



Common Sense Initiative

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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): _MyCare Ohio Rules – Chapter 5160-58 – Revisions due to Next Generation Managed Care Implementation

Rule Number(s): 5160-58-01.1, 5160-58-02.1, 5160-58-03 and 5160-58-03.1. *Included for informational purposes only: 5160-58-01 and 5160-58-02.*

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

Public Comment Period End Date: 03/08/2022

Rule Type/Number of Rules:

New/_1_ rules

Amended/_3_ 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Rescinded/_ rules (FYR?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.

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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. MyCare Ohio plans (MCOPs) are considered MCOs per federal definitions. The rules in Ohio Administrative Code (OAC) Chapter 5160-58 govern the MyCare Ohio program. There are five MCOPs in Ohio, each with a network of health care professionals. MyCare Ohio is a managed care program aimed at providing integrated care for individuals who are dually eligible (e.g. members receive both Medicaid and Medicare services).

OAC rule 5160-58-01.1, entitled “MyCare Ohio plans: application of general managed care rules,” sets forth the applicability of general managed care rules used throughout Chapter 5160-58 of the Administrative Code. The rule is being proposed for amendment to update policy related to the administration of the MyCare Ohio program and for five-year rule review. Changes to the rule include: changing references from “managed care plans” to “managed care organizations” and adding a reference to managed care entity (MCE) in paragraph (A), removing reference to OAC rule 5160-26-09 due to rescission in paragraph (A)(5), removing language regarding prior authorization of covered outpatient drugs in paragraph (B) due to the creation of new OAC rule 5160-58-03.1 where this language has been moved to, adding clarification that cross-references to rule 5160-26-03.1 of the Administrative Code are replaced by cross-references to rule 5160-58-03.1 of the Administrative Code in paragraph (B)(5), adding clarification that rule 5160-26-03.1 does not apply to MyCare Ohio as OAC rule 5160-58-03.1 was created in paragraph (C)(4), and adding reference to the Ohio Resilience through Integrated Systems and Excellence (OhioRISE) program in paragraph (D).

OAC rule 5160-58-02.1, entitled “MyCare Ohio plans: termination of enrollment,” sets forth the reasons why an individual enrolled in a MyCare Ohio plan may be terminated and the process for termination. The rule is being proposed for amendment to update policy related to the administration of the MyCare Ohio program and for five-year rule review. Changes to the rule include: changing references from “plan” to “MCOP” for consistency throughout Chapter 5160-58, clarifying when termination of enrollment from a MyCare Ohio plan would occur when a third-party

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payer has been identified excluding Medicare in paragraph (A)(5), other grammatical and technical edits as necessary, and updating references to the Code of Federal Regulations (CFR).

OAC rule 5160-58-03, entitled “MyCare Ohio plans: covered services”, sets forth the services that must be covered by MCOPs and addresses exclusions and limitations for those services. Changes to the rule include: removing definitions in paragraph (C)(3)(f) that are included in OAC rule 5160-26-01, adding language regarding compensation to hospital inpatient capital costs pursuant to Ohio Revised Code 5167.10 in paragraph (C)(3)(f), adding a clarification that the MCOP is responsible for covering OhioRISE plan services in paragraph (E)(11), and other grammatical and technical edits.

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

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. Additionally, ODM has entered into a three-way contract with the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services and each MCOP to implement the MyCare Ohio demonstration program.

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; instead they require state Medicaid agencies to ensure MCO 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 5160-58 are necessary for various reasons. Federal regulations require state Medicaid agencies to ensure MCO 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:

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- 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 MCOPs to follow established guidelines and to ensure providers are paid appropriately for services delivered; 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 MyCare Ohio provider agreement. 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.

The MyCare Ohio Plans listed below were provided with the draft rules on July 13, 2021. The rules were then reviewed during a meeting on 07/23/2021. The plans were given until 07/21/2021 to comment.

