Common Sense Initiative

Mike DeWine, *Governor*
Jim Tressel, *Lt. Governor*
Joseph Baker, *Director*

Business Impact Analysis

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

Rule Contact Name and Contact Information: Tommi Potter; (614) 752-3877; Rules@medicaid.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Next Generation MyCare Ohio

Rule Number(s): 5160-58-02.1, 5160-58-03.1, 5160-58-04, 5160-58-08.4

Date of Submission for CSI Review: September 8, 2025

Public Comment Period End Date: September 15, 2025

Rule Type/Number of Rules:

New/_1_ rules

Amended/_3_ rules (FYR? Yes)

No Change/____ rules (FYR? Yes)

Rescinded/_1_ rules (FYR? Yes)

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. MyCare Ohio plans (MCOPs) are considered MCOs per federal definitions. The rules in Ohio Administrative Code (OAC) Chapter 5160-58 will govern the MyCare Ohio program. There will be four 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). House Bill 33 will require the Ohio Department of Medicaid to extend MyCare Ohio to all Ohio counties.

OAC Rule 5160-58-02.1, entitled "MyCare Ohio plans: termination of enrollment" is retitled as "MyCare Ohio plans: disenrollments." This rule will be amended and filed as a five-year rule review. The rule describes circumstances which could result in removal from the MyCare Ohio program or

changes in an individual's MyCare Ohio plan enrollment, including options to change plans outside the annual open enrollment period. Changes to this rule will include a new title with softer, clearer language (changed from terminate to disenroll), more clearly explaining different kinds of disenrollment- individual program disenrollment, individual-initiated disenrollment from a plan, plan-initiated disenrollment, ODM-initiated disenrollment, removal of a duplicated section, and removal of language limiting the ODM to communications by mail.

OAC Rule 5160-58-03.1, entitled "MyCare Ohio plans: primary care and utilization management." This rule explains availability of primary care physicians (PCP) for MyCare Ohio members, development and application of utilization management programs, including prior authorization in MyCare Ohio. This rule will be amended and filed for five-year rule review. Changes to this rule will include reduction in the standard authorization decision time frame from ten days to seven days to align with provisions in the Centers for Medicare & Medicaid Services Interoperability and Prior Authorization Final rule – CMS-0057-F, reduction in the wait time for requests for routine care from six weeks to thirty days, having clinical policies available on the plans' websites, prohibition of additional utilization requirements for MyCare Ohio HCBS waiver services which were identified and approved through the person-centered services planning process, requirement to submit policies and procedures for initial and continuing authorizations, additional clarification that turnaround times for prior authorization decisions are the same for both dual-benefits enrollees and Medicaid-only enrollees, MCOP must provide written notice of prior authorization decision extensions, and reducing the time MyCare Ohio dual-benefits members would need to wait for services covered by Medicare so that it matches the wait time for Medicaid.

OAC Rule 5160-58-04, entitled "MyCare Ohio waiver: covered services and providers." This rule establishes the services covered by the MyCare Ohio home and community-based services waiver program and the providers eligible to furnish those services to members enrolled in the MyCare Ohio waiver. This rule will be amended and filed for five-year rule review. Changes to this rule will include requirement of providers to be enrolled with ODM and the MyCare Ohio plan, or enroll with the financial management services (FMS), if the member participates in self-direction.

OAC Rule 5160-58-08.4, entitled "Appeals and grievances for "MyCare Ohio"" will be retitled as "MyCare Ohio plans: grievances, appeals, and state fair hearings." This rule will be rescinded and made new. This rule describes the grievances and appeals activities for MyCare Ohio. Changes to this rule will include added sections to clarify grievance and appeal pathways which differ when a member is enrolled as dual-benefits versus enrolled for Medicaid benefits only, reorganization to clearly identify grievances processes, first-level appeals, and state fair hearings for all Medicaid-covered MyCare services, and explains how grievances and appeals are directed for Medicaid-covered services when members are enrolled with MyCare Ohio for their Medicaid benefits only.

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 5164.02, 5166.02, 5167.02, and 5167.03 authorize ODM to adopt these rules, and 5160.34, 5164.02, 5164.91, 5164.911, 5166.02, 5166.16, 5167.01, 5167.02, 5167.03, 5167.11 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. The amendment of 5160-58-03.1 is a result of CMS Interoperability and Prior Authorization Final Rule - CMS-0057-F. 42 CFR 422 imposes requirements upon fully integrated dual-eligible special needs plans (FIDE-SNP) for operation of integrated managed care plans.

