Ohio | Common Sense Initiative

Mike DeWine, Governor
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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

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Regulation/Package Title (a general description of the rules' substantive content): Managed Care Procurement and Single Pharmacy Benefit Manager (SPBM) Implementation – Ohio Administrative Code (OAC) Chapter 26 Rule Updates

Rule Number(s): 5160-26-02.1, 5160-26-03, 5160-26-03.1, 5160-26-05, 5160-26-05.1, 5160-26-06, 5160-26-08.4, 5160-26-09.1, 5160-26-10, and 5160-26-12.

Included for informational purposes only; *5160-26-01, 5160-26-02, 5160-26-08.3, and 5160-26-11.*

Date of Submission for CSI Review: 03/01/2022

Public Comment Period End Date: 03/08/2022

Rule Type/Number of Rules:
New/___ rules
Amended/ 14 **rules (FYR?** Yes**)**
No Change/____ rules (FYR? ___)
Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**
   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**
   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**
   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.
   In Ohio, approximately 90% of Medicaid recipients receive their Medicaid services through the managed care delivery system. Managed care organizations (MCOs) are health insurance companies licensed by the Ohio Department of Insurance and have a provider agreement (contract) with the Ohio Department of Medicaid (ODM) to provide coordinated health care to Medicaid beneficiaries. There were seven MCOs procured to provide services in Ohio, each with a network of health care professionals. Medicaid recipients enrolled in an MCO will be mandatorily enrolled in Ohio's single pharmacy benefit manager (SPBM) for the administration of pharmacy benefits. The SPBM is a prepaid ambulatory health plan (PAHP) as defined in 42 Code of Federal Regulations (CFR) 438 and has a contract with ODM. The rules outlined in Chapter 5160-26 of the Ohio Administrative Code (OAC) set forth the requirements of the managed care program, MCOs, and the SPBM.

   All OAC rule titles in Chapter 5160-26 are being amended from "Managed health care programs" to "Managed care" in alignment with ORC 5167 titled "Medicaid Managed Care." This change applies to all rules listed below.

   Ohio Administrative Code (OAC) rule 5160-26-01, entitled "Managed care: definitions," sets forth the definitions used throughout Chapter 5160-26 of the Administrative Code regarding the managed care program. The definitions in this rule apply to managed care organizations (MCOs), MyCare Ohio Plans (MCOPs), the OhioRISE (Resilience through Integrated Systems and Excellence) plan, and the single Pharmacy Benefit Manager (SPBM). The rule is being proposed for amendment to update policy related to the administration of the Medicaid managed care program and for five year rule review. Changes to this rule include: revising the title of the rule, adding definitions to this rule that were previously found in other Chapter 26 rules in paragraphs (C), (D), (P), (EE), (FF), and (GG), adding new definitions specifically related to the SPBM in paragraphs (AAA) and (BBB), adding a definition of "care management system" in paragraph (F), adding a definition of "managed care entity (MCE)" in paragraph (W), adding a definition of "network provider" in paragraph (DD), adding a definition of

"respite services" in paragraph (UU), adding a definition of "single case agreement" in paragraph (ZZ), adding a definition of "state hearing" in paragraph (DDD), other grammatical and technical edits, and updating references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-02, entitled "Managed care: eligibility and enrollment", sets forth the eligibility criteria for individuals to be enrolled in an MCO or the SPBM and the enrollment process. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, adding a clarification that the rule does not apply to the OhioRISE plan in paragraph (A), adding language regarding voluntary MCO enrollment for individuals enrolled in the OhioRISE 1915(c) home and community based waiver in paragraph (B)(2)(e), adding language regarding SPBM enrollment in paragraph (C), adding language about infants placed for adoption or placed in the custody of an Ohio County Public Children's Services Agency (PCSA) in paragraph (D)(6), removing inpatient facility admission language in previous paragraph (D)(2) as the language is included in the MCO provider agreement, adding references to the SPBM where applicable throughout the rule, other grammatical and technical edits, and updating references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-02.1, entitled "Managed care: termination of enrollment", sets forth the reasons why an individual enrolled in an MCO or the SPBM may be terminated and the process for termination. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, adding a clarification that the rule does not apply to the OhioRISE plan in paragraph (A), adding SPBM termination language in paragraph (C), clarifying language regarding mandatory populations and voluntary populations in paragraphs (E)(1)-(3), other grammatical and technical edits, and updating references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-03, entitled "Managed care: covered services" sets forth the services which must be covered by MCOs and the SPBM and addresses any exclusions or limitations for those services. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program and for five year rule review. Changes to the rule include: revising the title of the rule, adding a clarification that the rule does not apply to the OhioRISE plan or MyCare Ohio plans in paragraph (A), removing definitions in paragraph (E)(3)(f) that are now included in OAC rule 5160-26-01, adding a requirement for the MCO to cover two dental screenings per year for pregnant members in paragraph (E)(16), removing language related to respite services in paragraph (E)(17) as this language is included in a new OAC rule 5160-26-03.2, adding a clarification that the MCO is not responsible for covering OhioRISE plan services in paragraph (E)(18), adding references to the SPBM where applicable throughout the rule, and other grammatical and technical edits.

OAC rule 5160-26-03.1, entitled "Managed care: primary care and utilization management", sets forth the requirements for MCOs and the SPBM related to members' primary care providers (PCPs) and utilization management. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program and for five year rule review. Changes to the rule include: revising the title of the rule, adding a clarification that the rule does not apply to the OhioRISE plan or MyCare Ohio plans in paragraph (A), changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, adding language about compliance with the Metal Health Parity and Addiction Equity Act (MHPAEA)

in paragraph (C)(2)(h), removing language regarding service authorizations not being reached in the specified timeframes in paragraph (C)(3)(g) as the language is duplicative of requirements found in OAC rule 5160-26-08.4, clarifying prior authorization requirements and timeframes for covered outpatient drugs in new paragraph (C)(3)(g), removing requirement to implement an emergency department diversion program in paragraph (C)(4), adding references to the SPBM where applicable throughout the rule, other grammatical and technical edits, and updating references to United States Code.

OAC rule 5160-26-05, entitled "Managed care: provider panel and contracting requirements", sets forth MCE provider panel and contracting requirements. This rule is applicable to MCOs, the SPBM, MCOPs, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program and for five year rule review. Changes to the rule include: revising the title of the rule, changing references from "subcontracts" to "provider contracts" throughout the rule, adding references to MCE and SPBM where applicable throughout the rule, adding requirement that network providers must be activley enrolled with Ohio Medicaid in paragraph (A)(4), adding clarification about ODM credentialed providers in paragraph (C)(4), adding reference to OAC rule 5160-1-13.1 regarding billing member and removed duplicative rule language in paragraph (D)(9)(b), other grammatical and technical edits, and updating references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-05.1, entitled "Managed care: provider services", sets forth the requirements for information that MCEs must make available to providers and interested parties. This rule is applicable to MCOs, the SPBM, MCOPs, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, adding references to MCE where applicable throughout the rule, removing requirements for credentialing providers in paragraph (A)(6), other grammatical and technical edits, and updating references to the Code of Federal Regulations.

OAC rule 5160-26-06, entitled "Managed care: program integrity – fraud, waste and abuse, audits, reporting, and record retention" sets forth the managed care requirements related to fraud and abuse prevention, program integrity, audits, reporting and record retention. This rule is applicable to MCOs, the SPBM, MCOPs, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program and for five year rule review. Changes to the rule include: revising the title of the rule, adding references to MCE where applicable throughout the rule, adding references to the SPBM contract where applicable throughout the rule, and other grammatical and technical edits.

OAC rule 5160-26-08.3, entitled "Managed care: member rights", sets forth the rights of a managed care enrollee. This rule is applicable to MCOs, the SPBM, MCOPs, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, adding references to MCE where applicable throughout the rule, other grammatical and technical edits, and updating references to the Code of Federal Regulations.

OAC rule 5160-26-08.4, entitled "Managed care: appeal and grievance system", sets forth the appeal and grievance rights and responsibilities for MCOs, the SPBM, and members enrolled with those

entities. This rule is applicable to MCOs, the SPBM, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, removing definitions in paragraph (A) that are now included in OAC rule 5160-26-01, removing language regarding notification to ODM of an expedited appeal due to the process being discontinued in paragraph (E)(2)(g), changing references from "Plan" to "Entity" in paragraph (G)(3)(a)-(c), revising the timeframe to request a state hearing to align with fee-for-service Medicaid in paragraph (G)(4), adding references to SPBM where applicable throughout the rule, other grammatical and technical edits, and updating references to the Code of Federal Regulations.

OAC rule 5160-26-09.1, entitled "Managed care: third party liability and recovery", sets forth the coordination of benefits and third-party liability (TPL) requirements for MCOs and the SPBM. This rule is applicable to MCOs, the SPBM, MCOPs, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, adding references to MCE where applicable, adding a TPL exclusion for children in custody in paragraph (C)(3), other grammatical and technical edits, and updating references to United States Code.

OAC rule 5160-26-10, entitled "Managed care: sanctions and provider agreement actions", sets forth the sanctions and provider agreement actions for Medicaid MCOs. This rule is applicable to MCOs, MCOPs, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, adding a clarification that the rule does not apply to the SPBM in paragraph (A), changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, other grammatical and technical edits, and updating references to United States Code and the Code of Federal Regulations.

OAC rule 5160-26-11, entitled "Managed care: non-contracting providers", sets forth the requirements for payment to non-contracting providers for services provided to members. This rule is applicable to MCOs, the SPBM, MCOPs, and the OhioRISE plan. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, removing definitions in paragraph (A) that are now included in OAC rule 5160-26-01, streamlining language regarding billing members in paragraph (D)(1), adding references to MCE where applicable, other grammatical and technical edits, and updating references to the Code of Federal Regulations.

OAC rule 5160-26-12, entitled "Managed care: member co-payments", sets forth requirements for MCOs and the SPBM when they elect to implement a co-payment program. This rule is applicable to MCOs and the SPBM. The rule is being proposed for amendment to update policy related to administration of the Medicaid managed care program. Changes to the rule include: revising the title of the rule, adding a clarification that the rule does not apply to the OhioRISE plan in paragraph (A), changing references from "managed care plans" to "managed care organizations" in accordance with OAC rule 5160-26-01, adding SPBM co-payment program requirements in paragraph (C), adding references to the SPBM where applicable throughout the rule, other grammatical and technical edits, and updating references to the Code of Federal Regulations.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**
   Revised Code Section 5167.02 authorizes ODM to adopt the rule, and 5162.02, 5162.03, 5164.02, 5167.02, 5167.03, 5167.10, and 5167.12 amplify that authority.

4. **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 CFR Part 438 imposes comprehensive requirements on the state regarding Medicaid managed care programs, however the proposed changes to the rule are not related to changes to federal regulation.

5. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**
   Federal regulations do not impose requirements directly on MCOs or PAHPs; instead they require state Medicaid agencies to ensure MCO and PAHP compliance with federal standards. The rules are consistent with federal managed care requirements outlined in 42 CFR Part 438 that require the state to implement policies and regulations as the state deems necessary and appropriate.

6. **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)?**
   The rules in OAC Chapter 5160-26 are necessary for various reasons. Federal regulations require state Medicaid agencies to ensure MCO and PAHP compliance with federal standards, therefore these rules ensure ODM compliance with federal regulations governing Medicaid managed care programs. The public purpose of this regulation is to:
   - Ensure the provision of medically necessary services, preventative care, emergency services, and post stabilization services to promote the best outcomes for individuals enrolled in the Medicaid managed care program by requiring MCOs and the SPBM to follow established guidelines and to ensure providers are paid appropriately for services delivered;
   - Ensure that information maintained by MCOs and the SPBM is readily available to the State and, if requested, by the Centers for Medicare and Medicaid Services (CMS);
   - Provide authority for ODM to sanction MCOs that do not apply with applicable state and federal laws or the MCO provider agreement; and
   - Ensure members' rights and protections.

7. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**
   ODM monitors compliance with the regulation through reporting requirements established within the managed care provider agreement and the SPBM contract. Successful outcomes are measured through a finding of compliance with these standards as determined by monitoring and oversight.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
If applicable, please include the date and medium by which the stakeholders were initially contacted.
Draft versions of the OAC Chapter 5160-26 rules were included in the SPBM Request for Proposal (RFP) process (ODMR20210020). The RFP was posted on July 24, 2020. The selected vendor, Gainwell Technologies, was provided an updated version of the draft rules electronically on 06/09/2021 for review. Gainwell was given until 06/18/2021 to comment.

   A link to the current OAC Chapter 5160-26 rules was included in the bidders library for the MCO RFP (ODMR20210024). The RFP was posted on September 30, 2020. The managed care organizations listed below, both currently contracted and newly selected MCOs, were provided the draft rules electronically on 06/09/2021. The MCOs were given until 06/09/2021 to comment.
   - UnitedHealthcare Community Plan of Ohio, Inc.
   - Humana Health Plan of Ohio, Inc.
   - Molina Healthcare of Ohio, Inc.
   - AmeriHealth Caritas Ohio, Inc.
   - Anthem Blue Cross and Blue Shield
   - CareSource Ohio, Inc.
   - Aetna Better Health Ohio, Inc.
   - Paramount Advantage, Inc.
   - Buckeye Community Health Plan
   - Ohio Association of Health Plans (OAHP)

   The OAC Chapter 5160-26 rule were posted for public comment on the ODM website on 06/09/2021. Stakeholders were given until 06/18/2021 to comment.

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**
As a result of MCO, SPBM, and additional stakeholder outreach, no concerns were expressed. Therefore, no changes were made to the rules.

11. **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 to develop these rules or the measurable outcomes of the rules.

12. **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 amendments to the rules include general updates to keep the rules current and to implement changes to the managed care program due to managed care procurement, implementation of centralized credentialing, and the implementation of the SPBM and the OhioRISE (Resilience

through Integrated Systems and Excellence) program. No alternative regulations were discussed during the rule process for this reason.

13. **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 be appropriate because ODM is required to comply with detailed federal requirements set forth in 42 CFR Part 438. MCO and SPBM performance requirements are outlined in the MCO provider agreement and the SPBM contract available on the ODM website: https://medicaid.ohio.gov/.

14. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**
All Medicaid regulations governing MCOs and the SPBM are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid managed care program, and the rules and regulations found in the rules in Chapter 5160-26 are not duplicated elsewhere in Agency 5160.

15. **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.**
ODM will notify the MCOs and the SPBM of the final rule changes via email notification. Additionally, per the MCO provider agreement, MCOs are required to subscribe to the appropriate distribution lists for notification of all OAC rule clearances, BIA and filings with the Joint Committee on Agency Rule Review including RuleWatch Ohio and the CSIO eNotification System. ODM will ensure MCOs and the SPBM are made aware of any future rule changes via established communication processes.

Adverse Impact to Business

16. **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; and**
    This rule impacts the SPBM (Gainwell Technologies), MCOs in the State of Ohio (UnitedHealthcare Community Plan of Ohio, Humana Health Plan of Ohio, Molina Healthcare of Ohio, AmeriHealth Caritas Ohio, Athem Blue Cross and Blue Shield, Buckeye Community Health Plan, and CareSource Ohio), MyCare Ohio plans in the State of Ohio (Aetna Better Health Ohio, Buckeye Community Health Plan, CareSource Ohio, Molina Healthcare of Ohio, and UnitedHealthcare Community Plan of Ohio), and the OhioRISE Plan (Aetna Better Health Ohio).

    b. **Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and**
    - **OAC rule 5160-26-02.1** requires MCOs to provide notice and potentially documentation to ODM upon member disenrollment from the MCO.
    - **OAC rule 5160-26-03** requires:
        - MCOs to pay for certain services, including respite for children;
        - Respite provider agencies to be accredited by at least one of several national accreditation entities, hold a Medicaid provider agreement, comply with

applicable background check requirements, and behavioral health agencies to be OhioMHAS certified; and
    - Agency employees to obtain a certificate of completion from the Ohio Department of Health or a Medicare competency evaluation program, first aid certification, and evidence of completion of twelve hours of in-services continuing education each year.
- **OAC rule 5160-26-03.1** requires MCOs and the SPBM to share specific information with ODM and certain providers, to maintain a log, and to implement written policies and procedures.
- **OAC rule 5160-26-05** requires MCOs and the SPBM to report certain information related to their subcontracts to ODM upon request including making subcontracts themselves available. MCOs and the SPBM are also required to notify ODM, providers, and/or members of the addition or removal of health care providers from their provider panel including the expiration, non-renewal, or termination of any provider subcontract.
- **OAC rule 5160-26-05.1** requires MCOs and the SPBM to provide written information to their contracting providers. It also requires MCOs to disseminate practice guidelines to providers and, upon request, to members. This rules also requires MCOs and the SPBM to have staff specifically responsible for resolving provider issues.
- **OAC rule 5160-26-06** requires MCOs and the SPBM to maintain written policies and procedures that articulate their commitment to comply with federal and state standards including the prevention, identification, investigation, correction and reporting of fraud, waste, and abuse.
    - MCOs and the SPBM must promptly report all instances of fraud, waste, and abuse to ODM.
    - MCO and SPBM policies and procedures, reports, and additional information must be made available to ODM upon request.
    - MCOs and the SPBM must submit an annual report to ODM that summarizes the MCO and SPBM's fraud and abuse prevention activities for the year.
    - MCOs and the SPBM, and its subcontractors, must retain and safeguard all records as required by the record retention schedule set forth in this rule and the MCO provider agreement or the SPBM contract.
- **OAC rule 5160-26-08.4** requires MCOs and the SPBM to maintain records and other documentation, to provide notice to members in specified timeframes, and to submit reports to ODM. These requirements are federally mandated.
    - MCOs and the SPBM must provide a written notice to members of an adverse benefit determination.
    - MCOs and the SPBM must acknowledge receipt of an appeal or grievance with the member or authorized representative.
    - MCOs and the SPBM must provide the member or authorized representative written notice of the resolution.
    - MCOs and the SPBM must maintain records of all appeals and grievances and submit this information to ODM as directed.
- **OAC rule 5160-26-09.1** requires MCOs and the SPBM to report information to ODM and service providers.
    - MCOs and the SPBM must notify ODM of requests related to tort action using specific ODM forms.

