federal regulations. However, through the submission of the requested data, the Agency is able to determine whether the MCPs are meeting the standards specified in federal regulations.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    All Medicaid regulations governing MCPs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid program. Furthermore, this regulation was reviewed by ODM's legal and legislative staff to ensure that there is no duplication within ODM rules.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    All five MCPs are required to publish claims submission requirements and the required reports consistently. A robust effort will be employed by the department to notify the MCPs and stakeholders of the rules. A variety of communication methods will be used, including, but not limited to e-mail notification and posting of the rules on the ODM website.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

a. **Identify the scope of the impacted business community;**
This rule only impacts MCPs in the State. The MCPs that will be impacted are Buckeye, CareSource, Molina, Paramount and UnitedHealthCare.

b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**

Below is a listing of the nature of the adverse impact (i.e., provision of material and reports) necessary to comply with the following rules.

5160-26-02:

(C)(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.

(D)(4)(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)(4)(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.

5160-26-06:

(A) Each MCP must have administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud and abuse that includes:

(A)(1)(d) Prompt reporting of all instances of fraud and abuse to ODM and member fraud to the CDJFS.

(A)(2) These arrangements or procedures must be made available to ODM upon request.

(A)(3) The MCP must annually submit to ODM a report that summarizes the MCP's fraud and abuse activities for the previous year and identifies any proposed changes to the MCP's fraud and abuse program for the coming year.

(D) The MCP must submit required reports and additional information, as requested by ODM, as related to their its duties and obligations and where needed to assure operation in accordance with all state and federal regulations or requirements.

(F) Record retention.
The MCP and its subcontractors shall retain and safeguard all hard copy or electronic records originated or prepared in connection with the MCP's performance of its obligations under the provider agreement, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports in accordance with applicable sections of the federal regulations, the Revised Code, and the Administrative Code. Records stored electronically must be produced at the MCP's expense, upon request, in the format specified by state or federal authorities. All such records must be maintained for a minimum of eight years from the renewal, amendment or termination date of the provider agreement, or in the event that the MCP has been notified that state or federal authorities have commenced an audit or investigation of the provider agreement, until such time as the matter under audit or investigation has been resolved. For the initial three years of the retention period, the MCP and its subcontractors must store the records in a manner and place that provides readily available access.

5160-26-07

(C) MCPs must timely submit data and information, including member medical records, at no cost to the member or Department, as requested by the Department or its designee for the annual external quality review.

5160-26-07.1

(A)(4) MCP must report on the status and/or results of each performance improvement project (PIP) to the Department, at least annually, including a report on the mechanisms specified in paragraphs (A)(2) and (A)(3) of this rule.

(A)(5) Submit performance measurement data as required by the Department that enables the Department to calculate standard measures; and/or uses standard measures as required by the Department.

(C) Each MCP must establish appropriate administrative oversight arrangements and accountability for the quality assessment and performance improvement (QAPI) program. MCPs must be able to document, upon request, that such arrangements include: the assignment of a senior official responsible for the QAPI program; provision for and a record of ongoing communication and coordination between the area that oversees the QAPI program and relevant functional areas of the organization; and assurance that the medical director is involved in all clinically-related projects and that all staff responsible for QAPI implementation have education, experience, and training appropriate to their position.

5160-26-08

(D)(6) An MCP must have a solicitation brochure available to eligible individuals. The solicitation brochure must comply with the elements found in rule 5160-26-08.

(F)(6)(e) MCP marketing representatives must offer the ODM-approved solicitation brochure to the eligible individual(s) at the time of the marketing presentation and must provide, at a minimum:
(i) An explanation of the importance of reviewing the information in the ODM-approved solicitation brochure, how the individual can receive additional information about the MCP prior to making an MCP membership selection, and the process for contacting ODM to select an MCP.
(ii) Information that membership in the particular MCP is voluntary and that a decision to select or not select the MCP will not affect eligibility for Medicaid or other public assistance benefits.
(iii) Information that each member must choose a PCP and must access providers and services as directed in the MCP's member handbook and provider directory.
(iv) Information that all medically-necessary Medicaid-covered services, as well as any additional services provided by the MCP, will be available to all members.

(G) Upon request, MCPs must provide eligible individuals with a provider directory which has been approved by ODM.

(H)(1) The MCP must immediately notify ODM in writing of its discovery of an alleged/ or suspected marketing violation.

5160-26-08.1

(B) Any entity providing information and enrollment services must submit all related policies, procedures, and materials in writing to the Department for approval prior to use.

5160-26-08.2

(A)(3) In the event the consumer contact record (CCR) does not identify a member-selected primary care provider (PCP) for each assistance group member, or if the member-selected PCP is not available, the MCP must:

(a) Select a PCP for each member prior to the effective date of coverage based on the PCP assignment methodology prior-approved by ODM;
(b) Notify each member members of the name of his or her PCP prior to the effective date of coverage and pursuant to the provisions rule 5160-26-02 of the Administrative Code;
(c) Simultaneously notify each member with an MCP-selected PCP of the ability within the first month of initial MCP membership to change the MCP-selected PCP effective on the date of contact with the MCP; and
(d) Explain that PCP change requests after the initial month of MCP membership shall be processed according to the procedures outlined in the MCP member handbook.

(B)(1) The MCP must develop and disseminate member materials, including at a minimum member materials specified in paragraph (B)(3) of this rule. All MCP member materials, including but not limited to those used for member education, member appreciation and member incentive programs, and changes thereto must be prior-approved in writing by ODM.

(B)(5) If a member's MCP membership is automatically renewed as specified in rule 5160-26-02 of the Administrative Code, the MCP must issue an identification card as specified in paragraph (B)(3) of this rule prior to the new effective date of coverage. Additionally, in the event the member handbook has been revised since the initial

MCP membership date of the member's assistance group, the MCP must issue a new member handbook to the member.

(B)(6) At least annually, the MCP must determine the predominant health care needs of its Medicaid members and provide health education materials as indicated by these assessments. The MCP must provide ODM a summary of the results of the health care needs assessment and a list of the materials distributed to members as a result of the assessment.

5160-26-08.3

MCPs must advise members via the member handbook of the member rights specified in paragraph (A) of this rule.

5160-26-08.4

(B) Each MCP must have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of this rule. The policies and procedures must be made available for review by ODM, and must include the following:
(1) A process by which members may file grievances with the MCP, in compliance with paragraph (H) of this rule;
(2) A process by which members may file appeals with the MCP, in compliance with paragraphs (C) through (G) of this rule; and
(3) A process by which members may access the state's hearing system through the Ohio Department of Job and Family Services (ODJFS) in compliance with paragraph (I) of this rule.

(C) When an MCP action has occurred or will occur, the MCP must provide the affected member(s) with a written NOA.

5160-26-08.5

(A) MCPs must develop and implement written policies and procedures that ensure the MCP's compliance with the applicable state hearing provisions specified in division 5101:6 of the Administrative Code.

(B)(5) Copies of all annual and quarterly financial statements and any revision to such copies must be submitted to ODM. For purposes of this rule, "annual financial statement" is the annual statement of financial condition prescribed by the "National Association of Insurance Commissioners" (NAIC) statutory filing of financial condition as adopted and required by the Ohio department of insurance (ODI) in accordance with sections 1751.32 and 1751.47 of the Revised Code.

The MCP must submit to ODM a copy of its audited financial statement as compiled by an independent auditor and including the statement of reconciliation with statutory accounting principles as required by ODI in accordance with section 1751.321 of the Revised Code. The statement must be submitted annually to ODM.

The following items must be submitted by each MCP as so indicated:

A copy of the MCP's current license or certificate of authority must be submitted to ODM annually, no later than thirty days after issuance.

Cost reports on ODM forms quarterly and annually. The MCP must adhere to ODM provider agreement and cost report instructions.

Financial disclosure statements to be submitted in conjunction with cost report submissions as specified in paragraph (B)(5)(b) of this rule for MCPs. The MCP must also submit copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP, or an indirect interest of five percent or more or a combination of direct and indirect interest equal to five percent or more in the MCP; and MCP physician incentive plan disclosure statements and other information as required in accordance with 42 C.F.R. 438.6.

A copy of the fully-executed reinsurance agreement to provide the specified coverage must be submitted to ODM prior to the effective date of the provider agreement.

The MCP shall provide written notification to ODM when directed by ODM, specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all Medicaid members for which reinsurance claims have been submitted.

The MCP must give ODM prior written notice of any proposed changes or modifications in the reinsurance agreements for ODM review and approval. Such notice shall be submitted to ODM thirty days prior to the intended effective date of any proposed change and must include the complete and exact text of the proposed change. The MCP must provide copies of new or modified reinsurance agreements to ODM within thirty days of execution

5160-26-11

MCP non-contracting providers, including MCP non-contracting providers of emergency services, must contact the twenty-four hour post-stabilization services phone line designated by the MCP to request authorization to provide post-stabilization services in accordance with 5160-26-03 of the Administrative Code.

5160-26-12

MCPs may elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for dental services, vision services, non-emergency emergency department services, or prescription drugs as provided for in this rule. MCPs must receive prior approval from ODM before notifying members that a co-payment program will be implemented.

c. Quantify the expected adverse impact from the regulation.

The Ohio Department of Medicaid (ODM) estimates that up to 80-85 employees are necessary for an MCP to meet the requirements within these regulations. This is based on input from one of the managed care plans, CareSource. CareSource has an enrollment of approximately 1 million Medicaid members and is paid approximately $4 billion dollars per year in capitation payments on behalf of Medicaid members.

All MCPs were aware of the need to maintain and submit various reports prior to deciding to do business with the State. Through the administrative component of the capitation rate paid to the MCPs by ODM, MCPs will be compensated for the cost of the time required in maintaining and submitting required reports. For CY 2014, the administrative component of the capitation rate varies by population/program and ranges from $2.05 to $5.52 per person per month.

15. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

    The MCPs were aware of the federal requirements for the reporting of information prior to seeking contracts with the state, as well as before signing their contracts with the state. More importantly, without the requested reports the State would be out of compliance with federal regulations.

Regulatory Flexibility

16. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

    No, as none of the five plans qualifies as a small business.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    The Agency will not apply this section of the ORC as the waiving of penalties would render Ohio's Medicaid agency out of compliance with federal regulations.

18. **What resources are available to assist small businesses with compliance of the regulation?**

    None, as none of the five plans qualifies as a small business.

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

(A) ~~For the purpose of this rule, "authorized representative" means an individual eighteen years of age or older who stands in the place of the consumer. The authorized representative may act on behalf of individuals inside or outside of the household in which the authorized representative lives. For the purpose of this rule, the authorized representative may be the primary information person of the household, another member of the same assistance group, a custodial parent, or a person designated by custodial parent.~~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) ~~For the purpose of this rule, an eligible individual is a medicaid consumer who is either subject to mandatory MCP membership or has the option to select MCP membership, and is~~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) ~~Found eligible~~ Eligible for covered families and children (CFC) medicaid in accordance with Chapter ~~5101:1-40~~ 5160:1-4 of the Administrative Code or modified gross income adjusted (MAGI)-based medicaid eligibility in accordance with division 5160:1 of the Administrative Code~~, and paragraphs (B)(2) to (B)(4) of this rule do not apply~~; ~~and~~or

(b) ~~Found eligible~~ Eligible for aged, blind, or disabled (ABD) medicaid in accordance with Chapter ~~5101:1-39~~5160:1-3 of the Administrative Code~~, and paragraphs (B)(2), (B)(4), and (B)(5) of this rule do not apply~~.