5. **If the regulation implements a federal requirement, but 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. These rules ensure MCO compliance with federal regulation and are consistent with federal managed care requirements outlined in 42 CFR Part 438 and 42 CFR 422 that require the state to implement policies and regulations as the state deems necessary and appropriate. The provisions outlined in CMS Final Rule (CMS-0057-F) pose provisions that require compliance by two separate dates, January 1, 2026 and January 1, 2027.

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)?**
   House Bill 33 requires the Ohio Department of Medicaid to extend MyCare Ohio to all Ohio counties. Federal regulations require state Medicaid agencies to ensure MCO compliance with federal standards, therefore this rule ensures ODM compliance with federal regulations governing Medicaid managed care programs.

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, Sand 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 stakeholders listed below were provided the draft rules electronically on 03/31/2025 and given until 04/08/2025 to provde ODM with comments.
    - The Ohio Association of Health Plans
    - The Ohio Association of Area Agencies on Aging
    - Ohio Senior Health Insurance Information Program

    The stakeholders were afforded an opportunity to comment on the draft rules via public clearance beginning 7/2/2025, and given until 7/9/2025 to provide ODM with comments. ODM provided the draft rules directly to all members of the ODM MyCare Advisory Council for comment during the same timeframe.

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**
ODM received technical questions during preclearance from the Ohio Association of Area Agencies on Aging. ODM provided assistance to answer the questions but the questions did not have any impact on the rules' language. During the public clearance process, ODM received comments from LeadingAge Ohio, the Ohio Association of Community Health Centers, the Ohio Health Care Association, the Ohio Associaiation of Area Agencies on Aging, ProSeniors, and the Ohio Council. ODM made updates to 5160-58-01, 5160-58-02, 5160-58-05, and 5160-58-08.4 to correct typographical errors, correct terminology, and clarify the grievances and appeals process related to hybrid services.

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? *Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.*

The program is governed by the Code of Federal Regulations, US Code, and Ohio Revised Code. The program is operated through a contract between ODM and individual MyCare Ohio plans. In our outreach with stakeholders in community listening sessions, stakeholders expressed that they wanted to have clear and concise explanations of MyCare program operations.

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

    To avoid duplication, ODM incorporated by reference the regulations related to implementation of these rules. ODM confirmed that the requirements found in Chapter 58 are not duplicated elsewhere.

14. **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, BIAs, and filings affecting managed care program requirements with the Joint Committee on Agency Rule Review including RuleWatch Ohio. ODM will ensure MCOPs are made aware of any future rule changes via established communication processes.

Adverse Impact to Business

15. **Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:**

    a. **Identify the scope of the impacted business community, and**

       These rules impact MCOPs in the State of Ohio (this includes: Anthem Blue Cross and Blue Shield, Buckeye Community Health Plan, CareSource Ohio, and Molina Healthcare of Ohio).

    b. **Quantify and identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance, etc.).**

       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.

5160-58-02.1: This rule requires MCOPs to provide notice and potentially documentation to ODM upon member disenrollment from the MCOP. A precise estimate of these costs would vary depending on multiple factors, including the number of members who are disenrolled from an MCOP, and the systems employed by each MCOP to provide notice and documentation.

5160-58-03.1: This rule requires the MCOP to report information to ODM, members, and service providers including: written utilization management criteria, the MCOP's policies and procedures for initial and continuing authorizations, written notice of action for any service approval, termination, reduction, or denial, written notice of extension to service authorization decision time frame, and maintain a record of all authorization requests.

5160-58-04: This rule will require providers to be enrolled with ODM and the MyCare Ohio plan or enroll with the financial management services (FMS), if the member participates in self direction, in order to be eligible for payment of claims for services provided to MyCare Ohio waiver members. There is no cost to providers for enrolling with FMS and providers are enrolled within 14 days of completing all paperwork.