    - MCOs and the SPBM are required to submit information regarding members with third party coverage as directed by ODM.
    - In order to comply with coordination of benefits requirements outlined in this rule, MCOs and the SPBM are required to share information regarding third party resources with the service provider via explanation of payment.
- **OAC rule 5160-26-10** describes sanctions that may be imposed on an MCO for failure to comply with its duties and obligations under law and contract.
    - The types of sanctions include but are not limited to corrective action, the imposition of temporary management, suspension of the MCO's enrollment of members, disenrollment of the MCO's members, the prohibition or reduction of enrollees assigned to the MCO, the termination of the MCO's members without cause, the retention of premium payments by ODM, and the imposition of fines or other financial sanctions.
    - The rule also allows ODM to terminate, non-renew, or deny the MCO's entire provider agreement or terminate the provider agreement in one or more service areas.
    - This rule requires MCOs to submit corrective action plans (CAPs) to ODM upon request.
- **OAC rule 5160-26-12** may adversely affect MCOs and the SPBM due to them potentially incurring administrative costs if an MCO or the SPBM elects to implement and impose co-payment(s) on their members. The costs would vary based on the MCO or SPBM's business practices.

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

MCOs are paid a per member per month amount. ODM must pay MCOs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.4, 42 CFR 438.5, and CMS's Medicaid Managed Care Rate Development Guide. ODM's actuary will develop capitation rates for the MCOs that are "actuarially sound" for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. Costs include but are not limited to expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government mandated assessments, fees, and taxes.

Through the administrative component of the capitation rate paid to MCOs by ODM, MCOs will be compensated for the cost of the requirements found in these rules.

- For CY 2021, the administrative component of the managed care capitation rate varies by program/population and ranges from 4.0% to 6.5% for MCOs and from 3.0% to 6.0% for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates. For MCOs, all rates and actuarial methods will be found in Appendix M ("Rate Methodology") of the Medicaid Managed Care provider agreement.

The SPBM will be paid a monthly administrative fee. Through this administrative fee, the SPBM will be compensated for the costs of the requirements found in these rules.

17. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**
    MCOs and the SPBM are aware of federal requirements for covered services prior to seeking and signing contracts with the state. More importantly, without the requirements outlined in OAC rule, the State would be out of compliance with federal regulations.

Regulatory Flexibility

18. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**
    The requirements of this rule must be applied uniformly, and no exception is made based on an MCO or the SPBM's size.

19. **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?**
    These rules do not impose any monetary fines or penalties for first-time paperwork violations for small businesses as outlined in ORC section 119.14.

20. **What resources are available to assist small businesses with compliance of the regulation?**
    While there are no small businesses negatively impacted by these rules, MCOs may contact ODM directly through their assigned Contract Administrator and the SPBM may contact ODM directly through their Contract Manager.

DRAFT - NOT FOR FILING

5160-26-01 Managed ~~health~~ care ~~programs~~: definitions.

As used in Chapter 5160-26 of the Administrative Code:

(A) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the medicaid program.

(B) "Advance directive" means written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.

(C) "Adverse benefit determination" is a managed care entity's (MCE's):

(1) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

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

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

(4) Failure to act within the resolution time frames specified in rule 5160-26-08.4 of the Administrative Code;

(5) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities, if applicable; or

(6) Denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" as defined in 42 C.F.R. 447.45(b) (October 1, 2021) is not an adverse benefit determination.

(D) "Appeal" is the member's request for an MCE to review an adverse benefit determination.

~~(C)~~ (E) "Authorized representative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(F) "Care management system" means the system established by the Ohio department of medicaid (ODM) in accordance with section 5167.03 of the Revised Code.

~~(D)~~ (G) "Consumer contact record (CCR)" means the record containing demographic health-related information provided by an eligible individual, managed care member, or ~~the Ohio department of medicaid (ODM)~~ODM that is used by the Ohio medicaid consumer hotline to process membership transactions.

~~(E)~~ (H) "Coordination of benefits (COB)" means a procedure establishing the order in which health care entities pay their claims as described in rule 5160-26-09.1 of the Administrative Code.

~~(F)~~ (I) "Covered services" means those medical services set forth in rule 5160-26-03 of the Administrative Code or a subset of those medical services.

~~(G)~~ (J) "Eligible individual" means any medicaid recipient who is a legal resident of the managed care service

area and is in one of the categories specified in rule 5160-26-02 of the Administrative Code.~~the MCO's provider agreement with ODM.~~

~~(H)~~ (K) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

~~(I)~~ (L) "Emergency services" means covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. As used in this chapter, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with ~~an MCO~~an MCE.

~~(J)~~ (M) "Explanation of benefits (EOB)," otherwise known as "explanation of payment (EOP)," or "remittance advice (RA)," means the information sent to providers and/or members by any other third party payer, or ~~MCO~~MCE, to explain the adjudication of a claim.

~~(K)~~ (N) "Federally qualified health center (FQHC)" has the same meaning as in rule 5160-28-01 of the Administrative Code.

~~(L)~~ (O) "Fraud" means any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes fraud under applicable federal or state law. Member fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's identification card to obtain services or supplies.

~~(Q)~~ (P) "Grievance" is the member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by an MCE to make an authorization decision.

~~(M)~~ (Q) "Healthchek" services, otherwise known as early and periodic screening, diagnostic, and treatment (EPSDT) services, are comprehensive preventive health services available to individuals under twenty-one years of age who are enrolled in medicaid as those services are described in rule 5160-1-14 of the Administrative Code.

~~(N)~~ (R) "Hospital" means an institution located at a single site that is engaged primarily in providing to inpatients, by or under the supervision of an organized medical staff of physicians licensed under Chapter 4731. of the Revised Code, diagnostic services and therapeutic services for medical diagnosis and treatment or rehabilitation of injured, disabled, or sick persons. "Hospital" does not mean an institution that is operated by the United States government.

~~(O)~~ (S) "Hospital services" means those inpatient and outpatient services that are generally and customarily provided by hospitals.

~~(P)~~ (T) "Inpatient facility" means an acute or general hospital.

~~(Q)~~ (U) "Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" has the same meaning as in section 5124.01 of the Revised Code.

~~(R)~~ (V) "Managed care" means a health care delivery system operated by the state in accordance with 42 C.F.R. part 438 (October 1, ~~2019~~2021).

~~(X)~~ (W) "Managed care entity" means a managed care organization, the single pharmacy benefit manager, a MyCare Ohio plan as defined in rule 5160-58-01 of the Administrative Code, and the OhioRISE plan as defined in rule 5160-59-01 of the Administrative Code.

~~(S)~~ (X) "Managed care organization (MCO)" ~~or "managed care plan (MCP)"~~ has the same definition as in 42 C.F.R 438.2 (October 1, 2021) ~~means~~ and is a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM.

~~(T)~~ (Y) "Medicaid" means medical assistance as defined in section 5162.01 of the Revised Code.

~~(U)~~ (Z) "Medicaid fraud control unit (MCFU)" means an identifiable entity of state or federal government charged with the investigation and prosecution of fraud and related offenses within medicaid.

~~(V)~~ (AA) "Medically necessary," or "medical necessity," has the same meaning as in rule 5160-1-01 of the Administrative Code.

~~(W)~~ (BB) "Medicare" means the federally financed medical assistance program defined in 42 U.S.C. 1395 (as in effect ~~July 1, 2020~~July 1, 2022).

~~(X)~~ (CC) "Member" ~~or "enrollee"~~ means a medicaid recipient who has selected or been assigned to ~~MCO membership or has been assigned to an MCO~~ an MCE for the purpose of receiving health care services.

(DD) "Network provider" means any provider, group of providers, or entity that has a network provider contract with the MCE in accordance with rule 5160-26-05 of the Administrative Code and receives medicaid funding directly or indirectly to order, refer, or render covered services as a result of the MCE's provider agreement or contract with ODM.

~~(DD)~~ (EE) "Non-contracting provider" means any provider with an ODM provider agreement who does not contract with an MCE, but delivers health care services to an MCE's members.

~~(EE)~~ (FF) "Non-contracting provider of emergency services" means any person, institution or entity that does not contract with an MCE, but provides emergency services to an MCE's members, regardless of whether that provider has an ODM provider agreement.

~~(EE)~~ (GG) "Notice of action (NOA)" is the written notice an MCE provides to members when an adverse benefit determination has occurred or will occur.

~~(Y)~~ (HH) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(Z)~~ (II) "Ohio medicaid consumer hotline" means the managed care enrollment broker and customer service agent for individuals receiving Ohio medicaid services.

~~(AA)~~ (JJ) "Oral interpretation services" means services provided to a limited-reading proficient eligible individual or member to ensure that he or she receives ~~MCO~~ MCE information in a format and manner that is easily understood by the eligible individual or member.

~~(BB)~~ (KK) "Oral translation services" means services provided to a limited-English proficient eligible individual or member to ensure that he or she receives ~~MCO~~ MCE information translated into the primary language of the eligible individual or member.

~~(CC)~~ (LL) "Pending member"~~," or "pending enrollee,"~~ means an eligible individual who has selected or been assigned to ~~an MCO~~an MCE but whose ~~MCO~~ membership in the MCE is not yet effective.

~~(DD)~~ (MM) "Post-stabilization care services" means covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (October 1, ~~2019~~2021) to improve or resolve the member's condition.

~~(EE)~~ (NN) "Premium" means the monthly payment amount per member to which the MCO is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM.

~~(FF)~~ (OO) "Primary care provider (PCP)" means an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Administrative Code contracting with an MCO to provide services as specified in rule 5160-26-03.1 of the Administrative Code. Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).

~~(GG)~~ (PP) "Protected health information (PHI)" means information received from or on behalf of ODM that meets the definition of PHI as defined by 45 C.F.R. 160.103 (October 1, ~~2019~~2021).

~~(HH)~~ (QQ) "Provider" means a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to ~~an MCO's~~an MCE's member.

~~(II)~~ (RR) "Provider agreement" means a formal agreement between ODM and an MCO for the provision of medically necessary services to medicaid recipients who are enrolled in the MCO.

~~(JJ)~~ (SS) "Provider ~~panel~~network"~~," otherwise known as "panel"~~ or "network," means ~~the MCO's~~ an MCE's contracted providers available to the ~~MCO's~~MCE's ~~general membership~~members.

~~(KK)~~ (TT) "Qualified family planning provider (QFPP)" means any public or nonprofit health care provider that complies with guidelines/standards set forth in 42 U.S.C. 300 (as in effect ~~July 1, 2020~~July 1, 2022), and receives either Title X funding or family planning funding from the Ohio department of health.

~~(TT)~~ (UU) "Respite services" are services that provide short-term, temporary relief to the informal unpaid caregiver of a managed care member in order to support and preserve the primary care giving relationship.

~~(LL)~~ (VV) "Risk" or "underwriting risk" means the possibility that an MCO may incur a loss because the cost of providing services may exceed the payments made by ODM to the contractor for services covered under the provider agreement.

~~(MM)~~ (WW) "Rural health clinic (RHC)" has the same meaning as in rule 5160-28-01 of the Administrative Code.

~~(NN)~~ (XX) "Self-referral" means the process by which an MCO member may access certain services without prior approval from the PCP or the MCO.

~~(OO)~~ (YY) "Service area" means the geographic area specified in the MCO's provider agreement where the MCO agrees to provide Medicaid services to members residing in those areas.

(ZZ) "Single case agreement" means a contract with an out-of-network provider to provide services to an MCE's member on a one-time, individual, or limited basis.

~~(XX)~~ (AAA) "Single pharmacy benefit manager (SPBM)" is a prepaid ambulatory health plan as defined in 42 C.F.R. 438.2 (October 1, 2021) and the state pharmacy benefit manager selected under section 5167.24 of the Revised code which is responsible for processing all pharmacy claims under the care management system. The SPBM service area is statewide.

~~(XX)~~ (BBB) "SPBM contract" means a formal agreement between ODM and the SPBM for the provision of medically necessary pharmacy services to medicaid recipients who are enrolled in the SPBM.

~~(PP)~~ (CCC) "State cut-off" means the eighth state working day prior to the end of a calendar month.

(DDD) "State hearing" means the process set forth in 42 C.F.R 431, Subpart E (October 1, 2021) and division 5101:6 of the Administrative Code.

~~(QQ)~~ (EEE) "Subcontract" means a written contract between ~~an MCO~~ an MCE and a third party, including the ~~MCO's~~ MCE's parent company or any subsidiary corporation owned by the ~~MCO's~~ MCE's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the MCO's provider agreement or the SPBM's contract with ODM.

~~(RR)~~ (FFF) "Subcontractor" means an individual or entity ~~any party~~ that has entered into a subcontract with an MCE to perform a specific part of the obligations specified under the MCO's provider agreement or the SPBM's contract with ODM. A provider or network provider is not a subcontractor by virtue of the provider's contract with an MCE.

~~(SS)~~ (GGG) "Third party" means the same as in section 5160.35 of the Revised Code.

~~(TT)~~ (HHH) "Third party administrator" means any entity used in accordance with the provisions of this chapter to manage or administer a portion of services in fulfillment of the provider agreement with ODM.

~~(UU)~~ (III) "Third party benefit" means any health care service(s) available to members through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the third party payer (TPP) or in part the obligation of the member, the TPP, and/or the ~~MCO~~MCE.

~~(VV)~~ (JJJ) "Third party claim" or "COB claim" means any claim submitted to ~~the MCO~~an MCE for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by ~~the MCO~~an MCE:

(1) Any claim received by the ~~MCO~~MCE that shows no prior payment by a TPP, but the ~~MCO's~~ MCE's records indicate that the member has third party benefits.

(2) Any claim received by the ~~MCO~~ MCE that shows no prior payment by a TPP, but the provider's records indicate that the member has third party benefits.

~~(WW)~~ (KKK) "Third party liability (TPL)" means the payment obligations of the TPP for health care services rendered to a member when the member also has third party benefits as described in paragraph (~~UU~~EEE) of this rule.

~~(XX)~~ (LLL) "Third party payer (TPP)" means an individual, an entity, or a program responsible for adjudicating and paying claims for third party benefits rendered to an eligible member.

~~(YY)~~ (MMM) "Title X services" means services and supplies allowed under 42 U.S.C. 300 (as in effect ~~July 1, 2020~~July 1, 2022), and provided by a qualified family planning provider.

~~(ZZ)~~ (NNN) "Tort action," or "subrogation," means the right of ODM to recover payment received from a third party payer who may be liable for the cost of medical services and care arising out of an injury, disease, or disability to the member.

~~(AAA)~~ (OOO) "Waste" means payment for or the attempt to obtain payment for items or services when there may be no intent to deceive or misrepresent, but poor or inefficient billing or treatment methods result in unnecessary costs.

DRAFT - NOT FOR FILING

5160-26-02 Managed ~~health~~ care ~~program~~: eligibility and enrollment.

(A) This rule does not apply to ~~"~~MyCare Ohio~~"~~ plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code. ~~The eligibility and enrollment provisions for "MyCare Ohio" plans are described in rule 5160-58-02 of the Administrative Code.~~

(B) Eligibility for managed care organization (MCO) enrollment.