(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; ~~and~~

(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) Indians who are members of federally recognized tribes are not required to enroll in an MCP, except as permitted under 42 C.F.R. 438.50(d)(2) (May 1, 2013).~~

~~(5)~~(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 ~~5111.85~~5166.02 of the Revised Code.

~~(6)~~(5) Individuals are excluded from MCP membership when excluded under a federally approved state plan or state law from MCP enrollment~~participating in the care management system pursuant to section 5111.16 of the Revised Code~~.

~~(7) Individuals are eligible for MCP membership in the manner prescribed in this rule if ODM has a provider agreement with an MCP(s) in the eligible individual's service area.~~

~~(8)~~(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) ~~MCP enrollment~~Enrollment.

~~(1) A managed care enrollment center (MCEC) shall assist the eligible individual or authorized representative of any eligible assistance group requesting help in selecting an MCP or other healthcare option.~~

~~(2) The ODM, MCEC, or other ODM-approved entity must accept and process initial MCP membership selection transactions on behalf of eligible individuals in accordance with paragraph (C)(3) of this rule.~~

~~(3)~~(1) The following applies to ~~MCP~~ enrollment in an MCP:

(a) The MCP ~~membership~~ must accept eligible individuals ~~occur~~ without regard to ~~an eligible individual's~~ 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 ~~as specified~~ in accordance with 42 C.F.R. 438.6(d)~~(4)~~ (~~May 1, 2013~~October 1, 2013).

~~(b) Except for individuals described in paragraphs (B)(3) and (B)(4) of this rule, all eligible individuals in the CFC assistance group will be enrolled in the same MCP.~~

~~(c) MCP membership for ABD as described in paragraph (B)(1)(b) of this rule must occur at the individual level.~~

~~(d) Eligible individuals for CFC, including newborns, who are added and authorized to the assistance group after the assistance group's initial MCP membership effective date will be enrolled in the same MCP as the rest of the assistance group.~~

~~(e)~~(b) The MCP must accept eligible individuals who request MCP membership~~, and honor~~ without restriction~~, the PCP(s) selected when available, except as otherwise provided in this rule~~.

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

~~(f) The MCEC shall document via the CCR all information provided by the eligible individual or the authorized representative of each eligible~~

~~assistance group requesting MCP membership. The MCEC shall document via the CCR that oral authorization of MCP membership was given and the date of the authorization.~~

~~(g) The MCEC shall complete MCP enrollment requests and assignments as described in paragraph (C)(5)(c) of this rule. The MCEC shall place enrollment information on the CCR and forward the CCR to the MCP.~~

~~(h)~~(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 ~~renewed~~re-instated.

~~(i)~~(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.

~~(j)~~(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)~~(6)~~(3) of this rule or upon mutual agreement between ODM and the MCP.

~~(4) ODM may designate that MCP membership is voluntary in any service area.~~

~~(5)~~(2) Should a service area change from voluntary to mandatory, the notice rights in this rule must be followed. ~~In addition to the provisions of paragraphs (C)(1) to (C)(3) and (C)(6) of this rule, the following applies to membership in service areas designated as mandatory by ODM.~~

~~(a) Except as specified in paragraphs (B)(2) to (B)(5) of this rule, MCP membership is required for eligible individuals who are residents of service areas designated as mandatory by ODM.~~

~~(b)~~(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)(3)(i)~~(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.

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

(i) An ~~eligible assistance group~~ 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 ~~MCEC~~medicaid consumer hotline, or other ODM-approved entity.

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

~~(iii) In the event that an eligible assistance group does not identify to the MCEC those individuals who are not required to enroll in an MCP because they meet the criteria as specified in paragraphs (B)(3) and (B)(4) of this rule, such individuals shall be enrolled in the same MCP as the rest of the assistance group until such time as the assistance group notifies the MCEC.~~

~~(6)~~(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 ~~unless the newborn is a case addition due to the mother's eligibility for ABD medicaid as described in paragraph (B)(1)(b) of this rule. Enrollment and disenrollment of newborns shall be in accordance with Chapter 5101:3-26~~ 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)~~(6)~~ (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 ~~5101:3~~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 ~~5101:3~~5160-26-02.1 of the Administrative Code, except if the member becomes ineligible for medicaid ~~for the reason specified in paragraph (C)(2)(a) of rule 5101:3-26-02.1 of the Administrative Code~~; 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 MCEC 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.

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5160-26-06 **Managed health care programs: program integrity - fraud and abuse, audits, reporting, and record retention.**

(A) Each MCP~~MCPs~~ must have administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud and abuse.

(1) These arrangements or procedures must include the implementation of sound business practices which support appropriate access to and appropriate payment for quality services and must include the following:

(a) Written policies, procedures, and standards of conduct that articulate the MCP's commitment to comply with all applicable federal and state standards, including the prevention, identification, investigation, correction, and reporting of fraud and abuse;

(b) Designation of a compliance officer and a compliance committee that are accountable to senior management;

(c) Effective training and education for the compliance officer and the MCP's employees;

(d) Effective lines of communication between the compliance officer and the MCP's employees. To ensure effective communication, the MCP must organize resources to respond to complaints of fraud and abuse and have established procedures to process these complaints;

(e) Education of providers and delegated entities about fraud and abuse;

(f) Enforcement of MCP standards through well-publicized disciplinary guidelines;

(g) Provision for internal monitoring and auditing, including procedures to monitor service patterns of providers and subcontractors;

(h) Establishment and/or modification of internal MCP controls to ensure the proper submission and payment of claims;

(i) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCP's contract; and

(j) Prompt reporting of all instances of fraud and abuse to ODM and member fraud to the CDJFS.

(2) These arrangements or procedures must be made available to ODM upon request.

(3) The MCP~~MCPs~~ must annually submit to ODM a report ~~which~~that summarizes the MCP's fraud and abuse activities for the previous year and ~~which~~ identifies any proposed changes to the MCP's fraud and abuse program for the coming year.

(B) ODM or its designee, the state auditor's office, the state attorney general's office, the MFCU and the U.S. department of health and human services may evaluate or audit a contracting MCP's performance for the purpose of determining compliance with the requirements of Chapter ~~5101:3~~5160-26 of the Administrative Code, fraud and abuse statutes, applicable state and federal regulations or requirements under federal waiver authority.

(C) ODM or its designee may conduct on-site audits and reviews as deemed necessary based on periodic analysis of financial, utilization, provider panel, and other information.

(D) The MCP must submit required reports and additional information, as requested by ODM, as related to ~~their~~ its duties and obligations and where needed to assure operation in accordance with all state and federal regulations or requirements.

(E) ~~Failure of~~If the MCP fails to submit any ODM-requested materials, as specified in paragraph (D) of this rule, without cause as determined by ODM, on or before the due date, ~~may result in application of~~ODM may impose any or all of the sanctions listed in rule ~~5101:3~~5160-26-10 of the Administrative Code.

(F) Record retention.

The MCP and its subcontractors shall retain and safeguard all~~All~~ hard copy or electronic records originated or prepared in connection with the MCP's performance of its obligations under the provider agreement, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, ~~will be retained and safeguarded by the MCP and its subcontractors~~ in accordance with applicable sections of the federal regulations, the Revised Code, and the Administrative Code. Records stored electronically must be produced at the MCP's expense, upon request, in the format specified by state or federal authorities. All

such records must be maintained for a minimum of eight years from the renewal, amendment or termination date of the provider agreement, or in the event that the MCP has been notified that state or federal authorities have commenced an audit or investigation of the provider agreement, until such time as the matter under audit or investigation has been resolved. For the initial three years of the retention period, the MCP and its subcontractors must store the records ~~must be stored~~ in a manner and place that provides readily available access.

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TO BE RESCINDED

5160-26-07 **Managed health care programs: annual external quality review survey.**

~~(A) ODJFS will select an external quality review organization (EQRO) to provide for an annual, external, and independent review of the quality, outcomes, timeliness of and access to services provided by managed care plans (MCPs).~~

~~(B) MCPs must participate in external quality review activities as specified by 42 C.F.R. 438.358 and ODJFS.~~

~~(C) MCPs must timely submit data and information, including member medical records, at no cost to the member or ODJFS, as requested by ODJFS or its designee for the annual external quality review.~~

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TO BE RESCINDED

5160-26-07.1 **Managed health care programs: Quality assessment and performance improvement program (QAPI).**

~~(A) Each MCP must have an ongoing QAPI program that is annually prior-approved by ODJFS. As part of the QAPI program, the MCP must, at a minimum:~~

~~(1) Conduct performance improvement projects (PIPs), including those specified by CMS or ODJFS. The PIPS must achieve, through periodic measurement and intervention, significant and sustained improvement in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The PIPs must include the following components:~~

~~(a) Measurement of performance using objective quality indicators;~~

~~(b) Implementation of system interventions to achieve improvement in quality;~~

~~(c) Evaluation of the effectiveness of the interventions;~~

~~(d) Planning, initiation, and implementation of activities for increasing or sustaining improvement;~~

~~(e) Clinical and non-clinical areas that are relevant to the MCP member population and reflect the members served in terms of age, disease categories and risk status; and~~

~~(f) Completion in a reasonable time period in order to produce new information on quality of care every year.~~

~~(2) Have in effect mechanisms to detect both underutilization and overutilization of services.~~

~~(3) Have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.~~

~~(4) Report on the status and/or results of each PIP to ODJFS, at least annually, including a report on the mechanisms specified in paragraphs (A)(2) and (A)(3) of this rule.~~

~~(5) Submit performance measurement data as required by ODJFS that:~~

~~(a) Enables ODJFS to calculate standard measures; and/or~~

~~(b) Uses standard measures as required by ODJFS.~~

~~(B) ODJFS will review the impact and effectiveness of each MCP's QAPI program at least annually. The review will include an assessment of:~~

~~(1) MCP performance, based on encounter data and other performance measurement data;~~

~~(2) The MCP's report on the status and/or results of each PIP; and~~

~~(3) The MCP's self-evaluation of the impact and effectiveness of its QAPI, including the mechanisms specified in paragraphs (A)(2) and (A)(3) of this rule.~~

~~(C) Each MCP must establish appropriate administrative oversight arrangements and accountability for the QAPI program. MCPs must be able to document, upon request, that such arrangements include:~~

~~(1) The assignment of a senior official responsible for the QAPI program;~~

~~(2) Provision for and a record of ongoing communication and coordination between the area that oversees the QAPI program and relevant functional areas of the organization; and~~

~~(3) Assurance that the medical director is involved in all clinically-related projects and that all staff responsible for QAPI implementation have education, experience, and training appropriate to their position.~~

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5160-26-08 **Managed health care programs: marketing.**

(A) Marketing means any communication from an MCP to an eligible individual who is not a member of that MCP that can reasonably be interpreted as intended to influence the individual to select membership in that MCP, or to not select membership in or to terminate membership from another MCP.

