Ohio | 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): January 2023 Chaper 26 Managed Care Rule Revisions

Rule Number(s): 5160-26-02.1, 5160-26-08.4, 5160-26-12

Included for informational purposes only: None.

Date of Submission for CSI Review: 9/6/2022

Public Comment Period End Date: 9/13/2022

Rule Type/Number of Rules:

New/___ rules

Amended/ 3 **rules (FYR?** No**)**

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Rescinded/____ rules (FYR?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.

   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: removing language in paragraph (E)(3)(f)(1) to align with federal requirements and reduce administrative burden.

   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: revisions to ODM form dates to reflect the most recent form revision dates.

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 language to align with ODM policy initiatives to extend the post-partum coverage period to twelve months.

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 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. 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 managed care entities listed below were provided the draft rules electronically onAugust 11, 2022. The entities were given until August 18, 2022 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.
   - Buckeye Community Health Plan
   - Gainwell Technologies
   - Ohio Association of Health Plans (OAHP)

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 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 minor changes to the managed care 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, Anthem Blue Cross and Blue Shield, and Buckeye Health Plan, CareSource 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 5160-26-08.4** 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.
    - 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.
    - 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. 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

5160-26-02.1 Managed care: 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.

(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) (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 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) Upon implementation of the single pharmacy benefit manager (SPBM), ODM will terminate a member from enrollment in the 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.

(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 unable to change to a different MCO. If the member then regains medicaid eligibility, the member may request to change plans within thirty days following reenrollment in the MCO.

(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 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 (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 (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) 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 (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 (E)(3)(f) of this rule;

(3) The following provisions apply when a member either requests a different MCO or, if applicable, requests to be returned to medicaid FFS:

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

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

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

~~(viii)~~ (vii) 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.

(F) MCO initiated terminations.

(1) 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.

(G) MCO 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.

DRAFT - NOT FOR FILING

5160-26-08.4 Managed care: appeal and grievance system.

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code.

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

(1) When an adverse benefit determination has occurred or will occur, the 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, 2021), and the NOA shall explain:

(a) The adverse benefit determination the 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 MCO or SPBM;

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

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the 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) NOAs shall be issued within the following time frames:

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

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO or SPBM, the 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 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, 2021), the 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 MCO or SPBM shall give notice simultaneously with the 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 MCO or SPBM's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal, or grievance resolution, the MCO or SPBM shall give notice simultaneously with the 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.

(1) A member may file a grievance with 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) The MCO or SPBM shall acknowledge the receipt of each grievance to the member filing the grievance. Oral acknowledgment by 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) 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, the MCO or SPBM shall provide oral notification to the member of a grievance resolution. If 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 MCO or SPBM's resolution.

(5) If 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 MCO or SPBM's denial of payment for that service, the 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.

(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. 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. The MCO or SPBM shall begin processing the appeal upon receipt of the written consent.

(3) 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 the MCO or SPBM within three business days of receipt of the appeal.

(4) 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 MCO or SPBM, or at the direction of the MCO or SPBM, in connection with the appeal of the adverse benefit determination.

(5) 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) 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) 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 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 interpretation and translation services as well as alternative formats that can be provided by the MCO or SPBM.

(9) For appeal resolutions decided in favor of the member, 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.

(1) The MCO and SPBM shall establish and maintain an expedited review process to resolve appeals when the member requests and the 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, the MCO and SPBM shall comply with the standard appeal process specified in paragraph (D) of this rule, except the 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 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.

(3) If the MCO or SPBM denies a member's request for expedited resolution of an appeal, the 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 the MCO or SPBM to resolve a grievance or a standard or expedited appeal be extended up to fourteen calendar days.

(2) 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 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 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 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) 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, 2021), members may request a state hearing only after exhausting the MCO or SPBM's appeal process. If 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 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 MCO.

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

(a) If an appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the MCO or SPBM shall simultaneously issue the "Notice of Denial of Medical Services By Your Managed Care Entity" (ODM 04043, ~~1/2018~~7/2022).

(b) If an appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as previously authorized by the MCO or SPBM, the MCO or SPBM shall issue the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Entity" (ODM 04066, ~~1/2018~~7/2022).

(c) If the MCO or SPBM learns a member has been billed for services received by the member due to the MCO or SPBM's denial of payment, and the MCO or SPBM upholds the denial of payment, the MCO or SPBM shall immediately issue the "Notice of Denial of Payment for Medical Services By Your Managed Care Entity" (ODM 04046, ~~1/2018~~7/2022).

(4) The member or member's authorized representative may request a state hearing within 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 the MCO pursuant to an MCO-initiated membership termination in accordance with rule 5160-26-02.1 of the Administrative Code.

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

(a) Complete the "Appeal Summary for Managed Care Entity" (ODM 01959, ~~7/2014~~7/2022) 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 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 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) 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 by the bureau of state hearings.

(8) The MCO or SPBM shall comply with the state hearing decision provided via the "State Hearing Decision" (JFS 04005, 01/2015). If the state hearing decision sustains the member's appeal, the 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 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 an appeal or state hearing are pending.

(1) Unless a member requests that previously authorized benefits not be continued, 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 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 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 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 the MCO or SPBM's original adverse benefit determination, at the discretion of ODM, the MCO or SPBM may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

(I) Additional provisions regarding appeals and grievances.

(1) 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 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) 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, 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

5160-26-12 Managed care: 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.

(B) The managed care organization (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 until implementation of the single pharmacy benefit manager (SPBM), prescription drugs as provided for in this rule. The MCO must receive prior approval from the Ohio department of medicaid (ODM) before notifying members that a co-payment program will be implemented.

(C) Upon implementation of the SPBM, the 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.

(D) If the MCO or SPBM implements a member co-payment program, the MCO and SPBM must:

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

(2) Not deny services to members as specified in paragraph (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, 2021);

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

(5) Ensure that the member is not billed for any difference between the 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.

(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~~twelve month 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). 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.

(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, the MCO or SPBM must still ensure that the member has access to needed services.

(G) The MCO or SPBM may 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.

(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.

(I) If the MCO has implemented a member co-payment program for non-emergency emergency department services, as described in paragraph (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)(4) of this rule, does not apply.

(J) If the MCO or SPBM 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.