(1) Except as specified in paragraphs (B)(3) to (B)(5) of this rule, in mandatory service areas as permitted by 42 C.F.R. 438.52 (October 1, ~~2020~~2021), an individual must be enrolled in an MCO if he or she has been determined medicaid eligible in accordance with division 5160:1 of the Administrative Code.

(2) MCO enrollment is mandatory for the following individuals:

(a) Children receiving Title IV-E federal foster care maintenance;

(b) Children receiving Title IV-E adoption assistance:

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

(d) Children 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 January 1, 2021)~~(July 1, 2022) and is defined by the state in terms of either program participation or special health care needs.

(e) Individuals who meet the criteria specified in rule 5160-59-04 of the Administrative Code and receive services through the OhioRISE home and community based services (HCBS) waiver administered by the Ohio department of medicaid (ODM).

(3) Medicaid eligible individuals may voluntarily choose to enroll in an MCO if they are:

(a) Indians who are members of federally recognized tribes; and

(b) Individuals diagnosed with a developmental disability who have a level of care that meets the criteria specified in rule 5123-8-01 of the Administrative Code and receive services through a ~~home and community based services (HCBS)~~HCBS waiver administered by the Ohio department of developmental disabilities (DODD)~~;~~.

(4) Except for individuals receiving medicaid in the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) ~~(as in effect January 1, 2021)~~(July 1, 2022), and individuals who meet criteria in ~~paragraph~~ paragraphs (B)(3)(b) and (B)(3)(c) of this rule, medicaid eligible individuals are excluded from MCO enrollment if they:

(a) Reside in a nursing facility; or

(b) Receive medicaid services through a medicaid waiver component, as defined in section 5166.02 of the

Revised Code.

(5) The following individuals are excluded from MCO enrollment.

(a) Inmates of public institutions as defined in 42 C.F.R. 435.1010 (October 1, ~~2020~~2021) unless otherwise specified by ODM;

(b) Dually eligible individuals enrolled in both the medicaid and medicare programs;

(c) Individuals receiving services in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or a developmental center as defined in rule 5123-9-30 of the Administrative Code;

(d) Individuals enrolled in the program of all-inclusive care for the elderly (PACE);

(e) Individuals who are determined to be presumptively eligible and receive temporary, time-limited medical assistance as described in rule 5160:1-2-13 of the Administrative Code;

(f) Individuals who receive alien emergency medical assistance in accordance with rule 5160:1-5-06 of the Administrative Code;

(g) Individuals who receive refugee medical assistance in accordance with rule 5160:1-5-05 of the Administrative Code; and

(h) Non-citizen victims of trafficking as set forth in rule 5160:1-5-08 of the Administrative Code.

(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) Any individual enrolled in an MCO as specified in paragraph (B) of this rule will be mandatorily enrolled in the single pharmacy benefit manager (SPBM).

~~(C)~~ (D) Enrollment and commencement of coverage in an MCO or the SPBM.

(1) The MCO and the SPBM must accept eligible individuals without regard to race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services. The MCO and the SPBM will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.3(d) (October 1, ~~2020~~2021).

(2) The MCO and the SPBM must accept eligible individuals who request MCO enrollment without restriction.

(3) If ~~an MCO~~a member loses managed care eligibility and is disenrolled from the MCO and the SPBM, and subsequently regains eligibility, his or her enrollment in the same MCO and the SPBM may be reinstated back to the date eligibility was regained in accordance with procedures established by ODM.

(4) ODM shall confirm the eligible individual's MCO and SPBM enrollment via the ODM-produced Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 834 daily and monthly enrollment files of new members, continuing members and terminating members.

(5) The MCO and SPBM shall not be required to provide coverage until MCO or SPBM enrollment is confirmed via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files except as provided in paragraph ~~(C)~~(D)(6) of this rule or upon mutual agreement between ODM and the MCO.

(6) Infants born to mothers enrolled in an MCO are enrolled in an MCO from their date of birth through at least the end of the month of the child's first birthday, or until such time that the MCO is notified of the child's disenrollment via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files. This does not include infants placed for adoption or legally placed in the custody of an Ohio county public children's serivces agency (PCSA).

(7) Coverage of MCO and SPBM members will be effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily and monthly enrollment files to the MCO and SPBM, except as specified in paragraph (D) of this rule.

~~(D) (D) Commencement of coverage.~~

~~(1) (1) Coverage of MCO members will be effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily and monthly enrollment files to the MCO, except as specified in paragraph (C)(6) of this rule.~~

~~(2) (2) When an eligible individual is admitted to an inpatient facility prior to the effective date of MCO enrollment and remains in an inpatient facility on the enrollment effective date, the following responsibilities apply:~~

~~(a) (a) The admitting medicaid payer, either fee-for-service or the admitting MCO, is responsible for all inpatient facility charges, pursuant to rule 5160-2-07.11 of the Administrative Code, through the date of discharge.~~

~~(b) (b) The enrolling MCO is responsible for all other medically necessary medicaid covered services including professional services related to the inpatient stay, beginning on the enrollment effective date.~~

DRAFT - NOT FOR FILING

5160-26-02.1 Managed ~~health~~ care ~~programs~~: termination of enrollment.

(A) This rule does not apply to ~~"~~MyCare Ohio~~"~~ plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code. ~~Termination of enrollment provisions for "MyCare Ohio" plans are described in rule 5160-58-02.1 of the Administrative Code.~~

(B) The Ohio department of medicaid (ODM) will terminate a member from enrollment in a managed care organization (MCO) for any of the following reasons:

(1) The member's permanent place of residence is moved outside the MCO service area. When this occurs, termination of MCO enrollment takes effect on the last day of the month in which the member moved from the service area.

(2) The member becomes ineligible for medicaid. When this occurs, termination of MCO enrollment takes effect on the last day of the month in which the member became ineligible.

(3) The member dies, in which case MCO enrollment ends on the date of death.

(4) The member is not receiving medicaid in the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (~~as in effect July 1, 2020~~July 1, 2022), is authorized for nursing facility services, and the following criteria are met:

(a) The MCO has authorized nursing facility services for no less than the month of nursing facility admission and for two complete consecutive calendar months thereafter;

(b) For the entire period in paragraph (B)(4)(a) of this rule, the member has remained in the nursing facility without any admission to an inpatient hospital or long-term acute care facility;

(c) The member's discharge plan documents that nursing facility discharge is not expected in the foreseeable future and the member has a need for long-term nursing facility care;

(d) For the entire period in paragraph (B)(4)(a) of this rule, the member is not using hospice services; and

(e) The MCO has requested disenrollment, and ODM has approved the request.

(f) The member is found by ODM to meet the criteria for the developmental disabilities level of care as specified in rule 5123-8-01 of the Administrative Code and resides in an intermediate care facility for individuals with intellectual disabilities (ICF-IID). Following MCO notification to ODM and written approval by ODM, termination of MCO membership takes effect on the last day of the month preceding the individual's stay in the ICF-IID.

(5) The member has third party coverage, and ODM determines that continuing MCO enrollment may not be in the best interest of the member. This determination may be based on the type of coverage the member has, the existence of conflicts between provider ~~panels~~networks, or access requirements. When this occurs, the effective date of termination of MCO enrollment shall be determined by ODM but in no event shall the termination date be later than the last day of the month in which ODM approves the termination.

(6) The member is not eligible for MCO enrollment for one of the reasons set forth in rule 5160-26-02 of the Administrative Code.

(7) The provider agreement between ODM and the MCO is terminated.

(C) ODM will terminate a member from enrollment in the single pharmacy benefit manager (SPBM) when a member is terminated from enrollment in an MCO as specified in paragraph (B) of this rule or if the contract between ODM and the SPBM is terminated.

~~(C)~~ (D) All of the following apply when enrollment in an MCO or the SPBM is terminated for any of the reasons set forth in paragraph (B) or (C) of this rule:

(1) Such terminations may occur either in a mandatory or voluntary service area.

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

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

(4) If ODM fails to notify the MCO or the SPBM of a member's termination from an MCO or the SPBM, ODM shall continue to pay the MCO or the SPBM the applicable monthly capitation rate for the member. The MCO or the SPBM shall remain liable for the provision of covered services as set forth in rule 5160-26-03 of the Administrative Code, until such time as ODM provides the MCO or the SPBM with documentation of the member's termination.

(5) ODM shall recover from the MCO or the SPBM any capitation paid for retroactive enrollment termination occurring as a result of paragraph (B) or (C) of this rule.

(6) A member may lose medicaid eligibility during an annual open enrollment period, and thus become ~~temporarily~~ unable to change to a different MCO. If the member then regains medicaid eligibility, ~~he or she~~ the member may request to change plans within thirty days following reenrollment in the MCO.

~~(D)~~ (E) Member-initiated MCO terminations.

(1) An MCO member who qualifies as a mandatory managed care enrollment population as specified in rule 5160-26-02 of the Administrative Code may request a different MCO ~~in a mandatory service area~~ as follows:

(a) From the date of enrollment through the initial three months of MCO enrollment;

(b) During an open enrollment month for the member's service area as described in paragraph ~~(F)~~(G) of this rule;

(c) At any time, if the member is a child receiving Title IV-E federal foster care maintenance or is in foster care or other out of home placement. The change must be initiated by the local public children's services agency (PCSA) or the local Title IV-E juvenile court; or

(d) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph ~~(D)~~(E)(3)(f) of this rule;

(2) An MCO member who qualifies as a voluntary managed care enrollment population as specified in rule 5160-26-02 of the Administrative Code may request a different MCO, if available, or be returned to medicaid fee-for-service (FFS) ~~in a voluntary service area~~ as follows:

(a) From the date of enrollment through the initial three months of MCO enrollment;

(b) During an open enrollment month for the member's service area as described in paragraph ~~(E)~~(G) of this rule; or

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph ~~(D)~~(E)(3)(f) of this rule;

(3) The following provisions apply when a member either requests a different ~~plan~~ MCO or, if applicable, requests to be returned to medicaid FFS: ~~in a mandatory service area, requests disenrollment in a voluntary service area, or qualifies as a voluntary managed care enrollment population as defined in paragraph (B)(3) of rule 5160-26-02 of the Administrative Code:~~

(a) The request may be made by the member, or by the member's authorized representative.

(b) All member-initiated changes or terminations must be voluntary. The ~~MCOs~~ MCO ~~are~~ is not permitted to encourage members to change or terminate enrollment due to a member's age, gender, gender identity, sexual orientation, disability, national origin, race, color, religion, military status, ancestry, genetic information, health status or need for health services. ~~MCOs~~ The MCO may not use a policy or practice that has the effect of discrimination on the basis of the criteria listed in this rule.

(c) If a member requests disenrollment because he or she meets the requirements of paragraph (B)(3) of rule 5160-26-02 of the Administrative Code, the member will be disenrolled after the member notifies the Ohio medicaid consumer hotline.

(d) Disenrollment will take effect on the last day of the calendar month in which the request for disenrollment was made.

(e) In accordance with 42 C.F.R. 438.56(d)(2) (October 1, ~~2019~~2021), a change or termination of MCO enrollment may be permitted for any of the following just cause reasons:

(i) The member moves out of the MCO's service area and a non-emergency service must be provided out of the service area before the effective date of the member's termination as described in paragraph (B)(1) of this rule;

(ii) The MCO does not, for moral or religious objections, cover the service the member seeks;

(iii) The member needs related services to be performed at the same time; not all related services are available within the ~~MCO~~MCO's network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk;

(iv) The member has experienced poor quality of care and the services are not available from another provider within the MCO's network;

(v) The member cannot access medically necessary medicaid-covered services or cannot access the type of providers experienced in dealing with the member's health care needs;

(vi) The PCP selected by a member leaves the MCO's network~~panel~~ and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCO in the member's service area; and

(vii) ODM determines that continued enrollment in the MCO would be harmful to the interests of the member.

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

(i) The member or an authorized representative must contact the MCO to identify providers of services before seeking a determination of just cause from ODM.

(ii) The member may make the request for just cause directly to ODM or an ODM-approved entity, either orally or in writing.

(iii) ODM shall review all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the member and the MCO. ODM shall make a decision within forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.

(iv) ODM may establish retroactive termination dates and recover capitation payments as determined necessary and appropriate.

(v) Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member requests change or termination.

(vi) If the just cause request is not approved, ODM shall notify the member or the authorized representative of the member's right to a state hearing.

(vii) Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate.

(viii) If a member submits a request to change or terminate enrollment for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall ensure that the member's MCO enrollment is not automatically renewed if eligibility for medicaid is reauthorized.

~~(E)~~ (F) MCO initiated terminations. ~~The following provisions apply when a termination in MCO enrollment is initiated by an MCO:~~

(1) ~~An~~ The MCO may submit a request to ODM for the termination of a member for the following reasons:

(a) Fraudulent behavior by the member; or

(b) Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the extent that such behavior seriously impairs the MCO's ability to provide services to either the

member or other MCO members.

(2) The MCO may not request termination due to the member's age, gender, gender identity, sexual orientation, disability, national origin, race, color, religion, military status, genetic information, ancestry, health status or need for health services.

(3) The MCO must provide medicaid-covered services to a terminated member through the last day of the month in which the MCO enrollment is terminated, notwithstanding the date of ODM written approval of the termination request. Inpatient facility services must be provided in accordance with rule 5160-26-02 of the Administrative Code.

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

~~(F)~~ (G) MCO ~~Open~~ open enrollment.

(1) Open enrollment months will occur at least annually.

(2) At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals by mail of the opportunity to change or terminate MCO enrollment and will explain where to obtain further information.

~~Open enrollment months will occur at least annually. At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals by mail of the opportunity to change or terminate MCO enrollment and will explain where to obtain further information.~~

DRAFT - NOT FOR FILING

5160-26-03 Managed ~~health~~ care ~~programs~~: covered services.

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code.

~~(A)~~ (B) Except as otherwise provided in this rule, a managed care ~~plan~~ organization~~(MCP)~~ (MCO) and the single pharmacy benefit manager (SPBM) must ensure members have access to all medically necessary services, as applicable, covered by Ohio medicaid under the state plan. ~~Specific coverage provisions for "MyCare Ohio" plans as defined in rule 5160-58-01 of the Administrative Code are described in Chapter 5160-58 of the Administrative Code.~~ The ~~MCP~~ MCO and SPBM must ensure:

(1) Services are sufficient in amount, duration, ~~or~~ and scope to reasonably be expected to achieve the purpose for which the services are ~~furnished~~provided;

(2) The amount, duration, ~~or~~ and scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) Prior authorization is available for services on which ~~an MCP~~the MCO or the SPBM has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary, unless the ~~MCP~~MCO or SPBM's ~~'s~~ limitation is also a limitation for fee-for-service medicaid coverage;

(4) Coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and

(5) If a member is unable to obtain medically necessary services offered by medicaid from ~~a~~ an ~~MCP~~MCO or SPBM ~~panel~~ network provider, the ~~MCP~~MCO or SPBM must adequately and timely cover the services out of ~~panel~~network, until the ~~MCP~~MCO or SPBM is able to provide the services from a ~~panel~~ network provider.

~~(B)~~ (C) The ~~MCP~~MCO and SPBM may place appropriate limits on a service:~~;~~

(1) On the basis of medical necessity for the member's condition or diagnosis; or

(2) For the purposes of utilization control, provided the services ~~furnished~~ can be reasonably expected to achieve their purpose as specified in paragraph ~~(A)~~(B)(1) of this rule.

~~(C)~~ (D) The ~~MCP~~SPBM will provide pharmacy services in compliance with rule 5160-9-03 of the Administrative Code, including all prescribing and prior authorization requirements, and any grandfathered drug classes as established by the Ohio department of medicaid (ODM) preferred drug list located at https://pharmacy.medicaid.ohio.gov/. The ~~MCP~~SPBM ~~is~~will not ~~required to~~ charge co-pays unless directed by ODM.

~~(D)~~ (E) Services covered by an MCO.

~~(D)~~ (1) The ~~MCP~~MCO must cover annual physical examinations for adults.

~~(E)~~ (2) At the request of the member, ~~an MCP~~the MCO must provide for a second opinion from a qualified health care professional within the ~~panel~~MCO's network. If such a qualified health care professional is not available within the ~~MCP~~MCO's ~~panel~~network, the ~~MCP~~MCO must arrange for the member to obtain a second opinion outside the ~~panel~~MCO's network, at no cost to the member.

~~(F)~~ (3) The ~~MCP~~MCO must ensure emergency services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:

~~(1)~~ (a) The ~~MCP~~MCO cannot deny payment for treatment obtained when a member had an emergency medical condition~~,~~ as defined in rule 5160-26-01 of the Administrative Code.