(B) MCPs:

(1) Must ~~assure~~ensure that representatives, as well as materials and plans, represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing or otherwise misrepresentative, or which defraud the eligible individuals or ~~ODJFS~~ODM.

(2) Must ~~assure~~ensure that no marketing activity directed specifically toward the medicaid population begins prior to approval by ~~ODJFS~~ODM.

(3) Are prohibited from engaging directly or indirectly in cold-call marketing activities including, but not limited to, door-to-door or telephone contact. Cold-call marketing means any unsolicited personal contact by the MCP with an eligible individual for the purpose of marketing as defined in paragraph (A) of this rule.

(4) Must receive prior approval from any event or location where the MCP plans to provide information to eligible individuals.

(5) Are prohibited from offering material or financial gain, including but not limited to, the offering of any other insurance, to an eligible individual as an inducement to select MCP membership.

(6) Are prohibited from offering inducements to CDJFS or ~~MCEC~~medicaid consumer hotline staff or to others who may influence an individual's decision to select MCP membership.

(7) Are allowed to offer nominal gifts prior-approved by ~~ODJFS~~ODM to an eligible individual as long as these gifts are offered whether or not the individual selects membership in the MCP.

(8) May reference member incentive/appreciation items, as specified in ~~paragraph (B) of~~ rule ~~5101:3~~5160-26-08.2 of the Administrative Code, in marketing

presentations and materials; however, such member items must not be made available to non-members.

(9) Must ensure that marketing representatives represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud the eligible individuals or ODM.

(10) Are prohibited from making one-on-one marketing presentations in any setting unless requested by the eligible individual.

(C) MCPs must comply with the following ~~requirement~~requirements:

(1) Only ~~ODJFS~~ODM-approved MCP marketing representatives may make a marketing presentation as outlined in paragraph (F)~~(5)~~(6)(e) of this rule to an eligible individual or in any way advise or recommend to an eligible individual that ~~he/she~~ he or she select MCP membership in a particular MCP. As provided in Chapter 1751. and section 3905.01 of the Revised Code, and rule 3901-1-10 of the Administrative Code, all non-licensed agents, including providers, are prohibited from advising or recommending to an eligible individual that ~~he/she~~he or she select MCP membership in a particular MCP as this would constitute the unlicensed practice of marketing.

~~(2) Must assure that marketing representatives represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud the eligible individuals or ODJFS.~~

~~(3) MCPs are prohibited from making one-on-one marketing presentations in any setting unless requested by the eligible individual.~~

~~(4)~~(2) MCP informational displays do not require the presence of a marketing representative if no marketing presentation will be made.

(D) Marketing materials are materials produced in any medium by or on behalf of an MCP and which can reasonably be interpreted as intended to market to eligible individuals. All new and revised materials, including materials used for marketing presentations, must be prior approved by ~~ODJFS~~ODM. MCPs must include with each marketing submission an attestation that the material is accurate and does not mislead, confuse or defraud the eligible individuals or ~~ODJFS~~ODM. Marketing materials must comply with the following requirements:~~.~~

(1) All MCP marketing materials must be available in a manner and format that may be easily understood.

(2) Written materials developed to promote membership selection in an MCP must be available in:

(a) The prevalent non-English languages of eligible individuals in the service area.

(b) Alternative formats in an appropriate manner that takes into consideration the special needs of eligible individuals including but not limited to visually-limited and LRP eligible individuals.

(3) Oral interpretation and oral translation services must be available for the review of marketing materials at no cost to eligible individuals.

(4) The mailing~~/~~ and distribution of all MCP marketing materials must be prior-approved by ~~ODJFS~~ODM and may contain no information or text on the outside of the mailing that identifies the addressee as a medicaid consumer. Marketing materials must be distributed to the MCP's entire service area.

(5) ~~ODJFS~~ODM or its designee may, at an MCP's request, mail MCP marketing materials to eligible individuals. Postage and handling for each mailing will be charged to the requesting MCP. The MCP address must not be used as the return address in mailings to eligible individuals processed by ~~ODJFS~~ODM.

(6) An MCP~~MCPs~~ must have a solicitation brochure available to eligible individuals which contains, at a minimum:

(a) Identification of the medicaid consumers eligible for the MCP's coverage.

(b) Information that the MCP's identification card replaces the member's monthly medicaid health card.

(c) A statement that all medically-necessary medicaid-covered services, including healthchek (EPSDT) services, will be available to all members.

(d) A description of any additional services available to all members.

(e) Information that membership selection in a particular MCP is voluntary, that a decision to select MCP membership or to not select MCP

membership in the MCP will not affect eligibility for medicaid or other public assistance benefits, and that individuals may change MCPs under certain circumstances.

(f) Information on how the individual can request or access additional MCP information or services, including clarification on how this information can be requested or accessed through:

(i) Sign language, oral interpretation and oral translation services at no cost to the eligible individual;

(ii) Written information in the prevalent non-English languages of eligible individuals or members in the MCP's service area;

(iii) Written information in alternative formats.

(g) Information clearly identifying corporate or parent company identity when a trade name or DBA is used for the medicaid product.

(h) A statement that this brochure contains only a summary of the relevant information and that more details, including at a minimum a list of providers~~,~~ and any physician incentive plans the MCP operates, will be provided upon request.

(i) Information that an individual must choose a PCP from the MCP's provider panel and that the PCP will coordinate the member's health care.

(j) Information that a member may change PCPs at least monthly.

(k) A statement that all medically-necessary health care services must be obtained in or through the ~~MCP facilities and/or providers~~MCP's providers except emergency care, behavioral health services provided through facilities and medicaid providers certified by the Ohio department of mental health and addiction services ~~the ODMH or at ODADAS certified facilities which are medicaid providers,~~ and any other services or provider types designated by ~~ODJFS~~ODM.

(l) A description of how to access emergency services including information that access to emergency services is available within and outside the service area.

(m) A description of the MCP's policies regarding access to providers outside the service area.

(n) Information on member-initiated termination options in accordance with ~~paragraph (D) of~~ rule ~~5101:3~~5160-26-02.1 of the Administrative Code.

(o) Information on the procedures an eligible individual must follow to select MCP membership in an MCP including any applicable ~~ODJFS~~ODM selection requirements.

(p) If applicable, information on any member co-payments the MCP has elected to implement in accordance with rule ~~5101:3~~5160-26-12 of the Administrative Code.

(E) An MCP ~~MCPs~~ must submit an annual marketing plan to ~~ODJFS~~ODM ~~which~~that includes all planned activities for promoting membership in or increasing awareness of the MCP. The marketing plan submission must include an attestation by the MCP that the plan is accurate and does not mislead, confuse, or defraud the eligible individuals or ~~ODJFS~~ODM.

(F) An MCP ~~MCPs~~ that ~~utilize~~ utilizes marketing representatives for marketing presentations requested by eligible individuals must comply with the following:

(1) All marketing representatives must be employees of the MCP. A copy of the representative's job description(s) must be submitted to ~~ODJFS~~ODM.

(2) Marketing representatives must be trained and duly licensed by ODI to perform such activities.

(3) The MCP must develop and submit to ~~ODJFS~~ODM for prior-approval a marketing representative training program. This training program must include, at a minimum:

(a) A training curriculum that includes at a minimum:

(i) A full review of the MCP's solicitation brochure, provider directory and all other marketing materials including all video, audio, electronic and print materials.

(ii) An overview of applicable public assistance benefits, designed to

familiarize and impart a working knowledge of these programs.

(iii) The MCP's process for providing sign language, oral interpretation and oral translation services to an eligible individual to whom a marketing presentation is being made, including a review of the MCP's written marketing materials.

(iv) Instruction on acceptable and appropriate marketing tactics, including a requirement that the marketing representatives may not discriminate on the basis of age, gender, sexual orientation, disability, race, color, religion, national origin, ~~veteran's~~military status, genetic information, ancestry, health status, or the need for health services.

(v) An overview of the ramifications to the MCP and/or the marketing representatives if ~~ODJFS~~ODM rules are violated.

(vi) Review of the MCP's code of conduct~~/~~ or ethics.

(b) Methods that the MCP will utilize to determine initial and ongoing competency with the training curriculum.

~~(c) Any revisions to the ODJFS-approved training program must be submitted to ODJFS for review and prior approval.~~

(4) Any revisions to the ODM-approved training program must be submitted to ODM for review and prior approval.

~~(4)~~(5) No more than fifty per cent of each marketing representative's total annual compensation, including salary, benefits, and bonuses may be paid on a commission basis. For the purpose of this rule, any performance-based compensation would be considered a form of commission. The MCP must make available for inspection, upon request by ~~ODJFS~~ODM, the compensation package(s) for marketing representatives as its assurance of compliance with this requirement.

~~(5)~~(6) Any MCP staff person providing information on the MCP or making marketing presentations to an eligible individual(s) must comply with the following:

(a) The MCP staff person must not discriminate on the basis of age, gender, sexual orientation, race, color, religion, national origin, ~~veteran's~~military status, ancestry, disability, genetic information, health

status, or the need for health services.

(b) No MCP staff person may ask eligible individual(s) questions related to health status or the need for health services.

(c) The MCP staff person must visibly wear or display an identification tag and offer a business card when speaking to an eligible individual(s) and provide information which ensures that the staff person is not mistaken for ~~an MCEC~~a medicaid consumer hotline, ~~or~~ federal, state or county employee.

(d) The MCP staff person must inform~~Inform~~ eligible individuals that the following MCP information or services are available and how the eligible individual can access the information or services:

(i) Sign language, oral interpretation, and oral translation services at no cost to the member;

(ii) Written information in the prevalent non-English languages of eligible individuals or members residing in the MCP's service area; and

(iii) Written information in alternative formats.

(e) For the purposes of this rule, a marketing presentation is defined as a one-on-one interaction between an MCP's marketing representative and an eligible individual(s). MCP marketing representatives must offer the ~~ODJFS~~ODM-approved solicitation brochure to the eligible individual(s) at the time of the marketing presentation and must provide, at a minimum:

(i) An explanation of the importance of reviewing the information in the ~~ODJFS~~ODM-approved solicitation brochure, how ~~they~~the individual can receive additional information about the MCP prior to making an MCP membership selection, and the process for contacting ~~ODJFS~~ODM to select an MCP.

(ii) Information that membership in the particular MCP is voluntary and that a decision to select or not select the MCP will not affect eligibility for medicaid or other public assistance benefits.

(iii) Information that each member must choose a PCP and must access

providers and services as directed in the MCP's member handbook and provider directory.

(iv) Information that all medically-necessary medicaid-covered services, as well as any additional services provided by the MCP, will be available to all members.

(G) Upon request, MCPs must provide eligible individuals with a provider directory which ~~is prior~~ has been approved by ~~ODJFS~~ODM.

(H) Alleged marketing violations.

(1) The MCP must immediately notify ~~ODJFS~~ODM in writing of its discovery of an alleged~~/~~ or suspected marketing violation.