5160-58-08.4: This rule requires MCOPs to report information to ODM, members, and service providers including: written acknowledgement of receipt of grievance, notification of grievance resolutions, notification of the member's right to request a state hearing, notice of action when an adverse benefit determination occurs, acknowledgement of receipt of appeal, upon request provide the case file relied upon or generated by an MCOP in connection with the appeal, written notice of appeal resolution, notice of limited time available for member to present evidence in writing for expedited appeal, written notice of grievance and appeal resolution time frame extension, when MCOP upholds the denial of service authorization issues the "Notice of Denial of Medical Services By Your Managed Care Entity", when MCOP upholds denial of payment issues the "Notice of Denial of Payment for Medical Services By Your Managed Care Entity," completes the "Appeal Summary for Managed Care Entities" filing it with the bureau of state hearings and sending a copy to the member and member's authorized representative, and the information required by the "Order of Compliance" to the bureau of state hearings if the state hearing decision sustains the member's appeal. This rule requires service providers to report information to the MCOP including member's written consent form when filing an appeal on their behalf. A precise estimate of these costs would vary depending on multiple factors, including the number

of members and providers who file a grievance or appeal and the systems employed by each MCO to provide notice and documentation.

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 capitation rates for the MCOPs 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. Related to the adverse impacts, 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 MCOPs by ODM, MCOPs will be compensated for the cost of the requirements found in these rules. For CY 2025, the administrative component of the managed care capitation rate varies by program/population and ranges from 2.60% to 7.20% for MCOPs. Note that these amounts exclude care management and risk margin included in the capitation rates. For MCOPs, all rates and actuarial methods will be found in Appendix E ("Rate Methodology") of the MyCare Ohio provider agreement.

16. **Are there any proposed changes to the rules that will <u>reduce</u> a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).***
The proposed changes reduce the regulatory burden imposed on the business community by adding clarification and improving the readability of the rules.

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

The MCOPs are aware of the federal requirements for covered services prior to seeking and signing their contracts with the State. More importantly, without the requirements outlined in the OAC rules 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 negatively impacted by these rules, MCOPs may contact ODM directly through their assigned Contract Administrator.

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

(A) ~~A member will be terminated from enrollment in a MyCare Ohio plan (MCOP) for any of the following reasons:~~ Disenrollment from the MyCare Ohio program occurs for the following reasons:

(1) The member becomes ineligible for full benefits under the medicaid program or medicare parts A or B or D. Termination of ~~MCOP~~ MyCare Ohio 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~~ MCOP ~~enrollment~~ disenrollment 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 MCOP notifies ODM this has occurred, ~~termination of~~ MCOP ~~enrollment~~ disenrollment 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 creditable third party coverage, excepting medicare coverage.~~:~~ ~~Termination of~~ MCOP ~~enrollment~~ disenrollment is effective the end of the last day of the month in which ODM identified the third party coverage. Members report third party coverage to the county department of job and family services in accordance with rule 5160:1-2-08 of the Administrative Code.

~~(6) The provider agreement between ODM and the MCOP is terminated or not renewed. The effective date of termination shall be the date of provider agreement termination or nonrenewal.~~

~~(7)~~(6) The member is not eligible for enrollment in 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:~~ Individual disenrollments.

(1) An individual's enrollment with an MCOP is terminated when the provider agreement between ODM and the MCOP is terminated or not renewed. The

effective date of disenrollment is the date of the provider agreement termination or nonrenewal. The individual is reassigned to a new MCOP without a break in coverage in such a circumstance.

(2) All of the following apply when enrollment in a MyCare Ohio plan ends for any of the reasons set forth in paragraph (A) of this rule:

~~(1)~~(3) All ~~terminations~~ disenrollments occur at the individual level;

~~(2)~~(4) ~~Terminations~~ Disenrollments do not require completion of a consumer contact record (CCR);

~~(3)~~(5) If ODM fails to notify the MCOP of a member's ~~termination~~ disenrollment from the plan, ODM ~~shall continue~~ continues to pay the MCOP the applicable monthly premium rate for the member. The MCOP ~~shall remain~~ remains liable for the provision of covered services as set forth in rule 5160-58-03 of the Administrative Code, until ODM provides the MCOP with documentation of the member's ~~termination~~disenrollment~~.~~; and

~~(4)~~(6) ODM ~~shall recover~~recovers from the MCOP any premium paid for retroactive ~~enrollment termination~~ disenrollment occurring as a result of paragraph (A) of this rule.

(C) Member-initiated ~~terminations~~disenrollments.

(1) As permitted in 42 CFR 422.38 (October 1, 2025) a dual-benefits member may request disenrollment from the MCOP and transfer ~~between plans~~ to another MCOP on a month-to-month basis any time during the year. MCOP coverage continues until the end of the month of disenrollment.