~~(2)~~ (b) The ~~MCP~~MCO cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

~~(3)~~ (c) The ~~MCP~~MCO must cover all emergency services without requiring prior authorization.

~~(4)~~ (d) The ~~MCP~~MCO must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the ~~MCP~~MCO, including but not limited to, the member's primary care provider (PCP) or the ~~MCP's~~ MCO's twenty-four-hour toll-free phone number.

~~(5)~~ (e) The ~~MCP~~MCO cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.

~~(6)~~ (f) ~~For the purposes of this paragraph, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCP but provides emergency services to an MCP member, regardless of whether that provider has a medicaid provider agreement with the ODM. An MCP~~The MCO must cover emergency services as defined in rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services. ~~and claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.~~ Such services must be reimbursed by the ~~MCP~~MCO at the lesser of billed charges or one hundred per cent of the Ohio medicaid program 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 reimbursement rate) in effect for the date of service. If an inpatient admission results, the ~~MCP~~MCO is required to reimburse at this rate only until the member can be transferred to a provider designated by the ~~MCP~~MCO. Pursuant to section 5167.10 of the Revised Code, the ~~MCP~~MCO shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.

~~(7)~~ (g) The ~~MCP~~MCO must cover emergency services until the member is stabilized and can be safely discharged or transferred.

~~(8)~~ (h) The ~~MCP~~MCO must adhere to the judgment of the attending provider when requesting a member's transfer to another facility or discharge. ~~MCPs~~ The MCO may establish arrangements with hospitals whereby the ~~MCP~~MCO may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat, and transfer the member.

~~(9)~~ (i) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

~~(G)~~ (4) The ~~MCP~~MCO must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services. ~~as described in paragraph (E)(6) of this rule.~~ Such information must be made available upon request to non-contracting providers, including non-contracting providers of emergency services. ~~An MCP~~The MCO shall not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

~~(H)~~ (5) The ~~MCP~~MCO must ensure post-stabilization care services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week.

~~(1)~~ (a) The ~~MCP~~MCO must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day. ~~An MCP~~The MCO must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The ~~MCP~~MCO must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the ~~MCP~~MCO communicated the decision in writing to the provider.

~~(2)~~ (b) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:

~~(a)~~ (i) The ~~MCP~~MCO must cover services obtained within or outside the ~~MCP's panel~~ MCO's network that are pre-approved in writing to the requesting provider by ~~a plan~~ an MCO provider or other ~~MCP~~MCO representative.

~~(b)~~ (ii) The ~~MCP~~MCO must cover services obtained within or outside the ~~MCP's panel~~ MCO's network that are not pre-approved by ~~a plan~~ an MCO provider or other ~~MCP~~MCO representative but are administered to maintain the member's stabilized condition within one hour of a request to the ~~MCP~~MCO for pre-approval of further post-stabilization care services.

~~(c)~~ (iii) The ~~MCP~~MCO must cover services obtained within or outside the ~~MCP's panel~~ MCO's network that are not pre-approved by ~~a plan~~ an MCO provider or other ~~MCP~~MCO representative but are administered to maintain, improve, or resolve the member's stabilized condition if:

~~(i)~~ (a) The ~~MCP~~MCO fails to respond within one hour to a provider request for authorization to provide such services.

~~(ii)~~ (b) The ~~MCP~~MCO cannot be contacted.

~~(iii)~~ (c) The ~~MCP's~~ MCO's representative and treating provider cannot reach an agreement concerning the member's care and ~~a plan~~ an MCO provider is not available for consultation. In this situation, the ~~MCP~~MCO must give the treating provider the opportunity to consult with ~~a plan~~ an MCO provider and the treating provider may continue with care until ~~a plan~~ an MCO provider is reached or one of the criteria specified in paragraph (E)(5)(c)~~(G)(3)~~ of this rule is met.

~~(3)~~ (c) The ~~MCP's~~ MCO's financial responsibility for post-stabilization care services not pre-approved ends when:

~~(a)~~ (i) ~~A plan~~ An MCO provider with privileges at the treating hospital assumes responsibility for the member's care;

~~(b)~~ (ii) ~~A plan~~ An MCO provider assumes responsibility for the member's care through transfer;

~~(c)~~ (iii) An ~~MCP~~MCO representative and the treating provider reach an agreement concerning the member's care; or

~~(d)~~ (iv) The member is discharged.

~~(I) (I) MCP responsibilities for payment of other services.~~

~~(1)~~ (6) When an ~~MCP~~MCO member has a nursing facility (NF) stay, the ~~MCP~~MCO is responsible for payment of medically necessary NF services~~,~~ until the member is discharged or until the member is disenrolled in accordance with the processes set forth in rule 5160-26-02.1 of the Administrative Code.

~~(2)~~ (7) The ~~MCP~~MCO is not responsible for payment of home and community-based services (HCBS) provided to a member who is enrolled in an HCBS waiver program administered by ODM, the Ohio department of aging (ODA), or the Ohio department of developmental disabilities (DODD).

~~(3)~~ (8) ~~MCP~~MCO members are permitted to self-refer to Title X services provided by any qualified family planning provider (QFPP). The ~~MCP~~MCO is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the ~~MCP~~MCO at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges~~,~~ in effect for the date of service.

~~(4)~~ (9) The ~~MCP~~MCO must permit members to self-refer to any women's health specialist within the ~~MCP's panel~~ MCO's network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.

~~(5)~~ (10) The ~~MCP~~MCO must ensure access to covered services provided by all federally qualified health

centers (FQHCs) and rural health clinics (RHCs).

~~(6)~~ (11) Where available, the ~~MCP~~MCO must ensure access to covered services provided by a certified nurse practitioner.

~~(7)~~ (12) ODM may approve an ~~MCP's~~ MCO's members to be referred to certain ~~MCP~~MCO non-contracting hospitals, as specified in rule 5160-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODM permits such authorization, ODM will notify the ~~MCP~~MCO and the ~~MCP~~MCO non-contracting hospital of the terms and conditions, including the duration, of the approval and the ~~MCP~~MCO must reimburse the ~~MCP~~MCO non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the ~~MCP~~MCO non-contracting hospital. ODM will base its determination of when an ~~MCP~~MCO's members can be referred to ~~MCP~~MCO non-contracting hospitals pursuant to the following:

(a) The ~~MCP's~~ MCO's submission of a written request to ODM for the approval to refer members to a hospital that has declined to contract with the ~~MCP~~MCO. The request must document the ~~MCP's~~ MCO's contracting efforts and why the ~~MCP~~MCO believes it will be necessary for members to be referred to this ~~particular~~ hospital; and

(b) ODM consultation with the ~~MCP~~MCO non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the ~~MCP~~MCO, including but not limited to whether the ~~MCP's~~ MCO's contracting efforts were unreasonable and/or that contracting with the ~~MCP~~MCO would have adversely impacted the hospital's business.

~~(8)~~ (13) Paragraph ~~(H)(7)~~(E)(12) of this rule is not applicable when ~~an MCP~~the MCO and an ~~MCP~~MCO non-contracting hospital have mutually agreed ~~to~~ that the non-contracting hospital will ~~providing~~ provide non-emergency hospital services to an ~~MCP's~~ MCO's members. The ~~MCP~~MCO must ensure that such arrangements comply with rule 5160-26-05 of the Administrative Code.

~~(9)~~ (14) The ~~MCP~~MCO is not responsible for payment of services provided through medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. ~~An MCP~~The MCO must ensure access to medicaid-covered services for members who are unable to timely access services or unwilling to access services through MSP providers.

~~(10) (10) The MCP is not required to cover services provided to members outside the United States.~~

~~(11)~~ (15) When a member is determined to be no longer eligible for enrollment in an ~~MCP~~MCO during a stay in an institution for mental disease (IMD), the ~~MCP~~MCO is not responsible for payment of that IMD stay after the date of disenrollment from the ~~plan~~MCO.

(16) The MCO must provide two dental cleanings per year to pregnant members of the eligibility group described in section 5163.06 of the Revised Code.

~~(J)~~ (17) The MCO must cover respite services as described in rule 5160-26-03.2 of the Administrative

Code."Respite services" are services that provide short-term, temporary relief to the informal unpaid caregiver of an individual under the age of twenty-one in order to support and preserve the primary caregiving relationship. The MCP shall be responsible for payment for respite services. Respite services can be provided on a planned or emergency basis. The provider must be awake when the member is awake during the provision of respite services.

(1) (1) To be eligible for respite services, the member must:

(a) (a) Reside with his or her informal, unpaid primary caregiver in a home or an apartment that is not owned, leased or controlled by a provider of any health-related treatment or support services;

(b) (b) Not be a foster child, as defined in Chapter 5101:2-1 of the Administrative Code;

(c) (c) Be under twenty-one years of age;

(d) (d) Currently be participating in a care management /coordination arrangement; and

(e) (e) Meet either of the following:

(i) (i) Have long-term service and support (LTSS) needs as determined by the MCP through an institutional level of care determination as set forth in rule 5123:2-8-01, 5160-3-08 or 5160-3-09 of the Administrative Code, and

(a) (a) Require skilled nursing or skilled rehabilitation services at least once per week,

(b) (b) Be determined eligible for social security income for children with disabilities or supplemental security income,

(c) (c) Had a need for at least fourteen hours per week of home health aide services for at least two consecutive months immediately preceding the date respite services are requested, and

(d) (d) The MCP must have determined that the member's primary caregiver has a need for temporary relief from the care of the member as a result of the member's LTSS needs, or in order to prevent an inpatient, institutional or out-of-home stay; or

(ii) (ii) Have behavioral health needs as determined by the MCP through the use of a nationally recognized standardized functional assessment tool, and

(a) (a) Be diagnosed with serious emotional disturbance as described in the appendix to this rule resulting in a functional impairment,

(b) (b) Not be exhibiting symptoms or behaviors that indicate imminent risk of harm to himself or herself or others, and

(c) (c) The MCP must have determined that the member's primary caregiver has a need for temporary relief from the care of the member as a result of the member's behavioral health needs, either:

(i) (i) To prevent an inpatient, institutional or out-of-home stay; or

(ii) (ii) Because the member has a history of inpatient, institutional or out-of-home stays.

(2) (2) Respite services are limited to one hundred hours per calendar year per member, however, this may be exceeded through MCP prior authorization on the basis of medical necessity.

(3) (3) LTSS respite services must be provided by individuals employed by medicaid enrolled agency providers that are either medicare-certified home health agencies pursuant to Chapter 3701-60 of the Administrative Code, or accredited by the "Joint Commission," the "Community Health Accreditation Program," or the "Accreditation Commission for Health Care."

(a) (a) LTSS respite providers must comply with the criminal records check requirements set forth in rules 5160-45-07 and 5160-45-11 of the Administrative Code.

(b) (b) Before commencing service delivery, the LTSS provider agency employee must:

(i) (i) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.36 (October 1, 2019), and

(ii) (ii) Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

(c) (c) After commencing service delivery, the LTSS provider agency employee must:

(i) (i) Maintain evidence of completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation, and

(ii) (ii) Receive supervision from an Ohio-licensed registered nurse (RN) and meet any additional supervisory requirements pursuant to the agency's certification or accreditation.

(4) (4) Behavioral health respite services must be provided by individuals employed by OhioMHAS-certified and medicaid enrolled agency providers that are also accredited by the "Joint Commission," "Council on Accreditation" or "Commission on Accreditation of Rehabilitation Facilities."

(a) (a) Behavioral health respite providers must comply with the criminal records check requirements set forth in rule 5160-43-09 of the Administrative Code when the service is provided in an HCBS setting.

(b) (b) Before commencing service delivery, the behavioral health provider agency employee must:

(i) (i) Either be credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board or received training for or education in mental health competencies and have demonstrated, prior to or within ninety days of hire, competencies in basic mental health skills along with competencies established by the agency; and

(ii) (ii) Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return

~~demonstration of what was learned in the course.~~

~~(c) (c) After commencing service delivery, the behavioral health provider agency employee must receive supervision from an independently licensed behavioral health professional credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board.~~

~~(5) (5) Respite services must not be delivered by the member's "legally responsible family member" as that term is defined in rule 5160-45-01 of the Administrative Code or the member's foster caregiver.~~

(18) The MCO is not responsible for covering services described in rule 5160-59-03 of the Administrative Code for a member enrolled in the OhioRISE plan.

~~(E)~~ (F) The MCO and SPBM are not required to cover services provided to members outside the United States.

~~(K)~~ (G) ~~An~~ The ~~MCP~~MCO and SPBM must ensure that eligible members receive ~~provide~~ all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with rule 5160-1-14 of the Administrative Code.~~, to eligible members~~ The MCO will ~~and~~ ensure healthchek exams:

(1) Include the components specified in rule 5160-1-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual external quality review.

(2) Are completed within ninety days of the initial effective date of enrollment for those children found to have a possible ongoing condition likely to require care management services.

DRAFT - NOT FOR FILING

5160-26-03.1 Managed ~~health~~ care ~~programs~~: primary care and utilization management.

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code.

~~(A)~~ (B) A managed care ~~plan~~ organization (MCO)~~(MCP)~~ must ensure each member has a primary care provider (PCP) who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member's needs.

(1) ~~An MCP~~ The MCO must ensure PCPs are in compliance with the following triage requirements:

(a) Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site;

(b) Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site; and

(c) Members with requests for routine care must be seen within six weeks.

(2) PCP care coordination responsibilities include at a minimum the following:

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

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

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

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

(e) Triaging members as described in paragraph ~~(A)~~(B)(1) of this rule.

~~(B)~~ (C) ~~An MCP~~ The MCO and the single pharamcy benfit manager (SPBM) must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. ~~An MCP~~ The MCO and the SPBM must ensure decisions rendered through the UM program are based on medical necessity.

(1) The UM program must be based on written policies and procedures that include, at a minimum:

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

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

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

(d) A description of how the ~~MCP~~ MCO or SPBM will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(2) ~~An MCP's~~ The MCO and SPBM's UM ~~program~~ programs must also ensure and document the following:

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

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

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

(d) The use of board-certified consultants to assist in making medical necessity determinations, as necessary.

(e) That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Administrative Code. ~~An MCP~~ The MCO may not impose conditions around the coverage of a medically necessary medicaid-covered service unless they are supported by such clinical practice guidelines.

(f) The reason for each denial of a service, based on sound clinical evidence.

(g) That compensation by the ~~MCP~~ MCO or SPBM to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member.

~~(h)~~ (h) Compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K (October 1, 2021).

(3) ~~An MCP~~ The MCO and the SPBM must process requests for initial and continuing authorizations of services from their providers and members. ~~An MCP~~ The MCO and the SPBM must have written policies and procedures to process initial requests and continuing authorizations. ~~, upon~~ Upon request, the ~~MCP's~~ MCO and SPBM's policies and procedures for initial and continuing authorizations must be made available for review by the Ohio department of medicaid (ODM). The ~~MCP's~~ MCO and SPBM's written policies and procedures for initial and continuing authorizations of services must also be made available to contracting and non-contracting providers upon request. The ~~MCP~~ MCO and SPBM must ensure and document the following occurs when processing requests for initial and continuing authorizations of services:

(a) Consistent application of review criteria for authorization decisions.

(b) Consultation with the requesting provider, when necessary.

(c) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

(d) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must meet the requirements of division 5101:6 and rule 5160-26-08.4 of the Administrative Code.

(e) For standard authorization decisions, the ~~MCP~~ MCOmust provide notice to the provider and member

as expeditiously as the member's health condition requires but no later than ten calendar days following receipt of the request for service., except as specified in paragraph (B)(3)(g) of this rule. If requested by the member, provider, or MCPMCO, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCPMCO, the MCP MCO must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCP's MCO's extension request, the MCP MCO must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP MCO must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(f) If a provider indicates or the MCP MCO determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCP MCO must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than forty-eight hours after receipt of the request for service. If requested by the member or MCPMCO, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCPMCO, the MCP MCO must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCP's MCO's extension request, the MCP MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP MCO must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(g) (g) Service authorization decisions not reached within the timeframes specified in paragraphs (B)(3)(e) and (B)(3)(f) of this rule constitute a denial, and the MCPs must give notice to the member as specified in rule 5160-26-08.4 of the Administrative Code.

(h) (g) For Prior prior authorization decisions for of covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect January 1, 20172022), the SPBM must be made by provide a response to the provider by telephone or other telecommunication device within twenty-four hours of the initial request. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the MCP is unable to obtain the information needed to make the prior-authorization decision within seventy-two hours, the decision timeframe has expired and the MCP must give notice to the member as specified in rule 5160-26-08.4 of the Administrative Code.

(i) If the prior authorization request contains sufficient information to render a final decision, the SPBM must provide notice to the provider of the decision within twenty-four hours of receipt of the initial request.