(2) ~~ODJFS~~ODM will forward information pertaining to alleged marketing violations to ~~ODI~~ the Ohio department of insurance and the ~~MFCU~~medicaid fraud control unit as appropriate.

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TO BE RESCINDED

5160-26-08.1 **Managed health care programs: information and enrollment services.**

~~(A) ODJFS may contract with or designate one or more entities to provide information and enrollment services to eligible individuals. Such services include informing eligible individuals about managed care and membership options and performing activities related to the selection of an MCP, or other health care option.~~

~~(B) Any entity providing information and enrollment services must submit all related policies, procedures, and materials in writing to ODJFS for approval prior to use.~~

~~(C) All initial MCP enrollment and MCP membership termination request transactions will be processed in accordance with rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code.~~

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5160-26-08.2 **Managed health care programs: member services.**

(A) MCP member services program.

(1) Each MCP must establish and operate a member services toll-free telephone number. This telephone line must have services available to assist:

(a) Hearing-impaired members; and

(b) LEP members in the primary language of the member.

(2) The member services program must, at a minimum, assist MCP members, and, as applicable, eligible individuals seeking information about MCP membership, with the following:

(a) Accessing medicaid-covered services;

(b) Obtaining or understanding information on the MCP's policies and procedures;

(c) Understanding the requirements and benefits of the plan;

(d) Resolution of concerns, questions, and problems;

(e) Filing of grievances and appeals as specified in rule ~~5101:3~~5160-26-08.4 of the Administrative Code;

(f) Obtaining information on state hearing rights;

(g) Appealing to or filing directly with the United States department of health and human services office of civil rights any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services;

(h) Appealing to or filing directly with the ~~ODJFS~~ODM office of civil rights any complaints of discrimination on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, ~~veteran's~~military status, genetic information, ancestry, health status, or need for health services in the receipt of health services; and

(i) Accessing sign language, oral interpretation, and oral translation services. The MCP~~MCPs~~ must ensure that these services are provided at no cost to the eligible individual or member. The MCP~~MCPs~~ must designate a staff person~~,~~ to coordinate and document the provision of these services.

(3) In the event the consumer contact record (CCR) does not identify a member-selected primary care provider (PCP) for each assistance group member, or if the member-selected PCP is not available, the MCP must:

(a) Select a PCP for each member prior to the effective date of coverage based on the PCP assignment methodology prior-approved by ~~ODJFS~~ODM;

(b) Notify each member ~~members~~ of the name of ~~their~~his or her PCP prior to the effective date of coverage and pursuant to the provisions of ~~paragraphs (D)(1) and (D)(2) of~~ rule ~~5101:3~~5160-26-02 of the Administrative Code;

(c) Simultaneously notify each ~~members~~ member with an MCP-selected PCP of the ability within the first month of initial MCP membership to change the MCP-selected PCP effective on the date of contact with the MCP; and

(d) Explain that PCP change requests after the initial month of MCP membership shall be processed according to the procedures outlined in the MCP member handbook.

(B) MCP member materials.

(1) The MCP must develop and disseminate member materials, including at a minimum member materials specified in paragraph (B)(3) of this rule. All MCP member materials, including but not limited to those used for member education, member appreciation and member incentive programs, and changes thereto must be prior-approved in writing by ~~ODJFS~~ODM.

(2) Member materials must be:

(a) Provided in a manner and format that may be easily understood.

(b) Printed in the prevalent non-English languages of members in the MCP's

service area.

(c) Available in alternative formats in an appropriate manner that takes into consideration the special needs of members including but not limited to visually-limited and LRP members.

(d) Consistent with the practice guidelines specified in paragraph (B) of rule ~~5101:3~~5160-26-05.1 of the Administrative Code.

(3) At a minimum, ~~MCPs~~the MCP must provide the following materials to each member or assistance group, as applicable. ~~: MCPs~~The MCP must provide the materials specified in paragraphs (B)(3)(a) and (B)(3)(c) of this rule by no later than the effective date of coverage and the materials specified in paragraphs (B)(3)(b) and (B)(3)(d) of this rule prior to the effective date of coverage.

(a) The MCP's member handbook as specified in paragraph (B)(4) of this rule.

(b) An MCP identification card bearing unique features, clearly listing:

(i) The MCP's name as stated in its article of incorporation and any other trade or DBA name used;

(ii) The name(s) of the member(s) enrolled in the MCP and ~~their~~ each member's medicaid management information system billing number~~(s)~~;

(iii) The MCP's emergency procedures, which must be consistent with those approved in the member handbook, including the toll-free call-in system phone numbers as specified in paragraph (A)(6) of rule ~~5101:3~~5160-26-03.1 of the Administrative Code;

(iv) The MCP's toll-free member services number(s) as specified in paragraph (A)(1) of this rule;

(v) The name(s) and telephone number(s) of the PCP(s) assigned to the member(s);

(vi) Information on how to obtain the current eligibility status for the member(s); and

(vii) Coordinated services program (CSP) information as specified by ~~ODJFS~~ODM.

(c) Information concerning a member's right to formulate, at the member's option, advance directives including a description of applicable state law.

(d) A letter informing each member~~members~~ at a minimum of:

(i) The new member materials issued by the MCP, what action the member should ~~members are to~~ take if ~~they have~~he or she has not yet received those materials, and how to access the MCP's provider directory;

(ii) How to access MCP-provided transportation services;

(iii) How to change primary care providers;

(iv) The population groups that are not required to select MCP membership and what action to take if a member believes he or she meets~~members believe they meet~~ this criteria and ~~do~~does not want to be an MCP member;

(v) The need and time frame for a member ~~members~~ to contact the MCP if the member has~~members have~~ a health care condition that the MCP should be aware of in order to most appropriately manage~~/~~ or transition the ~~members'~~ member's care; and

(vi) The need and how to access information on medications that require prior authorization.

(4) The MCP's member handbook must be clearly labeled as such and include, at a minimum:

(a) The rights of members that include at a minimum, all rights found in rule ~~5101:3~~5160-26-08.3 of the Administrative Code and any member responsibilities specified by the MCP. With the exception of any prior-authorization requirements the MCP ~~stipulates~~describes in the member handbook, the MCP cannot establish any member responsibility that would preclude the MCP's coverage of a medicaid-covered service.

(b) Information regarding services that are excluded from MCP coverage and the services and benefits that are available at or through the MCP, and how to obtain them, including at a minimum:

(i) All services and benefits requiring prior-authorization or referral by the MCP or the member's PCP;

(ii) Self-referral services, including at a minimum Title X services, and women's routine and preventative health care services provided by a woman's health specialist as specified in ~~paragraphs (H)(5) and (H)(6) of~~ rule ~~5101:3~~5160-26-03 of the Administrative Code;

(iii) FQHC~~/~~,RHC and certified nurse practitioner services as specified in ~~paragraphs (H)(7) and (H)(8) of~~ rule ~~5101:3~~5160-26-03 of the Administrative Code; and

(iv) If applicable, any pharmacy utilization management strategies prior-approved by ~~ODJFS~~ODM.

(c) Information that emergency services are available to the member, the procedures for accessing emergency services, and directives as to the appropriate utilization, including at a minimum:

(i) An explanation ~~Explanation~~ of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in rule ~~5101:3~~5160-26-01 of the Administrative Code;

(ii) A statement that prior~~Prior~~ authorization is not required for emergency services;

(iii) An explanation regarding the~~The~~ availability of the 911-telephone system or its local equivalent;

(iv) A statement that members~~Members~~ have a right to use any hospital or other appropriate setting for emergency services; and

(v) An explanation of the~~The~~ post-stabilization care services requirements specified in ~~paragraph (G) of~~ rule ~~5101:3~~5160-26-03 of the Administrative Code.

(d) The procedure for members to express their recommendations for change to the MCP's staff.

(e) Identification of the categories of medicaid consumers eligible for MCP membership.

(f) Information stating that the MCP's identification card replaces the member's monthly medicaid health card, how often the card is issued, and how to use it.

(g) A statement that medically necessary health care services must be obtained ~~in or~~ through the providers in the MCP's provider network except for emergency care, behavioral health services provided through facilities and medicaid providers certified by the Ohio department of mental health and addiction services, ~~MCP facilities and/or providers except emergency care, behavioral health services provided through the ODMH or at ODADAS-certified facilities that are medicaid providers,~~ and any other services or provider types designated by ~~ODJFS~~ODM.

(h) Information on the member's responsibility to select a PCP from the MCP provider directory, how to change PCPs including the ability to change PCPs no less often than monthly, the MCP's procedures for processing PCP change requests after the initial month of MCP membership, and how the MCP will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change.

(i) A description of the healthchek (EPSDT, early and periodic screening, diagnosis and treatment) program, including who is eligible and how to obtain healthchek (EPSDT) services through the MCP.

(j) Information on the additional services available to all members including, at a minimum, care management services as specified in ~~paragraph (A)(8) of~~ rule ~~5101:3~~5160-26-03.1 of the Administrative Code and the member services toll-free call-in system.

(k) A description of the MCP's policies regarding access to providers outside the service area for non-emergency services and if, applicable, access to providers within ~~and/~~or outside the service area for non-emergency after-hours services.

(l) Information on member-initiated termination options in accordance with ~~paragraph (D) of~~ rule ~~5101:3~~5160-26-02.1 of the Administrative Code.

(m) An explanation of automatic renewal of MCP membership in accordance with ~~paragraph (C)(3)(h) of~~ rule ~~5101:3~~5160-26-02 of the Administrative Code.

(n) The procedure for members to file an appeal, a grievance, or a state hearing request as specified in ~~rules~~rule ~~5101:3~~5160-26-08.4 ~~and 5101:3-26-08.5~~ of the Administrative Code.

(o) Information about MCP-initiated terminations.

(p) The issuance date of the member handbook.

(q) A statement that the MCP may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, ~~veteran's~~military status, ancestry, genetic information, health status, or need for health services in the receipt of health services.

(r) An explanation of subrogation and coordination of benefits.

(s) A clear identification of corporate or parent identity when a trade name or DBA is used for the medicaid product.

(t) Information on the procedures for members to access behavioral health services.

(u) Information on the MCP's policies respecting the implementation of the member's rights regarding advance directives, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

(v) Information stating that the MCP provides covered services to members through a provider agreement with ~~ODJFS~~ODM, and how members can contact ~~ODJFS~~ODM, by mail or by telephone, if they so desire.

(w) The toll-free call-in system phone numbers specified in paragraph (A)(1) of this rule and ~~paragraph (A)(6) of~~ rule ~~5101:3~~5160-26-03.1 of the Administrative Code.

(x) A statement that additional information is available from the MCP upon request including, at a minimum, the structure and operation of the

MCP and any physician incentive plans that the MCP operates.

(y) Information on how the member can request or access additional MCP information or services including, at a minimum:

(i) Oral interpretation and oral translation services;

(ii) Written information in the prevalent non-English languages of members in the MCP's service area; and

(iii) Written information in alternative formats.

(z) If applicable, detailed information on any member co-payments the MCP has elected to implement in accordance with rule ~~5101:3~~5160-26-12 of the Administrative Code.

(aa) Information on how members can access the MCP's provider directory.