(a) Members may also transfer medicare coverage during medicare open enrollment, a medicare special enrollment period under 42 CFR 422.62 (October 1, 2025), or when otherwise permitted by federal law.

(b) For members who choose disenrollment from a medicare plan to enroll with a MyCare Ohio plan, ODM will automatically align the member's medicaid enrollment to match the MyCare Ohio medicare selection.

(2) A medicaid-only member may request a different MCOP by contacting the Ohio medicaid consumer hotline ~~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~~

~~benefits or~~ for 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)~~ (C)(3)(e) of this rule.

~~(3) A medicaid-only member may request a different MCOP if available 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)~~(3) The following provisions apply when a member requests a different MCOP in a mandatory service area. Changes to the medicare coverage are made through medicare enrollment pathways (i.e. medicare.gov website, medicare call center, Ohio senior health insurance information program, licensed enrollment broker) and changes to medicaid-only enrollment are made through the Ohio medicaid consumer hotline:

(a) The request may be made by the member, or by the member's authorized representative. The request cannot be made by a facility in accordance with 42 CFR 435.923 (October 1, 2025).

(b) All member-initiated changes must be voluntary. MCOPs are not permitted to encourage members to change 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. MCOPs may not use a policy or practice that has the effect of discrimination on the basis of the listed 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~~ is disenrolled after the member notifies the consumer

hotline.

(d) Disenrollment ~~will take~~takes 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.~~CFR 438.56 (~~October 1, 2021~~ October 1, 2025), a change of MCOP enrollment may be permitted for any of the following just cause reasons:

(i) The member moves out of the MCOP's service area and a non-emergency service must be provided out of the service area before the effective date of a ~~termination~~ disenrollment that occurs for one of the reasons set forth in paragraph (A) of this rule;

(ii) The 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 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 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 MCOP and, as a result, would experience a disruption in their residence or employment;

(vi) The member cannot access medically necessary medicaid-covered services, under rule 5160-58-03.1 of the Administrative Code, 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 MCOP would be harmful to the interests of the member.

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

(i) The member or an authorized representative must contact the 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~~reviews all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the member and the MCOP. ODM ~~shall make~~makes a decision within ten working days of receipt of all necessary documentation, or forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.

(iv) ODM may establish retroactive ~~termination~~ disenrollment 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.

(vi) If the just cause request is not approved, ODM ~~shall notify~~ notifies 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 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 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.~~CFR 423.100 (~~October 1, 2021~~October 1, 2025) is precluded from changing MCOPs.

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

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

(a) Fraudulent behavior by the member as defined in rule 5160-26-01 of the Administrative Code; 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 MCOP's ability to provide services to either the member or other MCOP members.

(2) The MCOP may not request ~~termination~~ disenrollment 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 MCOP ~~must provide~~provides covered services to a ~~terminated~~ disenrolled member through the last day of the month in which the MCOP enrollment ~~is terminated~~ ends.

(4) If ODM approves the MCOP's request for ~~termination~~ disenrollment, ODM ~~shall notify~~ notifies in writing the member, the authorized representative, ~~the medicaid consumer hotline and the MCOP~~and the member is then assigned to another MCOP for their medicaid benefits. For dual-benefits members, this results in the member being disenrolled from the MCOPs medicare coverage as well.

(E) Open enrollment

Open enrollment for medicaid ~~months will occur~~occurs at least annually. At least

sixty days prior to the designated open enrollment month, ODM ~~will notify~~ notifies eligible individuals ~~by mail~~ of the opportunity to change enrollment in an MCOP and ~~will explain~~explains how the individual can obtain further information.

(F) Members enrolled in MyCare Ohio may exercise the choice of MCOP for their medicare benefits during their initial medicare enrollment, medicare open enrollment, or subject to 42 CFR 422.62 (October 1, 2025), 42 CFR 423.38 (October 1, 2025), or other enrollment period allowable under federal rules.

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

(A) A MyCare Ohio plan (MCOP) ~~will ensure~~ensures each member has a primary care provider (PCP) who ~~will serve~~serves as an ongoing source of primary care and ~~assist~~ assists with care coordination appropriate to the member's needs.