- Aetna Better Health Ohio, Inc.
- Buckeye Community Health Plan
- CareSource Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- UnitedHealthcare Community Plan of Ohio

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

Comments were received from Ohio Department of Aging (ODA) and ODM responded to their comments. No changes resulted from these comments. Additionally, as a result of MCOP 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 the 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

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centralized credentialing, and the implementation of the SPBM and the OhioRISE 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. MCOP performance requirements are outlined in the MCOP provider agreement 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 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 5160-58 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 MCOPs of the final rule changes via email notification. Additionally, per the MCOP provider agreement, MCOPs are required to subscribe to the appropriate distribution lists for notification of all OAC rule clearances and final published rules including RuleWatch Ohio and the Common Sense Initiative Office (CSIO) eNotification system. ODM will ensure MCOPs 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 MCOPs in the State of Ohio (this includes: Aetna Better Health Ohio, Buckeye Community Health Plan, CareSource Ohio, Molina Healthcare of Ohio, and UnitedHealthcare Community Plan of Ohio).

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

- **Rule 5160-58-01.1** requires MCOPs to give notice to a MyCare Ohio member when the plan is unable to obtain the information needed to make a prior authorization decision on a covered outpatient drug within 72 hours of receiving the request.
- **Rule 5160-58-02.1** requires MCOPs to provide notice and potentially documentation to ODM upon member disenrollment from the MCO.
- **Rule 5160-58-03** requires MCOPs to establish, in writing, the process and procedures for claims submissions from non-contracting providers and to maintain a record of any request for coverage of post-stabilization services. These written policies and procedures must be made available to non-contracting providers, including non-contracting providers of emergency services, on request.

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- **OAC rule 5160-58-03.1** requires MCOPs to share specific information with ODM and certain providers, to maintain a log, and to implement written policies and procedures.

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.

MCOPs are paid a per member per month amount. ODM must pay MCOPs 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 rates 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.

All rates and actuarial methods can be found on the ODM website in Appendix E of the MyCare Ohio provider agreement. Through the administrative component of the capitation rate paid to the MCOPs by ODM, MCOPs will be compensated for the cost of the reporting and notice requirements found in these rules. For CY 2021, the administrative component of the managed care capitation rate varies by program/population and ranges from 3.0% to 6.0% for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates.

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

The MCOPs were aware of the federal requirements for covered services prior to seeking and signing their contracts with the State. More importantly, without the requirement of certain covered health care services, 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 MCOP’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 impacted by this rule, the MCOPs may contact ODM directly through their assigned Contract Administrator.

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5160-58-01 MyCare Ohio plans: definitions.

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

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responsible for coordination and payment of medicaid benefits.

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

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

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

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

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

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

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

(5) All cross-references to rule 5160-26-03.1 of the Administrative Code are replaced by cross-references to rule 5160-58-03.1 of the Administrative Code.

~~(5) (6)~~ All cross-references to rule 5160-26-08.4 of the Administrative Code are replaced by cross-references to rule 5160-58-08.4 of the Administrative Code.

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

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

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

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

(A) Eligibility.

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

(B) MyCare Ohio plan enrollment.

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

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

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

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

- (a) When a service area is initially designated by ODM as mandatory for eligible individuals specified in paragraph (A)(1) of this rule, ODM shall confirm the eligibility of each individual as prescribed in paragraph (A)(1) of this rule. Upon the confirmation of eligibility:
 - (i) Eligible individuals residing in the service area who are currently ~~plan~~-MCOP members are deemed participants in the mandatory program; and
 - (ii) All other eligible individuals residing in the mandatory service area may request ~~plan~~-MCOP membership at any time but must select a ~~plan~~-MCOP following receipt of a notification of mandatory enrollment (NME) issued by ODM.

(b) MyCare Ohio plan membership selection procedures for the mandatory program:

- (i) A newly eligible individual who does not make a choice following issuance of a NME by ODM and one additional notice, will be assigned to a ~~plan~~-MCOP by ODM, the medicaid consumer hotline, or other ODM-approved entity.
- (ii) ODM or the medicaid consumer hotline shall assign the individual to a ~~plan~~-MCOP based on prior medicaid fee-for-service, managed care organization, or ~~plan~~-MCOP membership history, whenever available, or at the discretion of ODM.

(C) Commencement of coverage.

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

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

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

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

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

(C) Member-initiated terminations.

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

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the consumer hotline.