(bb) The standard and expedited state hearing resolution time frames as outlined in 42 C.F.R. 431.244 (f)~~.~~ (October 1, 2013).

(5) If a member's MCP membership is automatically renewed as specified in ~~paragraph (C)(3)(h) of~~ rule ~~5101:3~~5160-26-02 of the Administrative Code, the MCP must issue an identification card as specified in paragraph (B)(3) of this rule prior to the new effective date of coverage. Additionally, in the event the member handbook has been revised since the initial MCP membership date of the member's assistance group, the MCP must issue a new member handbook to the member.

(6) At least annually, ~~MCPs~~the MCP must determine the predominant health care needs of ~~their~~its medicaid members and provide health education materials as indicated by these assessments. ~~MCPs~~The MCP must provide ~~ODJFS~~ODM a summary of the results of the health care needs assessment and a list of the materials distributed to members as a result of the assessment.

(7) No information or text that identifies the addressee as a medicaid recipient may appear on the outside of any MCP or MCP subcontractor mailing.

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5167.02
Rule Amplifies:	5162.03 , 5164.02 , 5167.03 , 5167.10 , 5167.13
Prior Effective Dates:	4/1/85, 2/15/89 (Emer), 5/8/89, 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 12/10/99, 7/1/00, 7/1/01, 7/1/03, 7/1/04, 10/31/05, 6/1/06, 1/1/08, 9/15/08, 7/1/09, 8/1/10

5160-26-08.3 **Managed health care programs: member rights.**

(A) MCPs must develop and implement written policies ~~which~~that ensure that members have and are informed of the following rights:

(1) To receive all services that the MCP is required to provide pursuant to the terms of their provider agreement with ODM.

(2) To be treated with respect and with due consideration for their dignity and privacy.

(3) To be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history.

(4) To be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.

(5) To be given the opportunity to participate in decisions involving their health care ~~unless contraindicated~~.

(6) To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

(7) To ~~be assured of~~maintain auditory and visual privacy during all health care examinations or treatment visits.

(8) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

(9) To request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.

(10) To be afforded the opportunity to approve or refuse the release of information except when release is required by law.

(11) To be afforded the opportunity to refuse treatment or therapy. Members who

refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation will be entered into the medical record accordingly.

(12) To be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of ~~rules~~rule ~~5101:3~~5160-26-08.4 ~~and 5101:3-26-08.5~~ of the Administrative Code.

(13) To be ~~assured that all~~provided written member information from ~~provided by~~ the MCP ~~is available~~:

(a) At no cost to the member,

(b) In the prevalent non-English languages of members in the MCP's service area, and

(c) In alternative formats and in an appropriate manner that takes into consideration the special needs of members including but not limited to visually-limited and LRP members.

(14) To ~~be assured that~~receive necessary oral interpretation and oral translation services ~~are available~~ at no cost ~~to members~~.

(15) To ~~be assured that the~~receive necessary services of sign language assistance at no cost ~~are available to hearing impaired members~~.

(16) To be informed of specific student practitioner roles and the right to refuse student care.

(17) To refuse to participate in experimental research.

(18) To formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio department of health.

(19) To change PCPs no less often than monthly. The MCP~~MCP's~~ must mail written confirmation to the member of ~~their~~his or her new PCP selection prior to or on the effective date of the change.

(20) To appeal to or file directly with the United States department of health and human services office of civil rights any complaints of discrimination on the basis of race, color, national origin, age or disability in the receipt of health

services.

(21) To appeal to or file directly with the ODM office of civil rights any complaints of discrimination on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, ~~veteran's~~ military status, genetic information, ancestry, health status or need for health services in the receipt of health services.

(22) To be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way the MCP, the MCP's providers, or ODM treats the member.

(23) To be assured that the MCP must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.

(24) To choose his or her health professional to the extent possible and appropriate.

(25) ~~To be assured that~~For female members, ~~have~~ to obtain direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to ~~the~~a member's designated PCP if the PCP is not a woman's health specialist.

(26) To be provided a second opinion from a qualified health care professional within the MCP's panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for a second opinion outside the network, at no cost to the member.

(27) To receive information on their MCP.

(B) MCPs must advise members via the member handbook of the member rights specified in paragraph (A) of this rule.

Effective:

R.C. 119.032 review dates: 07/01/2018

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5167.02
Rule Amplifies:	5162.03, 5164.02, 5167.03, 5167.10
Prior Effective Dates:	4/1/85, 5/2/85, 10/1/87, 2/15/89 (Emer), 5/8/89, 11/1/89 (Emer), 2/1/90, 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 7/1/00, 7/1/01, 7/1/03, 1/1/08

5160-26-08.4 Managed health care programs: MCP grievance system.

This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code. Provisions regarding appeals and grievances for MyCare Ohio are described in Chapter 5160-58 of the Administrative Code.

(A) ~~General requirements~~Definitions.

For the purposes of this rule the following terms are defined as:

(1) An "action" is the MCP's

(a) Denial or limited authorization of a requested service, including the type or level of service;

(b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP;

(c) Denial, in whole or part, of payment for a service;

(d) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code; or

(e) Failure to act within the resolution timeframes specified in this rule.

(2) An "appeal" is the request for an MCP's review of an action.

(3) A "grievance" is an expression of dissatisfaction with any aspect of the MCP's or provider's operation, provision of health care services, activities, or behaviors, other than an MCP's action as defined in paragraph (A)(1) of this rule.

(4) "Resolution" means a final decision is made by the MCP and the decision is communicated to the member.

(5) "Notice of action (NOA)" is the written notice an MCP must provide to members when an MCP action has occurred or will occur.

~~(1) For the purposes of this rule the following terms are defined as:~~

~~(a) An "action" is the MCP's:~~

~~(i) Denial or limited authorization of a requested service, including the type or level of service;~~

(ii) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP;

(iii) Denial, in whole or part, of payment for a service;

(iv) Failure to provide services in a timely manner as specified in paragraph (A)(7)(c) of rule 5101:3-26-03.1 of the Administrative Code; or

(v) Failure to act within the resolution timeframes specified in this rule.

(b) An "appeal" is the request for a review of an action.

(c) A "grievance" is an expression of dissatisfaction with any aspect of the MCP's or provider's operation, provision of health care services, activities, or behaviors, other than an MCP's action as defined in paragraph (A)(1)(a) of this rule.

(d) "Resolution" means a final decision is made by the MCP and the decision is communicated to the member.

(e) "Notice of action (NOA)" is the written notice an MCP must provide to members when an MCP action has occurred or will occur.

(2) For the purposes of filing grievances or appeals on behalf of a member under the age of eighteen, written consent to file is not required when the individual filing the grievance or appeal belongs to the member's assistance group.

(3) Each MCP must develop and implement a grievance system for members that includes an appeals process, a grievance process, and a process to access the state's hearing system as specified in this rule. MCPs must have written grievance system policies and procedures and, upon request, the MCP's policies and procedures must be made available for review by ODJFS.

(4) MCPs must give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including but not limited to:

(a) Explaining the MCP's process to be followed in resolving the member's appeal or grievance.

(b) Completing forms and taking other procedural steps as outlined in this rule.

(c) Providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

~~(5) Members are not required to exhaust the MCP's appeal or grievance process in order to access the state's hearings system.~~

~~(6) MCPs must ensure that the individuals who make decisions on appeals and grievances are individuals who:~~

~~(a) Were not involved in previous levels of review or decision-making.~~

~~(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:~~

~~(i) An appeal of a denial that is based on lack of medical necessity.~~

~~(ii) A grievance regarding the denial of an expedited resolution of an appeal.~~

~~(iii) An appeal or grievance that involves clinical issues.~~

~~(7) The procedure to be followed to file an appeal, grievance, or state hearing request must be described in the MCP's member handbook and must include the telephone number(s) for the MCP's toll-free member services hotline, the MCP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file an appeal or grievance must also be made available through the MCP's member services program.~~

~~(8) Grievance system procedures must include the participation of individuals authorized by the MCP to require corrective action.~~

~~(9) MCPs are prohibited from delegating the appeal or grievance process to another entity.~~

(B) Each MCP must have written policies and procedures for an appeal and grievance system for members, in compliance with the requirements of this rule. The policies and procedures must be made available for review by ODM, and must include the following:

(1) A process by which members may file grievances with the MCP, in compliance with paragraph (H) of this rule;

(2) A process by which members may file appeals with the MCP, in compliance with paragraphs (C) through (G) of this rule; and

(3) A process by which members may access the state's hearing system through the Ohio Department of Job and Family Services (ODJFS) in compliance with

paragraph (I) of this rule.

~~(B)~~(C) Notice of action (NOA) by an MCP.

(1) When an MCP action has occurred or will occur, the MCP must provide the affected member(s) with a written NOA.

~~(1)~~(2) ~~When an MCP action has or will occur, the MCP must provide the affected member(s) with a written NOA.~~ The NOA must meet the language and format requirements for member materials specified in ~~paragraph (B)(2) of~~ rule ~~5101:3~~5160-26-08.2 of the Administrative Code and explain:

(a) The action the MCP has taken or intends to take;

(b) The reasons for the action;

(c) The member's or authorized representative's right to file an appeal to the MCP;

(d) If applicable, the member's right to request a state hearing through the state's hearing system;

(e) Procedures for exercising the member's rights to appeal or grieve the action;

(f) Circumstances under which expedited resolution is available and how to request it;

(g) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services;

(h) The date that the notice is being issued;

(i) Oral interpretation is available for any language;

(j) Written translation is available in prevalent languages as applicable;

(k) Written alternative formats may be available as needed; and

(l) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

~~(2)~~(3) An MCP ~~MCPs~~ must give members a written NOA within the following timeframes:

(a) For a decision to deny or limit authorization of a requested service, including the type or level of service, the ~~MCPs~~ MCP must issue an NOA simultaneously with the MCP's decision. ~~MCP service authorization decisions must be made in accordance with the timeframes specified in paragraphs (A)(7)(c)(v), (A)(7)(c)(vi), and (A)(7)(c)(viii) of rule 5101:3-26-03.1 of the Administrative Code~~.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP, the MCP ~~MCPs~~ must give notice fifteen calendar days before the date of action except:

(i) If probable recipient fraud has been verified, the MCP must give notice five calendar days before the date of action.

(ii) ~~The MCP must give notice on or before the date of action in accordance with~~ Under the circumstances set forth in 42 C.F.R. 431.213 (~~January 29, 1993~~October 1, 2013), the MCP must give notice on or before the date of action.

(c) For denial of payment for a noncovered service, MCPs must give notice simultaneously with the MCP's action to deny~~,~~ the claim, in whole or part, for a service that is not covered by medicaid, including a service that was determined through the MCP's prior authorization process as not medically necessary.

(d) For untimely prior authorization, ~~service,~~ appeal or grievance resolution, the MCP ~~MCPs~~ must give notice simultaneously with the MCP becoming aware of the action. A service~~Service~~ authorization ~~decisions~~decision not reached within the timeframes specified in ~~paragraphs (A)(7)(c)(v), (A)(7)(c)(vi), and (A)(7)(c)(viii) of~~ rule ~~5101:3~~5160-26-03.1 of the Administrative Code~~,~~ constitutes a denial and ~~are~~is thus considered to be an adverse ~~actions~~action. Notice must be given on the date that the authorization decision timeframe expires.