(1) The MCOP ~~will ensure~~ensures PCPs are in compliance with the following triage requirements. Members with:

(a) Emergency care needs ~~will be~~ are triaged and treated immediately on presentation at the PCP site;

(b) Persistent symptoms ~~will be~~ are 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~~ thirty business days.

(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;~~if necessary; and

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

(B) The MCOP ~~will have~~ operates 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~~ensures decisions rendered through the UM program are based on medical necessity.

(1) The UM program, based on written policies and procedures, ~~will include~~includes, 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~~ is made available to both contracting and non-contracting providers; and

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

(e) The MCOP cannot implement additional UM criteria for any MyCare Ohio waiver services which were identified and approved though the person-centered service planning process in accordance with rule 5160-44-02 of the Administrative Code.

(2) The MCOP's UM program ~~will ensure~~ensures and ~~document~~documents the following:

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

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

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

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

(e) That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Administrative Code. The MCOP ~~will not~~ cannot 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~~October 1, 2025).

(3) The MCOP ~~will process~~processes requests for initial and continuing authorizations of services from their providers and members. The MCOP ~~will have~~ has 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~~ are 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~~ are also made available to contracting and non-contracting providers ~~upon request~~. The MCOP ~~will ensure~~ensures and ~~document~~documents 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~~ is 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~~ is 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~~ 5160-58-08.4 of the Administrative Code.

(e) For standard authorization decisions, the MCOP ~~will provide~~provides notice to the provider and member as expeditiously as the member's health condition requires but no later than ~~ten~~ seven 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~~submits 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~~gives 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~~ carries 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~~makes an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than forty-eight hours after receipt of the request for service. If requested by the member or MCOP, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCOP, the MCOP ~~has to submit~~submits 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~~ carries 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~~January 1, 2026), the MCOP has to make a decision within the timeframes specified in 42 ~~C.F.R.~~CFR 423.568(b) (~~October 1, 2021~~October 1, 2025) for standard decisions and 42 ~~C.F.R.~~CFR 423.572(a) (~~October 1, 2021~~October 1, 2025) 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~~maintains and ~~submit~~submits 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~~includes 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) Turnaround times for authorization decisions in paragraph (B)(3) of this rule

also apply to organization determinations as described in 42 CFR 422.631 (October 1, 2025) for covered services by the medicare benefit for dual-benefits members enrolled with the MCOP.

~~(4)~~(5) The MCOP may, subject to ODM approval, develop other UM programs.

5160-58-04 **MyCare Ohio waiver: covered services and providers.**

(A) The purpose of this rule is to establish both the services covered by the MyCare Ohio home and community based services (HCBS) waiver program and the providers eligible to furnish those services to members enrolled in the MyCare Ohio waiver.

(B) Providers seeking to furnish services in the MyCare Ohio waiver program ~~shall~~ meet the requirements in Chapter 173-39, 5160-45, 5160-46, or 5160-44 of the Administrative Code, as appropriate. ~~Prior to furnishing services to MyCare Ohio waiver recipients, the services must be documented on the member's person-centered services plan as described in rule 5160-44-02 of the Administrative Code.~~

(1) Waiver services can be furnished to MyCare Ohio waiver members, of if the services are documented on the members' person-centered services plan as described in rule 5160-44-02 of the Administrative Code. Individuals who are not enrolled on the waiver are unable to receive waiver services.

(2) In order to be eligible for payment of claims for services provided to MyCare Ohio waiver members, providers need to enroll with ODM and the MyCare Ohio plan, or enroll with the financial management services (FMS), if the member participates in self direction.

(C) MyCare Ohio waiver covered services are limited to the following and exclude any reimbursement provisions in the Ohio Administrative Code rules cited therein:

(1) Adult day health services as set forth in rule 173-39-02.1 or 5160-46-04 of the Administrative Code;

(2) Alternative meal services as set forth in rule 173-39-02.2 of the Administrative Code;

(3) Assisted living services as set forth in rule 173-39-02.16 of the Administrative Code;

(4) Choices home care attendant services as set forth in rule 173-39-02.4 of the Administrative Code except MyCare waiver providers are not required to submit task sheets to the ~~financial management service (FMS)~~FMS, as identified in rule 173-39-02.4 of the Administrative Code;

(5) Community integration services as set forth in rule 173-39-02.15 or 5160-44-14 of the Administrative Code;

(6) Community transition services as set forth in rule 173-39-02.17 or 5160-44-26

of the Administrative Code;

(7) Enhanced community living services as set forth in rule 173-39-02.20 of the Administrative Code.