(ii) If the prior authorization request contains insufficient information to render a final decision, the SPBM must notify the provider of the need for additional information within twenty-four hours

of the initial request.

(iii) If the prior authorization request is for an emergency situation, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized while the SPBM reviews the prior authorization request.

~~(i)~~ (h) ~~MCPs~~ The MCO and the SPBM must maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. ~~MCP~~ MCO and SPBM records must include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

~~(4)~~ ~~(4) MCPs must implement the ODM-required emergency department diversion program for frequent users.~~

~~(5)~~ (4) ~~Pursuant to section 5167.12 of the Revised Code, an MCP~~ The SPBM may, subject to ODM prior approval, implement strategies for the management of drug utilization, and the MCO may, subject to ODM approval, develop other UM programs. ~~At a minimum, an MCP must implement a coordinated services program (CSP) as described in rule 5160-20-01 of the Administrative Code. An MCP must offer care management services to any member enrolled in CSP.~~

(5) At a minimum, the MCO has to implement a coordinated services program (CSP) as described in rule 5160-20-01 of the Administrative Code. The MCO has to offer care management services to any member enrolled in CSP

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

DRAFT - NOT FOR FILING

5160-26-05 Managed ~~health~~ care ~~programs~~: provider ~~panel~~ network and ~~subcontracting~~ contracting requirements.

(A) ~~Subcontracts~~Provider contracts.

(1) A managed care ~~organization (MCO)~~entity (MCE) must provide or arrange for the delivery of covered health care services described in rule 5160-26-03 of the Administrative Code either through the use of employees or through ~~subcontracts~~ contracts with network providers of health care services ("providers"). All ~~subcontracts~~provider contracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6 (October 1, ~~2019~~2021). The ~~MCO's~~ MCE's execution of a ~~subcontract~~provider contract ~~with a provider~~ does not terminate the ~~MCO's~~ MCE's legal responsibility to the Ohio department of medicaid (ODM) to ensure all of the ~~MCO's~~ MCE's activities and obligations are performed in accordance with ~~Chapter 5160-26 or Chapter 5160-58~~Agency 5160 of the Administrative Code, as applicable, the ~~MCO~~ MCE's provider agreement~~,~~ or contract with ODM, and all applicable federal, state, and local regulations.

(2) ~~An MCO~~ The MCE shall make all ~~subcontracts~~provider contracts ~~with providers~~ available to ODM upon request.

(3) ~~Subcontracts~~Provider contracts may not include language that conflicts with the specifications identified in paragraphs (C) and (D) of this rule.

(4) MCE network providers have to maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.

~~(4)~~ (5) When utilizing an out of ~~panel~~ network provider, the ~~MCO~~ MCE must establish a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph (D) of this rule. For medicaid-covered non-emergency hospital services outlined in rule 5160-26-03 of the Administrative Code, the compensation amount is identified in rule 5160-26-11 of the Administrative Code.

(B) Notification.

(1) Notwithstanding paragraph (D)(13) of this rule, ~~an MCO~~ the MCE must notify ODM of any addition to or deletion from its provider ~~panel~~ network on an ongoing basis, and must follow the time restrictions contained in this paragraph unless the explanation of extenuating circumstances is accepted by ODM.

(2) At the direction of ODM, the ~~MCO~~ MCE must submit evidence of the following:

(a) A copy of the provider's current licensure;

(b) Copies of written agreements with the provider, including but not limited to ~~subcontracts~~provider contracts, amendments, and the medicaid addendum as specified in paragraph (D) of this rule;

(c) Notification to ODM of any hospital ~~subcontract~~ provider contract for which a date of termination is specified; and

(d) The provider's medicaid provider number and provider reporting number, if applicable.

(3) The ~~MCO~~ MCE shall notify ODM in writing of the expiration, nonrenewal, or termination of any provider ~~subcontract~~contract at least fifty-five calendar days prior to the expiration, nonrenewal, or termination of the ~~subcontract~~provider contract in a manner and format directed by ODM. If the ~~MCO~~ MCE receives less than fifty-five calendar days' notice from the provider, the ~~MCO~~ MCE must inform ODM in writing within one working day of becoming aware of this information. ~~The MCO must also comply with the following:~~

~~(a)~~ (4) If the ~~subcontract~~provider contract is for a hospital:

~~(i)~~ (a) Forty-five calendar days prior to the effective date of the expiration, nonrenewal or termination of the hospital's ~~subcontract~~provider contract, the MCO shall notify in writing all providers who have admitting privileges at the hospital of the impending expiration, nonrenewal, or termination of the ~~subcontract~~provider contract and the last date the hospital will provide services to members under the MCO ~~subcontract~~provider contract. If the MCO receives less than forty-five calendar days' notice from the hospital, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the ~~subcontract~~provider contract.

~~(ii)~~ (b) Forty-five calendar days prior to the effective date of the expiration, nonrenewal, or termination of the hospital's ~~subcontract~~provider contract, the MCO shall notify in writing all members in the service area, or in an area authorized by ODM, of the impending expiration, nonrenewal, or termination of the hospital's ~~subcontract~~provider contract. If the MCO receives less than forty-five calendar days' notice from the hospital provider, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the ~~subcontract~~provider contract.

~~(iii)~~ (c) The MCO shall submit a template for member and provider notifications to ODM along with the MCO's notification to ODM of the impending expiration, nonrenewal, or termination of the hospital's ~~subcontract~~provider contract. The notifications shall comply with the following:

~~(a)~~ (i) The form and content of the member notice must be prior-approved by ODM and contain an ODM designated toll-free telephone number members can call for information and assistance.

~~(b)~~ (ii) The form and content of the provider notice must be prior-approved by ODM.

~~(iv)~~ (d) ODM may require the MCO to notify additional members or providers if the impending expiration, nonrenewal, or termination of the hospital's ~~subcontract~~provider contract adversely impacts additional members or providers.

~~(b)~~ (5) If the ~~subcontract~~provider contract is for a primary care provider (PCP):

~~(i)~~ (a) The MCO shall include the number of members that will be affected by the change in the notice to ODM; and

~~(ii)~~ (b) The MCO shall notify in writing all members who use or are assigned to the provider as a PCP at

least forty-five calendar days prior to the effective date of the change. If the MCO receives less than forty-five calendar days prior notice from the PCP, the MCO shall issue the notification within one working day of the MCO becoming aware of the expiration, nonrenewal, or termination of PCP's ~~subcontract~~ provider contract. The form of the notice and its content must be prior-approved by ODM and must contain, at a minimum, all of the following information:

~~(a)~~ (i) The PCP's name and last date the PCP is available to provide care to the MCO's members;

~~(b)~~ (ii) Information regarding how members can select a different PCP; and

~~(c)~~ (iii) An MCO telephone number members can call for further information or assistance.

~~(4)~~ (6) ODM may require the ~~MCO~~ MCE to notify members or providers ~~for~~ of the expiration, nonrenewal, or termination of ~~certain~~ other provider ~~subcontracts~~contracts that may adversely impact the ~~MCO's~~ MCE's members.

~~(5)~~ (7) In order to ensure availability of services and qualifications of providers, ODM may require submission of documentation in accordance with paragraph (B) of this rule regardless of whether the ~~MCO~~ MCE ~~subcontracts~~contracts directly for services or does so through another entity.

~~(6)~~ (8) In the event that ~~an MCO's~~ the MCE's medicaid managed care program participation in a service area is terminated, the ~~MCO~~ MCE must provide written notification to its affected ~~subcontracted~~ contracted providers at least forty-five calendar days prior to the termination date, unless otherwise specified by ODM.

(C) Provider qualifications.

(1) The ~~MCO~~ MCE must ensure that none of its employees or ~~subcontracted~~ contracted providers are sanctioned or excluded from providing medicaid or medicare services. ~~At a minimum, monthly, the~~ The MCE~~MCO~~ shall use available resources for identifying sanctioned providers, at least monthly, including, but not limited to, the following:

(a) The federal office of inspector general provider exclusion list;

(b) The ODM excluded provider web page; and

(c) The discipline pages of the applicable state boards that license providers or an alternative data resource, such as the national practitioner databank, that is as complete and accurate as the discipline pages of the applicable state boards.

(2) ~~An MCO~~ The MCE may not discriminate with regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If ~~an MCO~~ the MCE declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision. This paragraph may not be construed to:

(a) Require the ~~MCO~~ MCE to contract with providers beyond the number necessary to meet the needs of

its members as described in the MCE's provider agreement or contract with ODM;

(b) Preclude the ~~MCO~~ MCE from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(c) Preclude the ~~MCO~~ MCE from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

(3) The ~~MCO~~ MCE must have written policies and procedures for the selection and retention of providers that prohibit discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(4) The MCE will accept ODM credentialing of ODM-enrolled providers and will not conduct any further credentialing activities for those providers. ~~When credentialing or recredentialing providers in connection with policies, contracts and agreements providing basic health care services, the MCO must use the standardized credentialing form and process as prescribed by the Ohio department of insurance under sections 3963.05 and 3963.06 of the Revised Code. Upon ODM's request, the MCO must demonstrate to ODM the record keeping associated with maintaining this documentation.~~

(D) ~~Subcontracts~~Provider contract requirements.

All ~~subcontracts~~provider contracts, including single case agreements, must include a medicaid addendum that has been approved by ODM. The medicaid addendum must include the following elements, appropriate to the service being rendered, as specified by ODM:

(1) An agreement by the provider to comply with the applicable provisions for record keeping and auditing in accordance with Chapter 5160-26 of the Administrative Code.

(2) Specification of the medicaid population and service areas, pursuant to the ~~MCO's~~ MCE's provider agreement or contract with ODM.

(3) Specification of the health care services to be provided.

(4) Specification that the ~~subcontract~~provider contract is governed by, and construed in accordance with all applicable laws, regulations, and contractual obligations of the ~~MCO~~ MCE and:

(a) ODM shall notify the ~~MCO~~ MCE and the ~~MCO~~ MCE shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the ~~MCO~~MCE;

(b) The ~~subcontract~~provider contract shall be automatically amended to conform to such changes without the necessity for written execution; and

(c) The ~~MCO~~ MCE shall notify the provider of all applicable contractual obligations.

(5) Specification of the beginning date and expiration date of the ~~subcontract~~contract, or an automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination.

(6) Specification of the procedures to be employed upon the ending, nonrenewal, or termination of the ~~subcontract~~contract, including an agreement by the provider to promptly supply all records necessary for the settlement of outstanding medical claims.

(7) Full disclosure of the method and amount of compensation or other consideration to be received by the provider from the ~~MCO~~MCE.

(8) An agreement not to discriminate in the delivery of services based on the member's race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services.

(9) An agreement by the provider to not hold liable ODM or members in the event that the ~~MCO~~ MCE cannot or will not pay for services performed by the provider pursuant to the ~~subcontract~~contract with the exception that:

(a) Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be reimbursed by ODM in the event of ~~MCO~~ MCE insolvency.

(b) The provider may bill the member when the ~~MCO~~ MCE has denied prior authorization or referral for services and the ~~following~~ conditions described in rule 5160-1-13.1 of the Administrative Code are met.~~:~~

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

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

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

(10) An agreement by the provider that with the exception of any member co-payments the ~~MCO~~ MCE has elected to implement in accordance with rule 5160-26-12 of the Administrative Code, the ~~MCO's~~ MCE's payment constitutes payment in full for any covered service and the provider will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit nursing facilities or home and community-based services waiver providers from collecting patient liability payments from members as specified in rules 5160:1-6-07 and 5160:1-6-07.1 of the Administrative Code or FQHCs and RHCs from submitting claims for supplemental payments to ODM as specified in Chapter 5160-28 of the Administrative Code. Additionally, the ~~MCO~~ MCE and the provider agree to the following:

(a) The ~~MCO~~ MCE shall notify the provider whether the ~~MCO~~ MCE has elected to implement any member co-payments and if, applicable, the circumstances in which member co-payment amounts will be imposed in accordance with rule 5160-26-12 of the Administrative Code; and

(b) The provider agrees that member notifications regarding any applicable co-payment amounts must be carried out in accordance with rule 5160-26-12 of the Administrative Code.

(11) A specification that the provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the ~~subcontract~~contract, and that provider and all employees of the provider have not been excluded from participating in federally funded health care programs.

(12) An agreement that ~~MyCare Ohio~~ODM administered home and community based services (HCBS) waiver providers are currently enrolled as ODM providers with an active status in accordance with ~~rule 5160-58-04~~Agency 5160 of the Administrative Code, and all other providers are either currently enrolled as ODM providers and meet the qualifications specified in paragraph (C) of this rule, or they are in the process of enrolling as ODM providers;

(13) A stipulation that the ~~MCO~~ MCE will give the provider at least sixty-days' prior notice in writing for the nonrenewal or termination of the ~~subcontract~~contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the ~~subcontract~~contract be terminated sooner or when the contract is temporary in accordance with 42 C.F.R. 438.602 (October 1, ~~2019~~2021) and the provider fails to enroll as an ODM provider within one hundred twenty days.

(14) A stipulation that the provider may nonrenew or terminate the ~~subcontract~~contract if one of the following occurs:

(a) The provider gives the ~~MCO~~ MCE at least sixty days prior notice in writing for the nonrenewal or termination of the ~~subcontract~~contract, or the termination of any services for which the provider is contracted. The effective date for any nonrenewal or termination of the ~~subcontract~~contract, or termination of any contracted service must be the last day of the month.

(b) ODM has proposed action to terminate, nonrenew, deny or amend the MCO's provider agreement in accordance with rule 5160-26-10 of the Administrative Code, regardless of whether this action is appealed. The provider's termination or nonrenewal written notice must be received by the ~~MCO~~ MCE within fifteen working days prior to the end of the month in which the provider is proposing termination or nonrenewal. If the notice is not received by this date, the provider must agree to extend the termination or nonrenewal date to the last day of the subsequent month.

(15) The provider's agreement to serve members through the last day the ~~subcontract~~contract is in effect.

(16) The provider's agreement to make the medical records for medicaid eligible individuals available for transfer to new providers at no cost to the individual.

(17) A specification that all laboratory testing sites providing services to members must have either a current clinical laboratory improvement amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or certificate of registration along with a CLIA identification number.

(18) A requirement securing cooperation with the MCO's quality assessment and performance improvement (QAPI) program in all its provider ~~subcontracts~~contracts and employment agreements for physician and nonphysician providers.

(19) An agreement by the provider and ~~MCO~~ MCE that:

(a) The ~~MCO~~ MCE shall disseminate written policies in accordance with the requirements of 42 U.S.C. 1396a(a)(68) (as in effect ~~July 1, 2020~~July 1, 2022) and section 5162.15 of the Revised Code, regarding the reporting of false claims and whistleblower protections for employees who make such a report, and including the ~~MCO's~~ MCE's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(b) The provider agrees to abide by the ~~MCO's~~ MCE's written policies related to the requirements of 42 U.S.C. 1396a(a)(68) (as in effect ~~July 1, 2020~~July 1, 2022) and section 5162.15 of the Revised Code, including the ~~MCO's~~ MCE's policies and procedures for detecting and preventing fraud, waste, and abuse.

(20) A specification that hospitals and other providers must allow the ~~MCO~~ MCE access to all member medical records for a period of not less than ~~eight~~ ten years from the date of service or until any audit initiated within the ~~eight~~ ten year period is completed and allow access to all record-keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in rule 5160-26-06 of the Administrative Code.

(21) A specification, appearing above the signature(s) on the signature page in all PCP ~~subcontracts~~contracts, stating the maximum number of MCO members that each PCP can serve at each practice site for that MCO.

(22) A specification that the provider must cooperate with the ODM external quality reviews required by 42 C.F.R. 438.358 (October 1, ~~2019~~2021) and on-site audits as deemed necessary based on ODM's periodic analysis of financial, utilization, provider ~~panel~~ network and other information.

(23) A specification that the provider must be bound by the same standards of confidentiality that apply to ODM and the state of Ohio as described in rule 5160-1-32 of the Administrative Code, including standards for unauthorized uses of or disclosures of protected health information (PHI).

(24) A specification that any third party administrator (TPA) must include the elements of paragraph (D) of this rule in its ~~subcontracts~~contracts and ensure that its ~~subcontracted~~ contracted providers will forward information to ODM as requested.

(25) A specification that home health providers must meet the eligible provider requirements specified in Chapter 5160-12 of the Administrative Code and comply with the requirements for home care dependent adults as specified in section 121.36 of the Revised Code.

(26) A specification that PCPs must participate in the care coordination requirements outlined in rule 5160-26-03.1 of the Administrative Code.