~~(C)~~(D) Standard appeal ~~process~~to an MCP.

(1) A member, provider, or a member's authorized representative may file an appeal orally or in writing within ninety days from the date on the NOA. The ninety day period begins on the day after the mailing date of the NOA. An oral filing must be followed with a written appeal. The MCP must: ~~MCPs must ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal. An oral filing must be followed with a written appeal. The MCP must assist the member to ensure that a written appeal is filed by immediately converting an oral filing to a written record. If the member follows the oral filing with a written appeal, this appeal will supersede the written record, however, the date of the oral filing must be considered the filing date of the appeal.~~

(a) Assist members that file an oral appeal by immediately converting an oral filing to a written record;

(b) Ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal; and

(c) Consider the date of the oral filing as the filing date if the member follows the oral filing with a written appeal.

(2) ~~The member's authorized representative and a~~ Any provider acting on the member's behalf must have the member's written consent to file an appeal. The ~~MCPs~~ MCP must begin processing the appeal pending receipt of the written consent.

(3) The MCP~~MCPs~~ must acknowledge receipt of each appeal to the individual filing the appeal. At a minimum, acknowledgment must be made in the same manner that the appeal was filed. If an appeal is filed in writing, written acknowledgment must be made by the MCP within three working days of the receipt of the appeal.

(4) The MCP must provide members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member and/or member's authorized representative must be allowed to examine the case file, including medical records and any other documents and records, before and during the appeals process.

(5) ~~MCPs~~The MCP must consider the member, member's authorized representative, or estate representative of a deceased member as parties to the appeal.

(6) ~~MCPs~~The MCP must review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution timeframe must not

exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph ~~(E)~~(F) of this rule.

(7) The MCP must provide written notice to the member, and to the member's authorized representative if applicable, of the resolution including, at a minimum, the decision and date of the resolution.

(8) For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding:

(a) Oral interpretation that is available for any language;

(b) Written translation that is available in prevalent languages as applicable;

(c) Written alternative formats that may be available as needed;

(d) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP;

(e) The right to request a state hearing through the state's hearing system; and ~~;~~

(f) How to request a state hearing; and if applicable:

(i) The right to continue to receive benefits pending a state hearing,

(ii) How to request the continuation of benefits; and

(iii) If the MCP action is upheld at the state hearing that the member may be liable for the cost of any continued benefits.

(9) For appeals decided in favor of the member, the MCP must:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending.

(b) Pay for the disputed services if the member received the services while the appeal was pending.

~~(D)~~(E) Expedited appeals to an MCP.

(1) Each ~~MCPs~~MCP must establish and maintain an expedited review process to resolve appeals when the MCP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

(2) ~~MCPs~~ In utilizing an expedited appeal process, the MCP must comply with the standard appeal process specified in paragraph ~~(C)~~ (E) of this rule, except the ~~MCPs~~MCP must:

(a) Not require that an oral filing be followed with a written, signed appeal~~.~~;

(b) Make a determination within one working day of the appeal request whether to expedite the appeal resolution~~.~~;

(c) Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution~~.~~;

(d) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing~~.~~;

(e) Resolve the appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed three working days from the date the MCP received the appeal unless the resolution timeframe is extended as outlined in paragraph ~~(E)~~ (F) of this rule~~.~~;

(f) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification~~.~~;

(g) Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal~~.~~; and

(h) Notify ~~ODJFS~~ODM within one working day of any appeal that meets the criteria for expedited resolution as specified by ~~ODJFS~~ODM.

(3) If the MCP denies the request for expedited resolution of an appeal the MCP must:

(a) Transfer the appeal to the standard resolution timeframe of fifteen calendar days from the date the appeal was received unless the resolution timeframe is extended as outlined in paragraph ~~(E)~~(F) of this rule;

(b) Provide the member written notice of the denial to expedite the resolution within two calendar days of the receipt of the appeal, including information that the member can grieve the decision.

~~(E)~~(F) Appeal resolution extensions.

(1) A member may request that the MCP extend the timeframe to resolve a standard or expedited appeal up to fourteen calendar days.

(2) An MCP~~MCPs~~ may request that the timeframe to resolve a standard or expedited appeal be extended up to fourteen calendar days. The ~~MCPs~~MCP must seek such an extension from ODM prior to the expiration of the regular appeal resolution timeframe and its request must be supported by ~~submit~~ documentation that the extension is in the member's best interest ~~to ODJFS for prior approval~~. If ~~ODJFS~~ODM approves the extension, the MCP must immediately give the member written notice of the reason for the extension and the date ~~that~~by which a decision must be made.

(3) The ~~MCPs~~ MCP must maintain documentation of any extension request.

~~(F)~~(G) Continuation of benefits for an appeal to the MCP.

(1) The MCP must continue a member's benefits when an appeal has been filed if the following conditions are met:

(a) The member or authorized representative files the appeal on or before the later of the following:

(i) Within fifteen working days of the MCP mailing the NOA; or

(ii) The intended effective date of the MCP's proposed action;

(b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized course of treatment;

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

(d) The authorization period has not expired; and

(e) The member requests the continuation of benefits.

(2) If the MCP continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

(a) The member withdraws the appeal;

(b) Fifteen calendar days pass following the mailing date of the MCP's notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing ~~with continuation of benefits and~~in which case ~~therefore~~ the benefits must be continued as specified in rule 5101:6-4-01 of the Administrative Code;

(c) A state hearing regarding the ~~continuation of the benefits~~reduction, suspension or termination of services is decided adverse to the member; or

(d) The initial time period for the authorization expires or the authorization service limits are met.

(3) At the discretion of ~~ODJFS~~ODM, the MCP may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCP's original action.

~~(G)~~(H) Grievances to an MCP ~~process~~.

(1) A member or authorized representative can file a grievance. An authorized representative must have the member's written consent to file a grievance on the member's behalf.

(2) Grievances may be filed only with the MCP, orally or in writing, ~~only with the MCP,~~ within ninety calendar days of the date that the member became aware of the issue.

(3) The ~~MCPs~~ MCP must acknowledge the receipt of each grievance to the

individual filing the grievance. Oral acknowledgment is acceptable~~,~~. However ~~however~~, if the grievance is filed in writing, written acknowledgment must be made within three working days of receipt of the grievance.

(4) ~~MCPs~~The MCP must review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions including member notification must meet the following timeframes:

(a) Within two working days of receipt if the grievance is regarding access to services.

(b) Within thirty calendar days of receipt for non claims-related grievances except as specified in paragraph ~~(G)~~(H)(4)(a) of this rule.

(c) Within sixty calendar days of receipt for claims-related grievances.

(5) At a minimum, the MCP must provide oral notification to the member of a grievance resolution. However, if the MCP is unable to speak directly with the member ~~and/~~or the resolution includes information that must be confirmed in writing, the resolution must be provided in writing simultaneously with the MCP's decision.

(6) If the MCP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service or billing of a member due to the MCP's denial of payment for that service, the MCP must notify the member of his or her right to request a state hearing as specified in paragraph ~~(H)~~(I) of this rule, if the member has not previously been notified.

~~(H)~~(I) Access to state's hearing ~~process~~system.

(1) The MCP must develop and implement written policies and procedures that ensure the plan's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code.

(2) Members are not required to exhaust the appeal or grievance process through the MCP in order to access the state's hearing system.

~~(1)~~(3) When required by paragraph (C) of this rule and division 5101:6 of the Administrative Code, the MCP~~MCPs~~ must notify members, and any authorized representatives on file with the MCP, of the right to a state hearing. The following requirements apply ~~as follows~~:

(a) If the MCP denies a request for the authorization of a service, in whole or in part, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Medical Services By Your Managed Care Plan" (~~JFS~~ODM 04043, 7/2014 formerly JFS 04043~~rev. 7/2009~~).

(b) If the MCP decides to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the MCP, the MCP must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension, or termination, the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (~~JFS~~ODM 04066, 7/2014 formerly JFS 04066~~7/2009~~).

(c) If the MCP learns that a member has been billed for services received by the member due to the MCP's denial of payment, and the MCP upholds the denial of payment, the MCP must immediately complete and mail or personally deliver the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (~~JFS~~ ODM 04046, 7/2014 formerly JFS 04046~~rev. 7/2009~~).

(d) If the MCP proposes enrollment in the coordinated services program (CSP), the MCP must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed enrollment, the "Notice of Proposed Enrollment in the Coordinated Services Program (CSP) ~~By ODJFS Or By Your Managed Care Plan~~" (~~JFS~~ ODM 01717 ~~01704~~, 7/2014 formerly JFS 01717~~rev. 7/2011~~).

(e) If the MCP decides to continue enrollment in CSP, the MCP must simultaneously complete and mail or personally deliver the "Notice of Continued Enrollment in the Coordinated Services Program (CSP) ~~By ODJFS Or By Your Managed Care Plan~~" (~~JFS~~ ODM 01705, 7/2014 formerly JFS 01705~~rev. 7/2011~~).

(f) If the MCP denies a CSP member's request to change designated provider(s) within the MCP's provider panel, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Designated Provider or Pharmacy ~~Change~~ in the Coordinated Services Program (CSP) ~~By ODJFS Or By Your Managed Care Plan~~" (~~JFS 01706~~, (ODM 01718, 7/2014 formerly JFS 01718~~rev. 7/2011~~).

(4) The member or member's authorized representative may request a state hearing within ninety calendar days by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS). The

ninety-day period begins on the day after the mailing date on the state hearing form.

(5) There are no state hearing rights for a member(s) terminated from the MCP pursuant to an MCP-initiated membership termination as permitted in rule 5160-26-02.1 of the Administrative Code.

(6) Following the bureau of state hearings' notification to the MCP that a member has requested a state hearing the MCP must:

(a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014 formerly JFS 01959) with appropriate attachments, and file it with the bureau of state hearings at least three business days prior to the scheduled hearing date. The appeal summary must provide all facts and documents relevant to the issue, and be sufficient to demonstrate the basis for the MCP's action or decision.

(b) Send a copy of the completed appeal summary to the appellant, the bureau of state hearings, the local agency, and the designated ODM contact.

(c) Continue or reinstate the benefit(s) specified in rule 5101:6-4-01 of the Administrative Code, if the MCP is notified that the member's state hearing request was received within the prior notification period.

(d) Not enroll the individual in the coordinated services program (CSP) if the MCP is notified that the member's state hearing request was received within the prior notification period.

(7) The MCP must participate in the hearing in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, rev. 09/2012) sent to the MCP by the bureau of state hearings.

(8) In addition to the MCP and member, other parties to a state hearing may include an authorized representative of a member, or the representative of the member's estate, if the member is deceased.

(9) The MCP must comply with the state hearing officer's decision provided to the MCP via the "State Hearing Decision" (JFS 04005, rev. 03/2003). If the hearing officer's decision is to sustain the member's appeal, the MCP must complete the "State Hearing Compliance" form (JFS 04068, rev. 05/2001). A copy of the completed form, including applicable documentation, is due by no later than the compliance date specified in the hearing decision to the bureau of state hearings and the designated ODM contact. If applicable, the MCP must:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(b) Pay for the disputed services if the member received the disputed services while the appeal was pending.