(8) Homemaker services as set forth in rule 173-39-02.8 of the Administrative Code;

(9) Home care attendant services as set forth in rule 173-39-02.24 or 5160-44-27 of the Administrative Code;

(10) Home delivered meal services as set forth in rule 173-39-02.14 or 5160-44-11 of the Administrative Code;

(11) Home maintenance and chore services as set forth in rule 173-39-02.5 or 5160-44-12 of the Administrative Code.

(12) Home medical equipment and supplemental adaptive and assistive devices services as set forth in rule 173-39-02.7 ~~or 5160-46-04~~ of the Administrative Code;

(13) Home modification services as set forth in rule 173-39-02.9 or 5160-44-13 of the Administrative Code;

(14) Nutrition consultation services as set forth in rule 173-39-02.10 of the Administrative Code;

(15) Out-of- home respite services as set forth in rule 173-39-02.23 or 5160-44-17 of the Administrative Code;

(16) Personal care aide services as set forth in rule 173-39-02.11 or 5160-46-04 of the Administrative Code;

(17) Personal emergency response services as set forth in rule 173-39-02.6 or 5160-44-16 of the Administrative Code;

(18) Self-directed goods and services as set forth in rule 5160-45-03.5 of the Administrative Code;

~~(18)~~(19) Social work counseling services as set forth in rule 173-39-02.12 of the

Administrative Code;

(20) Supplemental adaptive and assistive device services as set forth in rule 5160-46-04 of the Administrative Code;

(21) Structured family caregiving services as set forth in rule 5160-44-33 of the Administrative Code;

(22) Vehicle modifications as set forth in rule 5160-46-04 of the Administrative Code;

~~(19)~~(23) Waiver nursing services as set forth in rule 173-39-02.22 or 5160-44-22 of the Administrative Code; ~~and~~

~~(20)~~(24) ~~Waiver~~ Non-medical transportation services as set forth in rule 173-39-02.18 or 5160-46-04 of the Administrative ~~Code.~~Code; and

(25) Any other HCBS waiver services included in Chapters 5160-44, 5160-45, 5160-46 or Chapter 173-39 of the Administrative Code, if not specifically mentioned in this rule.

(D) If a member enrolled in the MyCare Ohio waiver is also a participant in the helping ohioans move, expanding (HOME) choice demonstration program pursuant to Chapter 5160-51 of the Administrative Code, the member may use the HOME choice community transitions service in lieu of, but not in addition to, the community transition service available through the MyCare Ohio waiver.

(E) If a member receives enhanced community living services, the member ~~shall not~~ is unable to also receive personal care or homemaker services available through the MyCare Ohio waiver.

(F) The following services may be ~~participant-directed~~ self-directed using budget ~~and/~~or employer authority. To exercise these authorities, members ~~must~~ will need to demonstrate the ability to direct providers in accordance with paragraph (D) of rule 5160-58-03.2 of the Administrative Code:

(1) Employer authority which includes, but is not limited to, the ability of the member to hire, fire, and train employees is available for the following services:

(a) Choices home care attendant services provided by a ~~participant-directed~~ self-directed individual provider;

(b) Home care attendant services provided by a self-directed provider;

~~(b)~~(c) Personal care services provided by a ~~participant-directed~~ self-directed personal care provider; ~~and~~

(d) Waiver nursing provided by a self-directed provider; and

~~(c)~~(e) Any additional services that are permitted to be self-directed under an ODM-administered waiver in Chapter 5160-45 of the Administrative Code.

(2) Budget authority which includes the ability of the member to negotiate rates of reimbursement is available in the following services:

(a) Alternative meals;

(b) Choices home care attendant services;

(c) Home care attendant services;

~~(c)~~(d) Home maintenance and chore services;

~~(d)~~(e) Home modification services;

~~(e)~~(f) Home medical equipment and supplemental adaptive and assistive devices; ~~and~~

(g) Self-directed goods and services;

(h) Waiver nursing; and

~~(f)~~(i) Any additional services that are permitted to be self-directed under an ODM-administered waiver in ~~Chapter 5160-45~~ rule 5160-45-03.2 of the Administrative Code.

5160-58-08.4 **Grievances, appeals, and state fair hearings for MyCare Ohio.**

(A) Grievances and appeals vary depending on the MyCare Ohio enrollment of the member.