(27) A specification that the provider in providing health care services to members must identify and where necessary arrange, pursuant to the mutually agreed upon policies and procedures between the ~~MCO~~ MCE and provider, for the following at no cost to the member;

(a) Sign language services; and

(b) Oral interpretation and oral translation services.

(28) A specification that the ~~MCO~~ MCE agrees to fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the ~~MCO's~~ MCE's denial of payment of a service, as specified in rules 5160-26-08.4 and 5160-58-08.4 of the Administrative Code, utilizing the procedures and forms as specified in Chapter ~~5160~~5101:6-2 of the Administrative Code.

(29) The provider's agreement to contact the twenty-four-hour post-stabilization services phone line designated by the ~~MCO~~ MCE to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.

(30) A specification that the ~~MCO~~ MCE may not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

(a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the member needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment versus non-treatment; and

(d) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(31) A stipulation that the provider must not identify the addressee as a medicaid recipient on the outside of the envelope when contacting members by mail.

(32) An agreement by the provider that members will not be billed for missed appointments.

(33) An agreement that in the performance of the ~~subcontract~~contract or in the hiring of any employees for the performance of services under the ~~subcontract~~contract, the provider shall not by reason of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the ~~subcontract~~contract relates.

(34) An agreement by the provider that it shall not in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the ~~subcontract~~contract on account of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry.

(35) Notwithstanding paragraphs (D)(13) and (D)(14) of this rule, in the event of a hospital's proposed nonrenewal or termination of a hospital ~~subcontract~~contract, an agreement by the ~~subcontracted~~

contracted hospital to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the ~~subcontract~~contract and the last date the hospital will provide services to members under the ~~MCO~~ MCE contract. The ~~subcontracted~~ contracted hospital must send this notice to the providers with admitting privileges at least forty-five calendar days prior to the effective date of the nonrenewal or termination of the hospital ~~subcontract~~contract. If the contracted hospital issues less than forty-five days prior notice to the ~~MCO~~MCE, the notice to providers with admitting privileges must be sent within one working day of the ~~subcontracted~~ contracted hospital issuing notice of nonrenewal or termination of the ~~subcontract~~contract.

(36) An agreement by the provider to supply, upon request, the business transaction information required under 42 C.F.R. 455.105 (October 1, ~~2019~~2021).

(37) An agreement by the provider to release to the MCO, ODM or ODM designee any information necessary for the ~~MCO~~ MCE to perform any of its obligations under the ODM provider agreement, including but not limited to compliance with reporting and quality assurance requirements.

(38) An agreement by the provider that its applicable facilities and records will be open to inspection by the ~~MCO~~MCE, ODM, or ~~its~~ ODM's designee, or other entities as specified in rule 5160-26-06 of the Administrative Code.

(E) In lieu of including a medicaid addendum as required by paragraph (D) of this rule, an ~~MCO~~ MCE may permit a ~~benefit manager~~TPA that assists in the administration of health care services including pharmaceutical, dental, vision and behavioral health services on behalf of the ~~MCO's~~ MCE's members, to include elements in paragraphs (D)(1) to (D)(38) of this rule in ~~subcontracts~~contracts with entities that provide for the direct provision of health care services to ~~MCO~~ its members. The ~~MCO~~ MCE must receive written evidence that the ~~benefit manager~~ TPA complied with this paragraph and has informed the entities of the obligation to provide health care services to the ~~MCO's~~ MCE's members.

DRAFT - NOT FOR FILING

5160-26-05.1 Managed ~~health~~ care ~~programs~~: provider services.

(A) ~~Managed care organizations (MCOs)~~A managed care entity (MCE) must provide the following written information to their contracting providers:

(1) The ~~MCO's~~ MCE's grievance, appeal and state fair hearing procedures and time frames, including:

(a) The member's right to file grievances and appeals and the requirements and time frames for filing;

(b) The ~~MCO's~~ MCE's toll-free telephone number to file oral grievances and appeals;

(c) The member's right to a state fair hearing, the requirements and time frames for requesting a hearing, and representation rules at a hearing;

(d) The availability of assistance from the ~~MCO~~ MCE in filing any of these actions;

(e) The member's right to request continuation of benefits during an appeal or a state hearing and specification that at the discretion of ODM the member may be liable for the cost of any such continued benefits; and

(f) The provider's rights to participate in these processes on behalf of the provider's patients and to challenge the failure of the ~~MCO~~ MCE to cover a specific service.

(2) The ~~MCO's~~ MCE's requirements regarding the submission and processing of prior authorization requests including:

(a) A list of the benefits, if any, that require prior authorization approval from the ~~MCO~~MCE;

(b) The process and format to be used in submitting such requests;

(c) The time frames in which the ~~MCO~~ MCE must respond to such requests;

(d) Pursuant to the provisions of paragraph (A)(1) of this rule, how the provider will be notified of the ~~MCO's~~ MCE's decision regarding such requests; and

(e) Pursuant to the provisions of paragraph (A)(1) of this rule, the procedures to be followed in appealing the ~~MCO's~~ MCE's denial of a prior authorization request.

~~(3) (3) The MCO's requirements regarding the submission and processing of requests for specialist referrals including:~~

~~(a) (a) A list of the provider types, if any, that require prior authorization approval from the MCO;~~

~~(b) (b) The process and format to be used in submitting such requests;~~

~~(c) (c) How the provider will be notified of the MCO's decision regarding such requests; and~~

~~(d) (d) The procedures to be followed in appealing the MCO's denial of such requests.~~

~~(4)~~ (3) The ~~MCO's~~ MCE's documentation, legibility, confidentiality, maintenance, and access standards for

member medical records; including a member's right to amend or correct his or her medical record as specified in 45 C.F.R. 164.526 (October 1, ~~2019~~2021).

~~(5)~~ (4) The ~~MCO's~~ MCE's process and requirements for the submission of claims and the appeal of denied claims.

~~(6) (6) The MCO's process and standards for the recredentialing of providers.~~

~~(7)~~ (5) The ~~MCO's~~ MCE's policies and procedures regarding what action the ~~MCO~~ MCE may take in response to occurrences of undelivered, inappropriate, or substandard health care services, including the reporting of serious deficiencies to the appropriate authorities.

~~(8) (8) A description of the MCO's care coordination and care management programs, and the role of the provider in those programs, including:~~

~~(a) (a) The MCO's criteria for determining which members might benefit from care management;~~

~~(b) (b) The provider's responsibility in identifying members who may meet the MCO's care management criteria; and~~

~~(c) (c) The process for the provider to follow in notifying the MCO when such members are identified.~~

~~(9) (9) The MCO's requirements and expectations for PCPs, including triage requirements.~~

~~(10)~~ (6) The mutually agreed upon policies and procedures between the ~~MCO~~ MCE and the provider that explains the provider's obligation to provide oral translation, oral interpretation, and sign language services to the ~~MCO's~~ MCE's members including:

(a) The provider's responsibility to identify those members who may require such assistance;

(b) The process the provider is to follow in arranging for such services to be provided;

(c) Information that members will not be liable for the costs of such services; and

(d) Specification of whether the ~~MCO~~ MCE or the provider will be financially responsible for the costs of providing these services.

~~(11)~~ (7) The procedures that providers are to follow in notifying the ~~MCO~~ MCE of changes in their practice, including at a minimum:

(a) Address and phone numbers;

(b) Providers included in the practice;

(c) Acceptance of new patients; and

(d) Standard office hours.

~~(12)~~ (8) Specification of what service utilization and provider performance data the ~~MCO~~ MCE will make available to providers.

~~(13)~~ (9) Specification of the healthchek components to be provided to eligible members as specified in Chapter 5160-14 of the Administrative Code.

(B) In addition to the information in paragraph (A) of this rule, a managed care organization (MCO) has to provide the following written information to providers:

(1) The MCO's requirements and expectations for primary care providers (PCPs), including triage requirements.

(2) A description of the MCO's care coordination and care management programs, and the role of the provider in those programs, including:

(a) The MCO's criteria for determining which members might benefit from care management;

(b) The provider's responsibility in identifying members who may meet the MCO's care management criteria; and

(c) The process for the provider to follow in notifying the MCO when such members are identified.

(3) The MCO's requirements regarding the submission and processing of requests for specialist referrals including:

(a) A list of the provider types, if any, that require prior authorization approval from the MCO;

(b) The process and format to be used in submitting prior authorization requests;

(c) How the provider will be notified of the MCO's decision regarding prior authorization requests; and

(d) The procedures to be followed in appealing the MCO's denial of prior authorization requests.

~~(B)~~ (C) An ~~MCOs~~ MCO must adopt practice guidelines and disseminate the guidelines to all affected providers, and upon request to members and pending members. These guidelines must:

(1) Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

(2) Consider the needs of the MCO's members;

(3) Be adopted in consultation with contracting health care professionals; and

(4) Be reviewed and updated periodically, as appropriate.

~~(C)~~ (D) ~~MCOs~~ The MCE must have staff specifically responsible for resolving individual provider issues, including, but not limited to, problems with claims payment, prior authorizations and referrals. ~~MCOs~~ The MCE must provide written information to their contracting providers detailing how to contact these designated staff.

DRAFT - NOT FOR FILING

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

(A) ~~Each managed care plan (MCP)~~A managed care entity (MCE) must have administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud, waste and abuse as required in the ~~managed care plan~~MCE provider agreement or contract with the Ohio department of Medicaid (ODM) located at http://medicaid.ohio.gov/.

(1) These arrangements or procedures must be made available to ~~the Ohio department of medicaid (ODM)~~ODM upon request.

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

(B) ODM or its designee, the state auditor's office, the state attorney general's office, and the U.S. department of health and human services may evaluate or audit ~~a contracting MCP's~~ the MCE's performance for the purpose of determining compliance with the requirements of Chapter 5160-26 of the Administrative Code, fraud, waste, 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~~network, and other information.

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

(E) If the ~~MCP~~ MCE 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, ODM may impose any or all of the sanctions listed in rule 5160-26-10 of the Administrative Code or the MCE's provider agreement or contract with ODM.

(F) Record retention.

The ~~MCP~~ MCE and its contracted providers and subcontractors shall retain and safeguard all hard copy or electronic records originated or prepared in connection with the ~~MCP's~~ MCE's performance of its obligations under the MCO provider agreement or the SPBM contract, 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~~ MCE's expense, upon request, in the format specified by state or federal authorities. As specified in 42 C.F.R. 438.3 (October 1, ~~2018~~2021), such records must be maintained for a minimum of ten years from the renewal, amendment or termination date of the provider agreement. In the event the ~~MCP~~ MCE has been notified that state or federal

authorities have commenced an audit or investigation of the MCO provider agreement or the SPBM contract, records must be maintained until such time as the matter under audit or investigation has been resolved. For the initial three years of the retention period, the ~~MCP~~ MCE and its contracted providers and subcontractors must store the records in a manner and place that provides readily available access.

DRAFT - NOT FOR FILING

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

(A) ~~A managed care plan (MCP)~~ A managed care entity (MCE) must develop and implement written policies in accordance with 42 C.F.R. 438.100 (October 1, ~~2017~~2021), as applicable, to ensure each member has and is informed of his or her right to:

(1) Receive all services the ~~MCP~~ MCE is required to provide pursuant to the terms of ~~their~~ the MCE provider agreement or contract, as applicable, with the Ohio department of medicaid (ODM).

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

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

(4) 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) Be given the opportunity to participate in decisions involving their health care.

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

(7) Maintain auditory and visual privacy during all health care examinations or treatment visits.

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

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

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

(11) 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) Be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of rule 5160-26-08.4 of the Administrative Code.

(13) Be provided written member information from the ~~MCP~~MCE:

(a) At no cost to the member,

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

(c) In alternative formats and in an appropriate manner that takes into consideration the special needs of members.

(14) Receive necessary oral interpretation and oral translation services at no cost.

(15) Receive necessary services of sign language assistance at no cost.

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

(17) Refuse to participate in experimental research.

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

(19) Change primary care providers (PCPs) no less often than monthly. The ~~MCP~~ MCO must mail written confirmation to the member of his or her new PCP selection prior to or on the effective date of the change.

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

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

(23) Be assured the ~~MCP~~ MCE must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.

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

(25) For female members, 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 a member's designated PCP if the PCP is not a woman's health specialist.

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

(27) Receive information on their ~~MCP~~MCE.

(B) ~~An MCP~~ The MCE must advise members via the member handbook of the member rights specified in paragraph (A) of this rule.

DRAFT - NOT FOR FILING

5160-26-08.4 Managed ~~health~~ care ~~programs~~: ~~managed care plan~~ appeal and 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) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code.

~~(A)~~ ~~(A)~~ Definitions.

~~(1)~~ (1) "Adverse benefit determination" is a managed care plan (MCP)'s:

~~(a)~~ (a) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

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

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

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

~~(e)~~ (e) Failure to act within the resolution time frames specified in this rule; or

~~(f)~~ (f) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities, if applicable.

~~(2)~~ (2) "Appeal" is the member's request for an MCP's review of an adverse benefit determination.

~~(3)~~ (3) "Grievance" is the member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCP to make an authorization decision.

~~(4)~~ (4) "Notice of action (NOA)" is the written notice an MCP must provide to members when an MCP adverse benefit determination has occurred or will occur.

(B) Notice of Action (NOA) by a managed care organization (MCO) or the single pharmacy benefit manager (SPBM).~~NOA by an MCP.~~

(1) When ~~an MCP~~an adverse benefit determination has occurred or will occur, the ~~MCP~~MCO or SPBM shall provide the affected member with a NOA.

(2) The language and format of the NOA shall comply with the requirements listed in 42 CFR 438.10 (October 1, ~~2017~~2021), and the NOA shall explain:

(a) The adverse benefit determination the ~~MCP~~MCO or SPBM has taken or intends to take;

(b) The reasons for the adverse benefit determination, including the right of the member to be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other relevant determination information;

(c) The member's right to file an appeal to the ~~MCP~~MCO or SPBM;

(d) Information related to exhausting the ~~MCP~~MCO or SPBM appeal process;

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the ~~MCP~~MCO or SPBM appeal process;

(f) Procedures for exercising the member's rights to appeal the adverse benefit determination;

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

(h) 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; and

(i) The date the notice is issued.

(3) ~~An MCP~~NOAs shall be issued ~~each NOA~~ within the following time frames:

(a) For a decision to deny or limit authorization of a requested service the ~~MCP~~MCO or SPBM shall issue a NOA simultaneously with the ~~MCP's~~ MCO or SPBM's decision.

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the ~~MCP~~MCO or SPBM, the ~~MCP~~MCO or SPBM shall give notice at least fifteen calendar days before the effective date of the adverse benefit determination except:

(i) If probable recipient fraud has been verified, the ~~MCP~~MCO or SPBM shall give notice five calendar days before the effective date of the adverse benefit determination.

(ii) Under the circumstances set forth in 42 CFR 431.213 (October 1, ~~2017~~2021), the ~~MCP~~MCO or SPBM shall give notice on or before the effective date of the adverse benefit determination.

(c) For denial of payment for a non-covered service, the ~~MCP~~MCO or SPBM shall give notice simultaneously with the ~~MCP's~~ MCO or SPBM's determination to deny the claim, in whole or part, for a service not covered by medicaid, including a service determined through the ~~MCP's~~ MCO or SPBM's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal, or grievance resolution, the ~~MCP~~MCO or SPBM shall give notice simultaneously with the ~~MCP~~MCO or SPBM becoming aware of the untimely resolution. Service authorization decisions not reached within the time frames specified in rule 5160-26-03.1 of the Administrative Code constitutes a denial and is thus considered to be an adverse benefit determination. Notice shall be given on the date the authorization decision time frame expires.

(C) Grievances. ~~to an MCP.~~

(1) A member may file a grievance with ~~an MCP~~the MCO or SPBM orally or in writing at any time. An authorized representative must have the member's written consent to file a grievance on the member's behalf.

(2) ~~An MCP~~The MCO or SPBM shall acknowledge the receipt of each grievance to the member filing the grievance. Oral acknowledgment by ~~an MCP~~the MCO or SPBM is acceptable. If the grievance is filed in writing, written acknowledgment shall be made within three business days of receipt of the grievance.

(3) ~~An MCP~~The MCO or SPBM shall review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, shall meet the following time frames:

(a) Within two business 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 (C)(3)(a) of this rule.

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

(4) At a minimum, ~~an MCP~~the MCO or SPBM shall provide oral notification to the member of a grievance resolution. If ~~an MCP~~the MCO or SPBM is unable to speak directly with the member, or the resolution includes information that must be confirmed in writing, the resolution shall be provided in writing simultaneously with the ~~MCP's~~ MCO or SPBM's resolution.