~~(2)~~(10) ~~MCPs~~The MCP must provide a copy of the state hearing forms referenced in this paragraph to ~~(H)(1) of this rule to ODJFS~~ODM, as directed by ~~ODJFS~~ODM.

~~(3)~~(11) Upon request, the MCP's state hearing policies and procedures must be made available for review by ODM.~~The MCP, member, and member's authorized representative are parties to the state hearing.~~

~~(I)~~(J) Logging and reporting of appeals and grievances.

(1) ~~MCPs~~The MCP must maintain records of all appeals and grievances including resolutions for a period of ~~six~~ eight years and the records must be made available upon request to ~~ODJFS~~ODM and the ~~MFCU~~medicaid fraud control unit .

(2) The MCP~~MCPs~~ must identify a key staff person responsible for the logging and reporting of appeals and grievances and assuring that the grievance system is in accordance with this rule.

(3) ~~MCPs~~The MCP is ~~are~~ required to submit information regarding appeal and grievance activity as directed by ~~ODJFS~~ODM.

(K) Other duties of a MyCare Ohio plan regarding appeals and grievances.

(1) The MCP must give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including but not limited to:

(a) Explaining the MCP's process to be followed in resolving the member's appeal or grievance;

(b) Completing forms and taking other procedural steps as outlined in this rule; and

(c) Providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) The MCP must ensure that the individuals who make decisions on appeals and grievances are individuals who:

(a) Were not involved in previous levels of review or decision-making; and

(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:

(i) An appeal of a denial that is based on lack of medical necessity;

(ii) A grievance regarding the denial of an expedited resolution of an appeal; or

(iii) An appeal or grievance that involves clinical issues.

(3) The procedure to be followed to file an appeal, grievance, or state hearing request must be described in the MCP's member handbook and must include the telephone number(s) for the MCP's toll-free member services hotline, the MCP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file an appeal or grievance must also be made available through the MCP's member services program.

(4) Appeals and grievance procedures must include the participation of individuals authorized by the MCP to require corrective action.

(5) The MCP is prohibited from delegating the appeal or grievance process to another entity.

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R.C. 119.032 review dates:

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Certification

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Date

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TO BE RESCINDED

5160-26-08.5 **Managed health care programs: responsibilities for state hearings.**

~~(A) MCPs must develop and implement written policies and procedures that ensure the MCP's compliance with the applicable state hearing provisions specified in division 5101:6 of the Administrative Code, including but not limited to:~~

~~(1) MCPs must notify members of their right to a state hearing as specified in paragraph (H) of rule 5101:3-26-08.4 of the Administrative Code. Members or their authorized representatives may request a state hearing within ninety calendar days by contacting the ODJFS bureau of state hearings or local agency. The ninety-day period begins on the day after the mailing date on the state hearing form.~~

~~(2) Following the bureau of state hearings' notification to the MCP that a member has requested a state hearing the MCP must:~~

~~(a) Complete the "Appeal Summary for Managed Care Plans" (JFS 01959, rev. 06/03) with appropriate attachments, at least three business days prior to the scheduled hearing date. The appeal summary must provide all facts and documents relevant to the issue, and be sufficient to demonstrate the basis for the MCP's action or decision.~~

~~(b) Send a copy of the completed appeal summary to the appellant, assigned hearings section, local agency, and the designated ODJFS contact.~~

~~(c) Continue or reinstate the benefit(s) specified in rule 5101:6-4-01 of the Administrative Code, if the MCP is notified that the member's state hearing request was received within the prior notification period and the member requested that the benefits be continued.~~

~~(d) Not enroll the individual in the coordinated services program (CSP) if the MCP is notified that the member's state hearing request was received within the prior notification period.~~

~~(3) The parties to a state hearing include the MCP, member, member's authorized representative, and estate representative of a deceased member.~~

~~(4) MCPs must participate in the hearing in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, rev. 09/02) sent to the MCP by the bureau of state hearings.~~

~~(5) MCPs must comply with the state hearing officer's decision provided to the~~

~~MCP via the "State Hearing Decision" (JFS 04005, rev. 03/03). If the hearing officer's decision is to sustain the member's appeal, the MCP must:~~

~~Complete the "State Hearing Compliance" form (JFS 04068, rev. 05/01). A copy of the completed form, including applicable documentation, is due by no later than the compliance date specified in the hearing decision to the bureau of state hearings and the designated ODJFS contact. If applicable, the MCP must:~~

~~(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.~~

~~(b) Pay for the disputed services if the member received the disputed services while the appeal was pending.~~

~~(B) Upon request, the MCP's state hearing policies and procedures must be made available for review by ODJFS.~~

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5160-26-09 **Managed health care programs: ~~reimbursement~~payment and financial responsibility.**

(A) ~~Reimbursement~~Payment.

(1) The Ohio department of medicaid (ODM) will compute managed care plan (MCP) premium rates on an actuarially sound basis. The premium rates do not include any amount for risks assumed under any other existing or any previous agreement or contract. ODM will review the premium rates at least annually and the rate(s) may be modified based on existing actuarial factors and experience.

~~(1)~~(2) The MCP~~MCPs~~ will receive a monthly premium payment for each member from ODM. ~~For the covered families and children category as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code, when MCPs provide or arrange maternity coverage, a separate payment will be made for each reimbursable delivery. These payments will be in effect for the duration of the agreement unless restricted in accordance with rule 5101:3-26-10 of the Administrative Code.~~

(3) When an MCP provides or arranges for maternity coverage, ODM will make a separate payment to the MCP for each reimbursable delivery for applicable covered populations described in rule 5160-26-02 of the Administrative Code.

~~(2) The premium rates are computed on an actuarially sound basis. This rate does not include any amount for risks assumed under any other existing or any previous agreement or contract. The premium rate will be reviewed at least once every two years and may be modified based on existing actuarial factors and experience.~~

~~(3)~~(4) ~~Under full-risk arrangements the~~The amounts paid by ODM in accordance with this paragraph ~~(A)(1) of this rule~~ represent a full-risk arrangement and the total obligation of ~~ODJFS~~ODM to the MCP for the costs of medical care and services provided. Any savings or losses remaining after costs have been deducted from the premium will be wholly retained by the MCP~~, except as provided in paragraph (A)(5) of this rule~~.

~~(4) Under partial-risk arrangements, the MCP and ODJFS will partially share the risk for the cost of medical care and services provided. Any savings which accrue will also be shared.~~

(5) Payments made by ODM in accordance with this paragraph will be in effect for

the duration of the provider agreement entered into between ODM and the MCP unless restricted in accordance with rule 5160-26-10 of the Administrative Code or the terms of the provider agreement.

~~(5)~~(6) ~~ODJFS~~ODM may establish financial incentive programs based on performance for MCPs.

(B) Fiscal responsibility requirements.

(1) ~~Each~~ An MCP must maintain a fiscally-sound operation and meet ~~ODFJS~~ODM performance standards.

(2) ~~Each~~ An MCP must make provisions against the risk of insolvency.

(3) Neither members nor ~~ODJFS~~ODM shall be liable for any MCP debts, including those that remain in the event of MCP insolvency or the insolvency of any subcontractors.

(4) ~~Each~~ An MCP must pay providers in accordance with 42 C.F.R. 447.46 (October 1, 2013).

(5) The following requirements apply to an MCP ~~MCPs~~ licensed as a health insuring corporation (HIC) by the Ohio department of insurance (ODI):

(a) A copy of the MCP's current license or certificate of authority must be submitted to ~~ODJFS~~ODM annually, no later than thirty days after issuance;

(b) Copies of all annual and quarterly financial statements and any revision to such copies must be submitted to ~~ODJFS~~ODM. For purposes of this rule, "~~Annual~~annual financial statement" is the annual statement of financial condition prescribed by the "National Association of Insurance Commissioners" (NAIC) ~~statutory filing of financial condition as adopted~~ and required by ~~the Ohio department of insurance (~~ODI~~)~~ in accordance with sections 1751.32 and 1751.47 of the Revised Code.

(c) ~~Each~~The MCP must submit to ~~ODJFS~~ODM a copy of its audited financial statement as compiled by an independent auditor and including the statement of reconciliation with statutory accounting principles as required by ODI in accordance with section 1751.321 of the Revised Code. The statement must be submitted annually to ~~ODJFS~~ODM.

(6) The following items must be submitted by each MCP as so indicated:

(a) ~~Each MCP must submit cost~~Cost reports on ~~ODJFS~~ODM forms quarterly and annually~~, no later than ninety days after the close of the calendar year or as otherwise specified~~ as directed by ~~ODJFS~~ODM. ~~The annual cost report must be audited by an independent licensed auditor and include a statement of reconciliation with statutory accounting principles. The annual cost report must also include a description of the methodology used to calculate incurred but not reported (IBNR) claims and an annual certification signed by an independent accredited actuary or licensed auditor that the methodology is valid. Such certification must be signed within the preceding twelve months and must be accompanied by a signed statement from the MCP that the methodology has not materially changed since the date the certification was signed by the independent actuary or auditor~~The MCP must adhere to ODM provider agreement and cost report instructions;

(b) Financial disclosure statements to be submitted in conjunction with cost report submissions as specified in paragraph (B)(5)(b) of this rule for MCPs. The MCP must also submit copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the ~~MCP ,~~MCP, or an indirect interest of five percent or more or a combination of direct and indirect interest equal to five percent or more in the MCP; and

(c) MCP physician incentive plan disclosure statements ~~and other information as required by~~in accordance with 42 C.F.R. ~~417~~438.6 (October 1, 2013).

(C) Reinsurance requirements.

(1) All MCPs must carry reinsurance coverage from a licensed commercial carrier to protect against catastrophic inpatient-related medical expenses incurred by medicaid members.

(2) To the extent that the risk for such expenses is transferred to a subcontractor, the MCP must provide proof of reinsurance coverage for that subcontractor in accordance with the provisions of this paragraph.

(3) A copy of the fully-executed reinsurance agreement to provide the specified coverage must be submitted to ~~ODJFS~~ODM prior to the effective date of the provider agreement. No provider agreement will be signed in the absence of

such documentation.

(4) The annual deductible must be specified in the reinsurance agreement and must not exceed the amount specified by ~~ODJFS~~ODM.

(5) The reinsurance coverage must remain in force during the term of the provider agreement with ~~ODJFS~~ODM and must contain adequate provisions for contract extensions.

(6) ~~Each~~ The MCP shall provide written notification to ~~ODJFS~~ODM when directed by ODM, specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all medicaid members for which reinsurance claims have been submitted. ~~The MCP must provide such notification to ODJFS as part of the ODJFS "Medicaid Managed Care Plan Cost Report."~~

(7) The MCP must give ~~ODJFS~~ODM prior written notice of any proposed changes or modifications in the reinsurance agreements for ~~ODJFS~~ODM review and approval. Such notice shall be submitted to ~~ODJFS~~ODM thirty days prior to the intended effective date of any proposed change and must include the complete and exact text of the proposed change. The MCP ~~MCPs~~ must provide copies of new or modified reinsurance agreements to ~~ODJFS~~ODM within thirty days of execution.