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

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- (iv) ODM may establish retroactive termination dates and/or recover premium payments as determined necessary and appropriate.
- (v) Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member requests change or termination.
- (vi) If the just cause request is not approved, ODM shall notify the member or the authorized representative of the member's right to a state hearing.
- (vii) Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate.
- (viii) If a member submits a request to change or terminate enrollment for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall assure that the member's ~~plan~~-MCOP enrollment is not automatically renewed if eligibility for medicaid is reauthorized.

(g) A member who is in a medicare Part D drug management program and is in a potentially at-risk or at-risk status as defined in 42 C.F.R. 423.100 (October 1, ~~2019~~2021) is precluded from changing ~~plans~~MCOPs.

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

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

(E) Open enrollment

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

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

- (A) A MyCare Ohio plan (MCOP) must ensure members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based services (HCBS) covered by Ohio medicaid. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the MCOP must 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~~the MCOP has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary, unless the MCOP's limitation is also a limitation for fee-for-service medicaid coverage;
 - (4) Medicaid coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code; and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and
 - (5)) If a member is unable to obtain medically-necessary medicaid services from an MCOP ~~panel~~network provider, the ~~plan~~MCOP must adequately and timely cover the services out of ~~panel~~network until the ~~plan~~MCOP is able to provide the services from a ~~panel~~network provider.
- (B) The MCOP may place appropriate limits on a service;
- (1) On the basis of medical necessity for the member's condition or diagnosis;~~or~~;
 - (2) Except as otherwise specified in this rule, to available ~~panel~~network providers; or
 - (3) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.

(C) Services covered by an MCOP.

- ~~(C)~~(1) The MCOP must cover annual physical examinations for adults.
- ~~(D)~~(2) At the request of a member, ~~an~~the MCOP must provide for a second opinion from a qualified health care professional within the ~~panel~~MCOP's network. If a qualified health care professional is not available within the ~~plan's~~MCOP's ~~panel~~network, the ~~plan~~MCOP must arrange for the member to obtain a second opinion outside the ~~panel~~MCOP's network, at no cost to the member.
- ~~(E)~~(3) The MCOP must ensure emergency services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:
- ~~(4)~~(a) The MCOP may not deny payment for treatment obtained when a member had an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.

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- ~~(2)~~ (b) The MCOP cannot limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.
- ~~(3)~~ (c) The MCOP must cover all emergency services without requiring prior authorization.
- ~~(4)~~ (d) The MCOP must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the plan-MCOP including but not limited to the member's primary care provider (PCP) or the plan's-MCOP's twenty-four-hour toll-free call-in-system.
- ~~(5)~~ (e) The MCOP cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.
- ~~(6)~~ (f) ~~For the purposes of this rule, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCOP but provides emergency services to a plan member, regardless of whether that provider has a medicaid provider agreement with ODM.~~ The plan-MCOP must cover emergency services as defined in rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services. ~~Claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.~~ Such services must be reimbursed by the plan-MCOP at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the plan-MCOP is required to reimburse at this rate only until the member can be transferred to a provider designated by the plan-MCOP. Pursuant to section 5167.10 of the Revised Code, the MCOP may not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.
- ~~(7)~~ (g) The MCOP must cover emergency services until the member is stabilized and can be safely discharged or transferred.
- ~~(8)~~ (h) The MCOP must adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The plan-MCOP may establish arrangements with hospitals whereby the plan-MCOP may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.
- ~~(9)~~ (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.
- ~~(F)~~ (4) The MCOP must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services. ~~as described in paragraph (E)(6) of this rule.~~ These written policies and procedures must be made available to non-contracting providers, including non-contracting providers of emergency services,

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on request. The ~~plan~~-MCOP may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

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

~~(4)~~(a) The MCOP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day, seven days a week. The ~~plan~~-MCOP must document the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The ~~plan~~-MCOP must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the ~~plan~~-MCOP communicated the decision in writing to the provider.

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

~~(a)~~(i) The MCOP must cover services obtained within or outside the ~~plan's~~-MCOP's ~~panel~~-network that have not been pre-approved in writing by a ~~plan~~-an MCOP provider or other ~~plan~~-MCOP representative.

~~(b)~~(ii) If the MCOP does not respond within one hour of a provider's request for preapproval of further services administered to maintain the member's stabilized condition, the ~~plan~~-MCOP must cover the services, whether or not they were provided within the ~~plan's~~-MCOP's ~~panel~~-network.