(5) If ~~an MCP's~~ the MCO or SPBM's resolution to a grievance is to uphold the denial, reduction, suspension, or termination of a service or billing of a member due to the ~~MCP's~~ MCO or SPBM's denial of payment for that service, the ~~MCP~~MCO or SPBM shall notify the member of his or her right to request a state hearing as specified in paragraph (G) of this rule, if the member has not previously been notified.

(D) Standard appeals. ~~to an MCP.~~

(1) A member, a member's authorized representative, or a provider may file an appeal orally or in writing within sixty calendar days from the date that the NOA was issued. An oral appeal filing must be followed with a written appeal. ~~An MCP~~The MCO or SPBM shall:

(a) Immediately convert an oral appeal filing to a written appeal on behalf of the member; and

(b) Consider the date of the oral appeal filing as the filing date.

(2) Any provider acting on the member's behalf shall have the member's written consent to file an appeal. ~~An MCP~~The MCO or SPBM shall begin processing the appeal upon receipt of the written consent.

(3) ~~An MCP~~The MCO or SPBM shall acknowledge receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment shall be made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment shall be made by ~~an MCP~~the MCO or SPBM within three

business days of receipt of the appeal.

(4) ~~An MCP~~The MCO or SPBM shall provide the member reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing, and inform the member of this opportunity sufficiently in advance of the resolution time frame. Upon request, the member and/or member's authorized representative shall be provided, free of charge and sufficiently in advance of the resolution time frame, the case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by the ~~MCP~~MCO or SPBM, or at the direction of the ~~MCP~~MCO or SPBM, in connection with the appeal of the adverse benefit determination.

(5) ~~An MCP~~The MCO or SPBM shall consider the member, the member's authorized representative, or an estate representative of a deceased member as parties to the appeal.

(6) ~~An MCP~~The MCO or SPBM shall review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution time frame shall not exceed fifteen calendar days from the receipt of the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule.

(7) ~~An MCP~~The MCO or SPBM shall provide written notice of the appeal's resolution to the member, and to the member's authorized representative if applicable. At a minimum, the written notice shall include the resolution decision and date of the resolution.

(8) For appeal resolutions not resolved wholly in the member's favor, the written notice to the member shall also include the following information:

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

(b) 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's~~ adverse benefit determination is upheld at the state hearing, the member may be liable for the cost of any continued benefit.

(c) Oral interpretation is available for any language;

(d) Written translation is available in prevalent non-English languages as applicable;

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

(f) How to access ~~the MCP's~~ interpretation and translation services as well as alternative formats that can be provided by the ~~MCP~~MCO or SPBM.

(9) For appeal resolutions decided in favor of the member, ~~an MCP~~the MCO or SPBM shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date, 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.

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

(1) ~~An MCP~~The MCO and SPBM ~~–~~shall establish and maintain an expedited review process to resolve appeals when the member requests and the ~~MCP~~MCO or SPBM determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that the standard resolution time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function.

(2) In utilizing an expedited appeal process, ~~an MCP~~the MCO and SPBM shall comply with the standard appeal process specified in paragraph (D) of this rule, except the ~~MCP~~MCO and SPBM shall:

(a) Determine within one business day of the appeal request whether to expedite the appeal resolution;

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

(c) 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;

(d) Resolve the appeal as expeditiously as the member's health condition requires, but the resolution time frame shall not exceed seventy-two hours from the date the ~~MCP~~MCO or SPBM received the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule;

(e) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification; and

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

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

(3) If ~~an MCP~~the MCO or SPBM denies a member's request for expedited resolution of an appeal, the ~~MCP~~MCO or SPBM shall:

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

(b) Make reasonable efforts to provide the member prompt oral notification of the decision not to expedite, and within two calendar days of the receipt of the appeal, provide the member written notice of the reason for the denial, including information that the member can grieve the decision.

(F) Grievance and appeal resolution extensions.

(1) A member may request the time frame for ~~an MCP~~the MCO or SPBM to resolve a grievance or a standard or expedited appeal be extended up to fourteen calendar days.

(2) ~~An MCP~~The MCO or SPBM may request the time frame to resolve a grievance or a standard or expedited appeal be extended up to fourteen calendar days. The following requirements apply:

(a) The ~~MCP~~MCO or SPBM shall seek such an extension from ODM prior to the expiration of the standard or expedited appeal or grievance resolution time frame;

(b) The ~~MCP~~MCO or SPBM request shall be supported by documentation of the need for additional information and that the extension is in the member's best interest; and

(c) If ODM approves the extension, the ~~MCP~~MCO or SPBM shall make reasonable efforts to provide the member prompt oral notification of the extension and, within two calendar days, provide the member written notice of the reason for the extension and the date by which a decision shall be made.

(3) ~~An MCP~~The MCO and SPBM shall maintain documentation of any extension request.

(G) Access to state's hearing system.

(1) Except as set forth in paragraph (G)(2) of this rule, and in accordance with 42 CFR 438.402 (October 1, ~~2017~~2021), members may request a state hearing only after exhausting the ~~MCP's~~ MCO or SPBM's appeal process. If ~~an MCP~~the MCO or SPBM fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the ~~MCP~~ appeal process and may request a state hearing.

(2) In accordance with rule 5160-20-01 of the Administrative Code, members proposed for enrollment or currently enrolled in the coordinated services program (CSP) are afforded state hearing rights in accordance with division 5101:6 of the Administrative Code and are not subject to the requirement of first appealing to the ~~MCP~~MCO.

(3) When required by paragraph (D)(8) of this rule, and in accordance with division 5101:6 of the Administrative Code, ~~an MCP~~the MCO or SPBM shall notify members, and any authorized representatives on file with the ~~MCP~~MCO or SPBM, of the right to a state hearing subject to the following requirements:

(a) If an ~~MCP~~ appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the ~~MCP~~MCO or SPBM shall simultaneously issue the "Notice of Denial of Medical Services By Your Managed Care ~~Plan~~Entity" (ODM 04043, 1/2018).

(b) If an ~~MCP~~ appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as previously authorized by the ~~MCP~~MCO or SPBM, the ~~MCP~~MCO or SPBM shall issue the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care ~~Plan~~Entity" (ODM 04066, 1/2018).

(c) If ~~an MCP~~the MCO or SPBM learns a member has been billed for services received by the member due to the ~~MCP's~~ MCO or SPBM's denial of payment, and the ~~MCP~~MCO or SPBM upholds the

denial of payment, the ~~MCP~~MCO or SPBM shall immediately issue the "Notice of Denial of Payment for Medical Services By Your Managed Care ~~Plan~~Entity" (ODM 04046, 1/2018).

(4) The member or member's authorized representative may request a state hearing within ~~one hundred twenty~~ninety calendar days from the date of an adverse appeal resolution by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS).

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

(6) Following the bureau of state hearing's notification to ~~an MCP~~the MCO or SPBM that a member has requested a state hearing, the ~~MCP~~MCO or SPBM shall:

(a) Complete the "Appeal Summary for Managed Care ~~Plans~~Entity" (ODM 01959, 7/2014) with appropriate supporting attachments, and file it with the bureau of state hearings at least three business days prior to the scheduled hearing date. The appeal summary shall include all facts and documents relevant to the issue, in accordance with rule 5160-26-03.1 of the Administrative Code, and be sufficient to demonstrate the basis for the ~~MCP's~~ MCO or SPBM's adverse benefit determination;

(b) Send a copy of the completed ODM 01959 to the member and the member's authorized representative, if applicable, the CDJFS, and the designated ODM contact; and

(c) If benefits were continued through the appeal process in accordance with paragraph (H)(1) of this rule, continue or reinstate the benefit(s) if the ~~MCP~~MCO or SPBM is notified that the member's state hearing request was received within fifteen days from the date of the appeal resolution.

(7) ~~An MCP~~The MCO or SPBM shall participate in the state hearing, in person or by telephone, on the date indicated on the "Notice to Appear for a Scheduled Hearing" (JFS 04002, 01/2015) sent ~~to the MCP~~ by the bureau of state hearings.

(8) ~~An MCP~~The MCO or SPBM shall comply with the state hearing decision provided ~~to the MCP~~ via the "State Hearing Decision" (JFS 04005, 01/2015). If the state hearing decision sustains the member's appeal, the ~~MCP~~MCO or SPBM shall submit the information required by the "Order of Compliance" (JFS 04068, 01/2015) to the bureau of state hearings. The information, including applicable supporting documentation, is due to the bureau of state hearings and the designated ODM contact by no later than the compliance date specified in the hearing decision. If applicable, the ~~MCP~~MCO or SPBM shall:

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the date it receives notice reversing the adverse benefit determination if 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.

(H) Continuation of benefits while ~~the~~ an appeal ~~to an MCP~~ or state hearing are pending.

(1) Unless a member requests that previously authorized benefits not be continued, ~~an MCP~~the MCO or SPBM shall continue a member's benefits when all the following conditions are met:

(a) The member requests an appeal within fifteen days of the ~~MCP~~MCO or SPBM issuing the NOA;

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

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

(d) The authorization period has not expired.

(2) If ~~an MCP~~the MCO or SPBM continues or reinstates the member's benefits while the appeal or state hearing are pending, the benefits shall be continued until one of the following occurs:

(a) The member withdraws the appeal or the state hearing request;

(b) The member fails to request a state hearing within fifteen days after the ~~MCP~~MCO or SPBM issues an adverse appeal resolution; or

(c) The bureau of state hearings issues a state hearing decision upholding the reduction, suspension or termination of services.

(3) If the final resolution of the appeal or state hearing upholds ~~an MCP's~~ the MCO or SPBM's original adverse benefit determination, at the discretion of ODM, the ~~MCP~~MCO or SPBM may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

(I) ~~Other duties of an MCP regarding~~ Additional provisions regarding appeals and grievances.

(1) ~~An MCP~~The MCO and SPBM shall give members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:

(a) Explaining the ~~MCP's~~ MCO or SPBM'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 interpretation and oral translation services, sign language assistance, and access to the appeals and grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) ~~An MCP~~The MCO and SPBM shall ensure the individuals who make decisions on appeals and grievances are individuals who:

(a) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual; 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 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 involving clinical issues.

(3) In reaching an appeal resolution, ~~an MCP~~the MCO and SPBM shall take into account all comments, documents, records, and other information submitted by the member or their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

DRAFT - NOT FOR FILING

5160-26-09.1 Managed ~~health~~ care ~~programs~~: third party liability and recovery.

(A) Tort.

(1) Pursuant to sections 5160.37 and 5160.38 of the Revised Code, the Ohio department of medicaid (ODM) maintains all rights of recovery (tort) against the liability of any third party payer (TPP) for the cost of medical services.

(2) A ~~Managed~~ managed care ~~plans~~ entity (MCE) ~~(MCPs) are~~ is prohibited from accepting any settlement, compromise, judgment, award, or recovery of any action or claim by ~~the~~ a member.

(3) ~~MCPs~~The MCE must notify ODM and/or its designated entity within fourteen calendar days of all requests for the release of financial and medical records to a member or the member's representative pursuant to the filing of a tort action. Notification must be made via the "Notification of Third Party (tort) Request For Release" form (ODM 03245, rev. 7/2014) or a method determined by the ODM designated entity, provided ODM approved the designated entity's method and notified ~~MCPs~~the MCE.

(4) ~~MCPs~~The MCE must submit a summary of financial information to ODM and/or its designated entity within thirty calendar days of receiving an original authorization to release a financial claim statement letter from ODM pursuant to a tort action. ~~MCPs~~The MCE must use the "Tort Summary Statement" form (ODM 03246, rev. 7/2014) or a method determined by the ODM designated entity, provided ODM has approved the designated entity's method and notified ~~MCPs~~the MCE. Upon request, the ~~MCPs~~MCE must provide ODM and/or its designated entity with true copies of medical claims.

(B) Fraud, waste, and abuse recovery. ODM assigns to ~~MCP~~the managed care organization (MCO)~~s~~ its rights of recovery against any TPP for costs due to provider fraud, waste, or abuse as defined in rule 5160-26-01 of the Administrative Code related to each member during periods of enrollment in the ~~MCP~~MCO. In instances when ~~an~~ the ~~MCP~~MCO fails to properly report suspected fraud, waste, or abuse, before the suspected fraud, waste, or abuse is identified by the state of Ohio, any portion of the fraud, waste, or abuse recovered by the state shall be retained by the state.

(C) Coordination of benefits.

(1) ODM assigns its right to third party resources (coordination of benefits) to ~~MCP~~ the MCO~~s~~ for services rendered to each member during periods of enrollment. ODM reserves the right to identify, pursue, and retain any recovery of third party resources assigned to ~~an MCP~~the MCO but not collected by the ~~MCP~~MCO after one year from date of claim payment.

(2) ~~MCP~~Except as specified in paragraph (C)(3) of this rule, the MCE~~s~~ must act to provide coordination of benefits if a member has third party resources available for the payment of medical expenses for medically necessary medicaid-covered services. Such expenses will be paid in accordance with this rule and sections 5160.37 and 5160.38 of the Revised Code.

(3) Children that have been legally placed in the custody of an Ohio county public children's services agency (PCSA) or related entity are excluded from third party liability cooperation and are exempt from post-payment recovery unless it is confirmed that the child will not be put at risk for doing so (e.g.

medical support order).

~~(3)~~ (4) The ~~MCP~~MCE is the payer of last resort when a member has third party resources available for payment of medical expenses for medicaid-covered services, except:

(a) The ~~MCP~~MCE pays after any TPP including medicare but before:

(i) Resources provided through the children with medical handicaps program under sections 3701.021 to 3701.0210 of the Revised Code.

(ii) Resources that are exempt from primary payer status under federal medicaid law, 42 U.S.C. 1396 (as in effect ~~July 1, 2018~~July 1, 2022).

(iii) Resources provided through the state sponsored program awarding reparations to victims of crime, as set forth in sections 2743.51 to 2743.72 of the Revised Code.

(b) The ~~MCP~~MCO pays first for preventive pediatric services before seeking reimbursement from any liable third party.

~~(4)~~ (5) ~~MCPs~~The MCE will take reasonable measures to ascertain and verify any third party resources available to a member. When ~~an MCP~~the MCE denies a claim due to third party liability (TPL), the ~~MCP~~MCE must timely share, on the explanation of payment sent to providers, available information regarding the third party resources for the purposes of coordination of benefits, including:

(a) Insurance company name;

(b) Insurance company billing address for claims;

(c) Member's group number;

(d) Member's policy number; and

(e) Policy holder name.

~~(5)~~ (6) ~~MCPs~~The MCE must require providers who are submitting TPL claims to the ~~MCPs~~MCE to request information regarding third party benefits from the member or his/her authorized representative. If the member or the member's authorized representative specifies that the member has no third party benefits, or the provider is unable to determine that the member has third party benefits, the ~~MCP~~MCE must permit the provider to submit a claim to the ~~MCP~~MCE. If, as a result of requesting the information, the provider determines that third party liability exists, the ~~MCP~~MCE must allow the provider to submit a claim for reimbursement if he/she first takes reasonable measures to obtain third party payment as set forth in paragraph (C)(~~6~~7) of this rule.

~~(6)~~ (7) The ~~MCP~~MCE must require providers to take reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing the ~~MCP~~MCE. The ~~MCP~~MCE must permit providers who have taken reasonable measures to obtain all third party payments, but who have not received payment from a TPP or received partial payment, to submit a claim to the ~~MCP~~MCE requesting reimbursement for rendered services.

(a) ~~MCPs~~The MCE must process claims when the provider has complied with one or more of the following reasonable measures:

(i) The provider first submits a claim to the TPP for the rendered services and does not receive a remittance advice or other communication from the TPP within ninety days after the submission date. ~~MCPs~~The MCE may require providers to document the claim and date of the claim submission to the TPP.

(ii) The provider has retained and/or submitted one of the following types of documentation indicating a valid reason for non-payment for the services not related to provider error:

(a) Documentation from the TPP;

(b) Documentation from the TPP's automated eligibility and claim verification system;

(c) Documentation from the TPP's member benefits reference guide/manual; or

(d) Any other documentation from the TPP showing there is no third party benefit coverage for the rendered services.

(iii) The provider submitted a claim to the TPP and received a partial payment along with a remittance advice documenting the allocation of the charges.

(b) Valid reasons for non-payment from a TPP to the provider for a third party benefit claim include, but are not limited to:

(i) The service is not covered under the member's third party benefits.

(ii) The member does not have third party benefits through the TPP for the date of service.

(iii) All of the provider's billed charges or the TPP's approved rate was applied, in whole or in part, to the member's third party benefit deductible amount, coinsurance and/or co-payment for the TPP. The provider may then submit a secondary claim to the ~~MCP~~MCE showing the appropriate amount received from the TPP.