(8) In the event of termination of the reinsurance agreement due to insolvency of the MCP or the reinsurance carrier, the MCP will be fully responsible for all pending or unpaid claims.

(9) Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency must include medicaid members as a covered class.

(10) Reinsurance requirements for partial-risk arrangements may differ from those specified in this paragraph.

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5160-26-11 **Managed health care programs: managed care plan non-contracting providers.**

(A) For the purposes of this rule, the following terms are defined as follows:

(1) "Managed care plan (MCP) non-contracting provider" means any provider with a medicaid provider agreement with ODM who does not contract with the MCP but delivers health care services to that MCP's member(s), as described in paragraphs (C) and (D) of this rule.

(2) "Managed care plan (MCP) non-contracting provider of emergency services" means any person, institution, or entity ~~who~~that does not contract with the MCP but provides emergency services to an MCP member, regardless of whether or not that provider has a medicaid provider agreement with the Ohio department of medicaid (ODM).

(B) MCP non-contracting providers of emergency services~~, as defined in paragraph (A)(2) of this rule,~~ must accept as payment in full from the MCP 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. Pursuant to section 5167.10 of the Revised Code, the MCP shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.

(C) When ~~the Ohio department of medicaid (ODM)~~ODM has approved an MCP's members to be referred to an MCP non-contracting hospital pursuant to ~~paragraph (H)(9) of~~ rule ~~5101:3~~5160-26-03 of the Administrative Code, the MCP non-contracting hospital must provide the service for which the referral was authorized and must accept as payment in full from the MCP one hundred per cent of the current Ohio medicaid program ~~fee-for-service~~ reimbursement rate in effect for the date of service. Pursuant to section 5167.10 of the Revised Code, the MCP shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM. MCP non-contracting hospitals are exempted from this provision when:

(1) The hospital is located in a county in which eligible individuals were required to enroll in an MCP prior to January 1, 2006;

(2) The hospital is contracted with at least one MCP serving the eligible individuals

specified in paragraph (C)(1) of this rule prior to January 1, 2006; and

(3) The hospital remains contracted with at least one MCP serving eligible individuals who are required to enroll in MCPs in the service area where the hospital is located.

(D) MCP non-contracting qualified family planning providers (QFPPs) must accept as payment in full from the MCP 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.

(E) An MCP non-contracting provider may not bill an MCP member unless all of the following conditions are met:

(1) The member was notified by the provider of the financial liability in advance of service delivery.

(2) The notification by the provider was in writing, specific to the service being rendered, and clearly states that the recipient is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.

(3) The notification is dated and signed by the member.

(4) The reason the service is not covered by the MCP is specified and is one of the following:

(a) The service is a benefit exclusion;

(b) The provider is not contracted with the MCP and the MCP has denied approval for the provider to provide the service because the service is available from a contracted provider, at no cost to the member; or

(c) The provider is not contracted with the MCP and has not requested approval to provide the service.

(F) An MCP non-contracting provider may not bill an MCP member for a missed appointment.

(G) MCP non-contracting providers, including MCP non-contracting providers of emergency services, must contact the twenty-four hour post-stabilization services

phone line designated by the MCP to request authorization to provide post-stabilization services in accordance with ~~paragraph (G) of~~ rule ~~5101:3~~5160-26-03 of the Administrative Code.

(H) MCP non-contracting providers, including MCP non-contracting providers of emergency services, must allow the MCP, ~~and/or~~ ODM, and ODM's ~~or its~~ designee access to all enrollee medical records for a period not less than ~~six~~eight years from the date of service or until any audit initiated within the ~~six~~eight year period is completed. Access must include ~~at least one copy~~copies of the medical record(s) at no cost for the purpose of activities related to the annual external quality review specified by 42.C.F.R. 438.358 (October 1, 2013) ~~in rule 5101:3-26-07 of the Administrative Code.~~

(I) When an MCP elects~~MCPs elect~~ to impose member co-payments in accordance with rule ~~5101:3~~5160-26-12 of the Administrative Code, applicable co-payments shall also apply to services rendered by MCP non-contracting providers. When an MCP has~~MCPs have~~ not elected to impose co-payments in accordance with rule ~~5101:3~~5160-26-12 of the Administrative Code, MCP non-contracting providers are not permitted to impose co-payments on MCP members.

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5160-26-12 **Managed health care programs: member co-payments.**

(A) Managed care plans (MCPs) may elect to implement a member co-payment program pursuant to section ~~5111.0112~~ 5162.20 of the Revised Code~~. MCPs may establish a member co-payment program~~ for dental services, vision services, non-emergency emergency department services, or prescription drugs as provided for in this rule. MCPs must receive prior approval from the Ohio department of medicaid~~job and family services~~ (~~ODJFS~~ODM) before notifying members that a co-payment program will be implemented. This rule does not apply to MyCare Ohio plans pursuant to Chapter 5160-58 of the Administrative Code.

(B) MCPs that elect to implement member co-payment amounts must:

(1) Exclude the populations and services set forth in paragraph (C) of this rule;

(2) Not deny services to members as specified in paragraph (D) of this rule;

(3) Not impose co-payment amounts in excess of the maximum amounts specified in 42 C.F.R. 447.54 (October 1, 2013);

(4) Specify in provider subcontracts ~~per paragraph (D) of~~governed by rule ~~5101:3~~5160-26-05 of the Administrative Code ~~under what~~the circumstances under which member co-payment amounts can be requested. For MCPs that elect to implement a co-payment program, no provider can waive a member's obligation to pay the provider a co-payment except as described in paragraph (G) of this rule;

(5) ~~Assure~~Ensure that the member is not billed for any difference between the MCP's payment and the provider's charge or request that the member share in the cost through co-payment or other similar charge, other than medicaid co-payments as defined in this rule;

(6) ~~Assure~~Ensure that member co-payment amounts are requested by providers in accordance with this rule; and

(7) ~~Assure~~Ensure that no provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent shall pay any co-payment on behalf of the member.

(C) Exclusions to the member co-payment program for dental, vision, non-emergency

emergency department services, and prescription medications include the following:

(1) Children. Members who are under the age of twenty-one are excluded from medicaid co-payment obligations.

(2) Pregnant women. With the exception of routine eye examinations and the dispensation of eyeglasses during a member's pregnancy or post-partum period, all services provided to pregnant women during their pregnancy and the post-partum period are excluded from a medicaid co-payment obligation. The post-partum period is the period that begins on the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends.

(3) Institutionalized members. Services or medications provided to members who reside in a nursing facility (NF) or intermediate care facility for ~~the mentally retarded (ICF-MR)~~individuals with intellectual disabilities (ICF/IID) are excluded from medicaid co-payment obligations.

(4) Emergency. ~~Members receiving~~An MCP shall not impose a co-payment obligation for emergency services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily part or organ.~~, are excluded from medicaid co-payments obligations.~~

(5) Family planning (pregnancy prevention~~/~~or contraceptive management). An MCP shall not impose a medicaid co-payment obligation on any~~Any~~ service identified by ~~ODJFS~~ODM as a pregnancy prevention/contraceptive management service in accordance with rule ~~5101:3~~5160-21-02 and the appendix to rule ~~5101:3~~5160-9-12 of the Administrative Code and provided to an individual of child-bearing age. ~~is not subject to a medicaid co-payment obligation.~~

(6) Hospice. Members receiving services for hospice care are excluded from medicaid co-payment obligation.

(7) Medicare cross-over claims. Medicare cross-over claims defined in accordance with rule ~~5101:3~~5160-1-05 of the Administrative Code will not be subject to medicaid co-payment obligations.

(8) Medications administered to a member during a medical encounter provided in a hospital, clinic, office or other facility, when the medication is part of the evaluation and treatment of the condition, are not subject to a member co-payment.

(D) No provider may deny services to a member who is eligible for ~~the~~ services due to the member's inability to pay the member co-payment. Members who are unable to pay their member co-payment may declare their inability to pay for services or medication and receive their services or medications without paying their member co-payment amount. This provision does not relieve the member from the obligation to pay a member co-payment or prohibit the provider from attempting to collect an unpaid member co-payment. If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid medicaid co-payment as an outstanding debt and may refuse service to a member who owes the provider an outstanding debt. If the provider intends to refuse service to a member who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services. In such situations, MCPs must still ~~assure~~ensure that the member has access to needed services.

(E) MCPs may elect to impose member co-payments as follows:

(1) For dental services, the member co-payment amount may not exceed ~~three dollars per date of service per provider, as~~ the amount set forth in Chapter 5160-5~~rule 5101:3-5-01~~ of the Administrative Code. Services provided to a member on the same date of service by the same provider are subject to only one co-payment.

(2) For non-emergency emergency department services, the member co-payment amount must not exceed ~~three dollars for non-emergency emergency department services, as~~the amount set forth in Chapter 5160-2~~rule 5101:3-2-21.1~~ of the Administrative Code. For purposes of this rule, the hospital provider shall determine if services rendered are non-emergency emergency department services and will report, through claim submission, the applicable co-payment to the MCP in accordance with medicaid hospital billing instructions.

(3) For vision services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-6 of the Administrative Code.~~:~~

~~(a) A two-dollar member co-payment per date of service per claim for the vision exam codes set forth in rule 5101:3-6-01 of the Administrative Code, and~~

~~(b) A one-dollar member co-payment per date of service per claim for the dispensing codes set forth in rule 5101:3-6-01 of the Administrative Code.~~

(4) For pharmacy services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-9 of the Administrative Code. ~~MCPs must not impose a member co-payment greater than:~~

~~(a) Two dollars for selected trade name drugs as indicated in the appendix to rule 5101:3-9-12 of the Administrative Code, and~~

~~(b) Three dollars for prescription medications not found in the appendix to rule 5101:3-9-12 of the Administrative Code.~~

(F) Prescriptions for medications are subject to the applicable member co-payment for medications if they are given to a member during a medical encounter provided in the emergency department or other hospital setting, clinic, office, or other facility as a result of the evaluation and treatment of the condition, ~~and if~~regardless of whether they are ~~to be~~ filled at a pharmacy located at the facility or at an outside location.

(G) If an MCP has implemented a member co-payment program for non-emergency emergency department services, as described in paragraph ~~(A)~~ (E)(2) of this rule, a hospital may take action to collect a co-payment by providing, at the time services are rendered to a managed care member, notice that a co-payment may be owed. If the hospital provides the notice and chooses not to take further action to pursue collection of the co-payment, the prohibition against waiving co-payments, as described in paragraph (B)(4) of this rule, does not apply.

(H) If an MCP elects not to impose a co-payment amount for dental services, vision services, non-emergency emergency department services or prescription drugs and the MCP reimburses contracting or non-contracting providers for these services using the medicaid provider reimbursement rate, the MCP must not reduce its provider payments by the applicable co-payment amount set forth in this rule.

Effective:

R.C. 119.032 review dates: 10/01/2016

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5167.02
Rule Amplifies:	5162.03, 5162.20 , 5164.02 , 5167.03 , 5167.10 , 5167.12
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