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

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

~~(ii)~~(b) The MCOP cannot be contacted.

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

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

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- ~~(a)~~ (i) A ~~plan~~ network provider with privileges at the treating hospital assumes responsibility for the member's care;
- ~~(b)~~ (ii) A ~~plan~~ network provider assumes responsibility for the member's care after the member is transferred to another facility;
- ~~(c)~~ (iii) A ~~plan~~ An MCOP representative and the treating provider reach an agreement concerning the member's care; or
- ~~(d)~~ (iv) The member is discharged.

~~(H)~~ (H) MCOP responsibilities for payment of other services.

- ~~(1)~~ (6) The MCOP must permit members to self-refer to Title X services provided by any qualified family planning provider (QFPP). The ~~plan~~ MCOP is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the ~~plan~~ MCOP at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges, in effect for the date of service.
- ~~(2)~~ (7) The MCOP must permit members to self-refer to any women's health specialist within the ~~plan's~~ MCOP's ~~panel~~ network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated primary care provider (PCP) if that PCP is not a women's health specialist.
- ~~(3)~~ (8) The MCOP must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- ~~(4)~~ (9) Where available, the MCOP must ensure access to covered services provided by a certified nurse practitioner.
- ~~(5)~~ (5) ~~The MCOP is not responsible for payment of services provided through the medicaid schools program pursuant to Chapter 5160-35 of the Administrative Code.~~
- ~~(6)~~ (10) The MCOP must ~~provide~~ ensure that all eligible members receive all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with rule 5160-1-14 of the Administrative Code, ~~to healthchek eligible members and~~ The MCOP will ensure healthchek exams:
 - (a) Include the components specified in rule 5160-1-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual external quality review.
 - (b) Are completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.
- ~~(6)~~ (11) The MCOP will provide services described in rule 5160-59-03 of the Administrative Code for members who are not enrolled in the Ohio resilience through integrated systems and excellence (OhioRISE) plan but necessitate OhioRISE services.

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~~(D)~~ MCOP service exclusions.

~~(7)~~ (1) ~~An~~ The MCOP is not required to cover services provided to members outside the United States.

~~(8)~~ (2) When a member is determined to be no longer eligible for enrollment in an MCOP during a stay in an institution for mental disease (IMD), the MCOP is not responsible for payment of that IMD stay after the date of disenrollment from the ~~plan~~ MCOP.

~~(4)~~ (3) The MCOP is not responsible for payment of services provided through the medicaid schools program pursuant to Chapter 5160-35 of the Administrative Code.

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

- (A) A MyCare Ohio plan (MCOP) 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) The MCOP will ensure PCPs are in compliance with the following triage requirements. Members with:
- (a) Emergency care needs will be triaged and treated immediately on presentation at the PCP site;
 - (b) Persistent symptoms will be treated no later than the end of the following working day after their initial contact with the PCP site; and
 - (c) Requests for routine care will be seen within six weeks.
- (2) PCP care coordination responsibilities include 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) Triageing members as described in paragraph (A)(1) of this rule.
- (B) The MCOP will have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. The MCOP will ensure decisions rendered through the UM program are based on medical necessity.
- (1) The UM program, based on written policies and procedures, will include, 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 MCOP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.
- (2) The MCOP's UM program will ensure and document the following:
- (a) An annual review and update of the UM program.
 - (b) The involvement of a designated senior physician in the UM program.
 - (c) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions.

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

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the authorization decision as expeditiously as the member's health condition requires but no later than forty-eight hours after receipt of the request for service. If requested by the member or MCOP, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCOP, the MCOP has to submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCOP's extension request, the MCOP will give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCOP will carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

- (g) For prior authorization of covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect July 1, 2022), the MCOP has to make a decision within the timeframes specified in 42 C.F.R. 423.568(b) (October 1, 2021) for standard decisions and 42 C.F.R. 423.572(a) (October 1, 2021) for expedited decisions. 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 MCOP reviews the prior authorization request.
- (h) The MCOP will maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. The MCOP's records will include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.
- (4) The MCOP may, subject to ODM approval, develop other UM programs.