(iv) The member has not met any required waiting periods, or residency requirements for his/her third party benefits, or was non-compliant with the TPP's requirements in order to maintain coverage.

(v) The member is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.

(vi) The member has reached the lifetime benefit maximum for the medical service or third party benefits being billed to the TPP.

(vii) The TPP is disputing or contesting its liability to pay the claim or cover the service.

~~(7)~~ (8) If the provider receives payment from the TPP after the ~~MCP~~MCE has made payment, the ~~MCP~~MCE must require the provider to repay the ~~MCP~~MCE any amount overpaid by the ~~MCP~~MCE. The ~~MCP~~MCE must not allow the provider to reimburse any overpaid amounts to the member.

~~(8)~~ (9) ~~MCPs~~The MCE must make available to providers information on how to submit a claim that will have a zero paid amount in the third party field on the claim.

~~(9)~~ (10) ~~MCP~~The MCE payment for third party claims will not exceed the ~~MCP~~MCE allowed amount for the service, less all third party payments for the service.

~~(10)~~ (11) ~~An MCP's~~ The MCE's timely filing limits for provider claims shall be at least ninety days from the date of the remittance advice that indicates adjudication or adjustment of the third party claim by the TPP.

~~(11)~~ (12) ~~MCPs~~The MCE must ensure that providers do not hold liable or bill members in the event that the ~~MCP~~MCE cannot or will not pay for covered services unless all of the specifications set forth in rule 5160-26-05 and rule 5160-26-11 of the Administrative Code are met. The provider may not collect and/or bill the member for any difference between the ~~MCP~~MCE's payment and the provider's charge or request the member to share in the cost through a deductible, coinsurance, co-payment, or other similar charge, other than ~~MCP~~MCE co-payments. ~~as permitted in rule 5160-26-12 of the Administrative Code.~~

(D) The ~~MCP is~~ MCE is required to submit information regarding members with third party coverage as directed by ODM.

DRAFT - NOT FOR FILING

5160-26-10 Managed ~~health~~ care ~~programs~~: sanctions and provider agreement actions.

(A) This rule does not apply to the single pharmacy benefit manager as defined in rule 5160-26-01 of the Administrative Code.

~~(A)~~ (B) If ~~the MCP~~the MCO fails to fulfill its duties and obligations under 42 C.F.R. Part 438 (October 1, ~~2013~~2021), 42 U.S.C. 1396b(m) (as in effect ~~January 1, 2015~~July 1, 2022), 42 U.S.C. 1396u-2 (as in effect ~~January 1, 2015~~July 1, 2022), ~~Chapter 5160-26 or 5160-58~~Agency 5160 of the Administrative Code, or the ~~MCP~~MCO provider agreement, ODM will provide timely written notification to the ~~MCP~~MCO identifying the violations or deficiencies, and may impose corrective actions or any of the following sanctions in addition to or instead of any actions or sanctions specified in the provider agreement:

(1) ODM may require corrective action plans (CAPs) in accordance with the following:

(a) If requested by ODM, the ~~MCP~~MCO must submit, within the specified time frame, a proposed CAP for each cited violation or deficiency.

(b) The CAP must contain the proposed correction date, describe the manner in which each violation or deficiency will be resolved, and address all items specified in the ODM notification.

(c) The CAP must be reviewed and approved by ODM.

(d) Following the approval of the CAP, ODM will monitor the correction process until all violations or deficiencies are corrected to the satisfaction of ODM.

(e) If the ~~MCP~~MCO fails to submit an approvable CAP within the ODM-specified time frames, ODM may impose an ODM-developed CAP, sanctions, or both.

(f) If ODM has already determined the specific action that must be implemented by the ~~MCP~~MCO, ODM may require the ~~MCP~~MCO to comply with an ODM-developed or directed CAP.

(g) Failure by the ~~MCP~~MCO to successfully complete the correction process and correct the violations or deficiencies to the satisfaction of ODM may lead to the imposition of any or all of the sanctions listed in paragraph (~~A~~B)(2) of this rule.

(2) Sanctions that may be imposed on ~~MCPs~~ the MCO by ODM include but are not limited to the following:

(a) Suspension of the enrollment of ~~MCP~~the MCO's members.

(b) Disenrollment of ~~the MCP's~~ the MCO's members.

(c) Prohibition or reduction of ~~the MCP's~~ the MCO's voluntary assignments.

(d) Prohibition or reduction of ~~the MCP's~~ the MCO's involuntary assignments.

(e) Granting ~~MCP~~the MCO's members the right to terminate without cause and notifying the affected members of their right to disenroll.

(f) Retention by ODM of ~~the MCP's~~ the MCO's premium payments or a portion thereof until the violations or deficiencies are corrected.

(g) Imposition of financial sanctions.

~~(B)~~ (C) ODM will select sanction(s) specified in paragraph ~~(A)~~(B)(2) of this rule based on a pattern of repeated violations or deficiencies, the severity of the cited violations or deficiencies, the failure of ~~the MCP~~the MCO to meet the requirements of an approved CAP, or all these factors.

~~(C)~~ (D) The sanctions in paragraph ~~(A)~~(B)(2) of this rule are subject to reconsideration by ODM as specified in Chapter 5160-70 of the Administrative Code, with the exception that the involuntary assignments referenced in paragraph ~~(A)~~(B)(2)(d) of this rule are not subject to reconsideration.

~~(D)~~ (E) Regardless of any other sanction that may be imposed, ODM may impose temporary management on any ~~MCP~~MCO that has repeatedly failed to meet substantive requirements in 42 U.S.C. 1396b(m) (as in effect ~~January 1, 2015~~July 1, 2022), 42 U.S.C. 1396 u-2 (as in effect ~~January 1, 2015~~July 1, 2022) or 42 C.F.R. Part 438 subpart I (October 1, ~~2013~~2021). Such temporary management shall be imposed in accordance with the following:

(1) ~~The MCP~~The MCO must pay the costs of a temporary manager for performing the duties of a temporary manager as determined by ODM.

(2) ~~The MCP~~The MCO is solely responsible for any costs or liabilities incurred on behalf of the ~~MCP~~MCO when temporary management is imposed by ODM.

(3) The imposition of temporary management is not subject to the appeals process provided under Chapter 119. of the Revised Code; however, ~~the MCP~~the MCO may request that the director for the medicaid program reconsider this action. ODM will not delay imposition of temporary management to provide reconsideration prior to imposing this sanction.

(4) Unless the director for the medicaid program determines through the reconsideration process that temporary management should not have been imposed, the temporary management will remain in place until such time as ODM determines that ~~the MCP~~the MCO can ensure that the sanctioned behavior will not recur.

(5) Regardless of the imposition of temporary management, ~~the MCP~~the MCO retains the right to appeal any proposed termination or nonrenewal of its provider agreement under Chapter 119. of the Revised Code. ~~The MCP~~The MCO also retains the right to initiate the sale of the ~~MCP~~MCO or its assets.

(6) If temporary management is imposed, ODM will notify the ~~MCP's~~ MCO's members that such action has occurred and inform them that they therefore have the right to terminate their membership in the ~~MCP~~MCO without cause. Termination of the ~~MCP's~~ MCO's membership without cause is not subject to the appeals process provided under Chapter 119. of the Revised Code; however, the ~~MCP~~MCO may request that the director for the medicaid program reconsider this action. ODM will not delay the notification to the ~~MCP's~~ MCO's membership to provide reconsideration prior to imposing this sanction.

~~(E)~~ (F) ODM will provide ~~an MCP~~ the MCO with written notice before imposing any sanction. The notice will describe any reconsideration or appeal rights that are available to the ~~MCP~~MCO.

~~(F)~~ (G) Regardless of whether ODM imposes a sanction, ~~MCPs~~ the MCO shall initiate corrective action for any ~~MCP~~MCO program violations or deficiencies as soon as they are identified by either the ~~MCP~~MCO or ODM.

~~(G)~~ (H) The following provisions apply in the event ODM decides to terminate, nonrenew, deny, or amend the ~~MCP's~~ MCO provider agreement.

(1) ODM may terminate, nonrenew, deny, or amend the ~~MCP's~~ MCO provider agreement if at any time ODM determines that continuation or assumption of a provider agreement is not in the best interest of recipients or the state of Ohio. For the purposes of this rule, an amendment to ~~an MCP's~~ the MCO provider agreement is defined as, and limited to, the elimination of one or more service areas included in ~~that MCP's~~ the MCO's current provider agreement. The phrase "not in the best interest" includes, but is not limited to, the following:

(a) The ~~MCP's~~ MCO's delivery system does not assure adequate access to services for its members.

(b) The ~~MCP's~~ MCO's delivery system does not assure the availability of all services covered under the provider agreement.

(c) The ~~MCP~~MCO fails to provide all medically-necessary covered services.

(d) The ~~MCP~~MCO fails to provide proper assurances of financial solvency.

(e) The number of members enrolled ~~by~~ in the ~~MCP~~ MCO's ~~in a~~ service area is not sufficient to ensure the effective or efficient delivery of services to members.

(f) The ~~MCP~~MCO fails to comply with any of the following:

(i) Chapter 5160-26, ~~or~~ 5160-58, or 5160-59 of the Administrative Code ~~or both~~;

(ii) The MCO provider agreement;

(iii) The applicable requirements in 42 U.S.C. 1396b(m) (as in effect ~~January 1, 2015~~July 1, 2022) or 42 U.S.C. 1396u-2 (as in effect ~~January 1, 2015~~July 1, 2022);

(iv) 42 C.F.R. Part 438 (October 1, 2021 ~~2013~~).

(2) If ODM has proposed termination, nonrenewal, denial, or amendment of ~~a~~ the MCO's provider agreement, ODM may notify the ~~MCP's~~ MCO's members of this proposed action and inform the members of their right to immediately disenroll from the ~~MCP~~MCO without cause.

(3) If ODM determines that the termination, nonrenewal, or denial of a provider agreement is warranted:

(a) ODM will provide notice, at a minimum, forty-five days prior to the effective date of the proposed

action;

(b) The action will be in accordance with and subject to Chapter 5160-70 of the Administrative Code; and

(c) The action will be effective at the end of the last day of a calendar month.

(4) If ODM determines that the amendment of a provider agreement is warranted, the proposed action is subject to reconsideration pursuant to Chapter 5160-70 of the Administrative Code.

(5) Notwithstanding the preceding paragraphs of this rule, ODM may terminate ~~an MCP's~~ the MCO's provider agreement effective on the last day of the calendar month in which any of the following occur:

(a) The determination by ODM that the loss or reduction of federal or state funding has reduced funding to a level which is insufficient to maintain the activities or services agreed to in the provider agreement;

(b) The exclusion from participation of the ~~MCP~~MCO in a program administered under Title XVIII, XIX, or XX of the Social Security Act due to criminal conviction or the imposition of civil monetary penalties in accordance with 42 C.F.R. Part 455 subpart B (October 1, ~~2013~~2021), 42 C.F.R. Part 1002 subpart A (October 1, ~~2013~~2021), and rule 5160-1-17.3 of the Administrative Code;

(c) The suspension, revocation, or nonrenewal of ODM's authority to operate the program under the state plan or waivers of certain federal regulations granted by CMS or congress;

(d) The suspension, revocation, or nonrenewal of the ~~MCP's~~ MCO's certificate of authority or license.

(e) The exclusion of the ~~MCP~~MCO from participation in accordance with 42 C.F.R. 438.808 (October 1, ~~2013~~2021).

(6) ~~MCPs~~ If the MCO's ~~whose~~ provider ~~agreements are~~ agreement is amended, terminated, denied, or nonrenewed for any reason including procurement, the MCO ~~are~~ is required to fulfill all duties and obligations under ~~Chapter 5160-26 or 5160-58 or both~~ Agency 5160 of the Administrative Code, as applicable, and the MCO provider agreement.

DRAFT - NOT FOR FILING

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

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

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

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

~~(B)~~ (A) ~~MCP non~~Non-contracting providers of emergency services must accept as payment in full from ~~the~~ a ~~MCP~~ managed care organization (MCO) the lesser of billed charges or one hundred per cent of the Ohio medicaid program 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 reimbursement rate) in effect for the date of service. Pursuant to section ~~5167.10~~5167.101 of the Revised Code, the ~~MCP~~ MCO shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.

~~(C)~~ (B) When ODM has approved ~~an MCP's~~ the MCO's members to be referred to ~~an MCP~~ a non-contracting hospital pursuant to rule 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~~MCO one hundred per cent of the current Ohio medicaid program reimbursement rate in effect for the date of service. Pursuant to section ~~5167.10~~5167.101 of the Revised Code, the ~~MCP~~MCO shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM. ~~MCP non~~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~~MCO prior to January 1, 2006;

(2) The hospital is contracted with at least one ~~MCP~~MCO serving the eligible individuals specified in paragraph ~~(C)~~(B)(1) of this rule prior to January 1, 2006; and

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

~~(D)~~ (C) ~~MCP non~~Non-contracting qualified family planning providers (QFPPs) must accept as payment in full from the ~~MCP~~MCO the lesser of one hundred per cent of the Ohio medicaid program reimbursement rate or billed charges, in effect for the date of service.

~~(E)~~ (D) ~~An MCP~~A managed care entity (MCE) non-contracting provider may not bill ~~an MCP~~the MCE member unless: ~~all of the following conditions are met:~~

(1) The conditions described in rule 5160-1-13.1 of the Administrative code are met; and

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

~~(2) (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) (3) The notification is dated and signed by the member.~~

~~(4)~~ (2) The reason the service is not covered by the ~~MCP~~MCE is specified and is one of the following:

(a) The service is a benefit exclusion;

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

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

~~(G)~~ (F) ~~MCP non~~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~~MCO to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.

~~(H)~~ (G) ~~MCP non~~Non-contracting providers, including ~~MCP~~ non-contracting providers of emergency services, must allow the ~~MCP~~MCE, ODM, and ODM's designee access to all member medical records for a period not less than ten years from the date of service or until any audit initiated within the ten year period is completed. Access must include copies of the medical records at no cost for the purpose of activities related to the annual external quality review specified by ~~42 C.F.R.~~42 C.F.R. 438.358 (October 1, ~~2017~~2021).

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

DRAFT - NOT FOR FILING

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

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code.

~~(A)~~ (B) The ~~Managed~~ managed care ~~organizations~~ organization (~~MCOs~~MCO) may elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for dental services, vision services, or non-emergency emergency department services~~, or prescription drugs~~ as provided for in this rule. The MCO~~MCOs~~ must receive prior approval from the Ohio department of medicaid (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.~~

(C) The single pharmacy benefit manager (SPBM) may only elect to implement a member co-payment program pursuant to section 5162.20 of the Revised Code for prescription drugs as provided for in this rule if directed to by ODM.

~~(B)~~ (D) ~~MCOs~~ If the MCO or SPBM ~~that elect to~~ implements a member co-payment program, the MCO and SPBM~~amounts~~ must:

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

(2) Not deny services to members as specified in paragraph (~~D~~F) 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, ~~2019~~2021);

(4) Specify in provider ~~subcontracts~~ contracts governed by rule 5160-26-05 of the Administrative Code the circumstances under which member co-payment amounts can be requested. ~~For MCOs~~ If the MCO or SPBM ~~that elect to~~ implements 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~~I) of this rule;

(5) Ensure that the member is not billed for any difference between the ~~MCO's~~ MCO or SPBM'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) Ensure that member co-payment amounts are requested by providers in accordance with this rule; and

(7) 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)~~ (E) 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 individuals with intellectual disabilities (ICF/IID) are excluded from medicaid co-payment obligations.

(4) Emergency. An MCO 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.

(5) Family planning (pregnancy prevention or contraceptive management). ~~An~~ The MCO or SPBM shall not impose a medicaid co-payment obligation on any service identified by ODM as a pregnancy prevention/contraceptive management service in accordance with rules 5160-21-02 and 5160-1-09 of the Administrative Code and provided to an individual of child-bearing age.

(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 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)~~ (F) No provider may deny services to a member who is eligible for 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, ~~MCOs~~ the MCO or SPBM must still ensure that the member has access to needed services.

~~(E)~~ (G) The~~MCOs~~ MCO or SPBM may ~~elect to~~ impose member co-payments as follows:

(1) For dental services, the member co-payment amount may not exceed the amount set forth in Chapter 5160-5 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 the amount set forth in Chapter 5160-2 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 MCO 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.

(4) For pharmacy services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-9 of the Administrative Code.

~~(F)~~ (H) 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, regardless of whether they are filled at a pharmacy located at the facility or at an outside location.

~~(G)~~ (I) If ~~an~~ the MCO has implemented a member co-payment program for non-emergency emergency department services, as described in paragraph (~~E~~G)(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 (D~~B~~)(4) of this rule, does not apply.

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