(1) If the member is enrolled as a dual-benefits member, as defined in rule 5160-58-01 of the Administrative Code, then all grievances and appeals are conducted by the MyCare Ohio plan (MCOP).

(2) If the member is enrolled as a medicaid-only member, as defined in rule 5160-58-01 of the Administrative Code, then the grievances and appeals for medicare benefits are conducted by the organization(s) that provide(s) the member's medicare services in accordance with 42 CFR 422 Subpart M (October 1, 2025):

(3) If the member is enrolled as a medicaid-only member, then appeals for hybrid services, as defined in rule 5160-58-01 of the Administrative Code, the services are first appealed to medicare and then to the MyCare Ohio plan. Grievances may be made to both medicare and medicaid.

(4) If the member is enrolled as a medicaid-only member, then grievances and appeals for all services which are not covered by medicare, but which are covered by medicaid, are handled by the MCOP.

(B) Grievances are defined in rule 5160-26-01 of the Administrative Code. Members may contact their MCOP to submit a grievance.

(1) A member may file a grievance with an MCOP orally or in writing at any time. An authorized representative needs the member's written consent to file a grievance on the member's behalf.

(2) An MCOP acknowledges the receipt of each grievance to the member filing the grievance. Oral acknowledgment by an MCOP is acceptable. If the grievance is filed in writing, written acknowledgment is made within three business days of receipt of the grievance.

(3) An MCOP reviews and resolves all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, 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 all other grievances that are not regarding access to services.

(4) At a minimum, an MCOP provides oral notification to the member of a grievance resolution. If an MCOP is unable to speak directly with the

member, or the resolution includes information that needs confirmed in writing, the resolution is provided in writing simultaneously with the MCOP's resolution.

(5) If an MCOP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service, or billing of a member due to the MCOP's denial of payment for that service, the MCOP notifies the member of his or her right to request a state hearing, if the member was not previously notified.

(C) A notice of action (NOA) is sent by an MCOP to a member when an MCOP adverse benefit determination occurs or has occurred.

(1) The NOA explains:

(a) The adverse benefit determination the MCOP 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 MCOP;

(d) Information related to exhausting the MCOP appeal;

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the MCOP 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 those services; and

(i) The date the notice is issued.

(2) The following language and format requirements apply to a NOA issued by an MCOP.

(a) It is provided in a manner and format that may be easily understood by the member;

(b) It explains that oral interpretation is available for any language, written translation is available in prevalent non-English languages, as applicable, and written alternative formats may be available, as needed;

(c) It explains how to access the MCOP's interpretation and translation services, as well as, alternative formats that can be provided by the MCOP;

(d) As directed by ODM, it is printed in the prevalent non-English languages of members in the MCOP's service area; and

(e) It is available in alternative formats, and in an appropriate manner, taking into consideration the special needs of members, including, but not limited to, members who are limited visually or members who have limited reading proficiency.

(3) An MCOP issues a NOA within the following time frames:

(a) For a decision to deny or limit authorization of a requested service, the MCOP issues a NOA simultaneously with the MCOP's decision.

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

(i) If probable recipient fraud, as defined in rule 5160-26-01 of the Administrative Code, is verified, the MCOP gives 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, 2025), the MCOP gives notice on or before the effective date of the adverse benefit determination.

(c) For denial of payment for a non-covered service, the MCOP gives notice simultaneously with the MCOP's action to deny the claim, in whole or part, for a service that is not covered by medicaid, including a service determined through the MCOP's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal, or grievance resolution, the MCOP gives notice simultaneously with the MCOP becoming aware of untimely resolution. Service authorization decisions not received within the time frames specified in rules 5160-58-01.1 and 5160-58-03.1 of the Administrative Code constitute a denial and is thus considered to be an

adverse benefit determination. Notice is given on the date the authorization decision time frame expires.

(e) There are two NOA documents in MyCare Ohio:

(i) The CMS-10003 "Notice of Denial of Medical Coverage/Payment" (NDMCP) is used for services that are covered by medicare and hybrid services.

(ii) The ODM 04043 "Notice of Denial of Medical Services by Your Managed Care Entity" is used for services covered only by medicaid.

(D) Standard medicaid appeals to an MCOP may be made by a member, a member's authorized representative, or a provider. An appeal may be made orally or in writing within sixty calendar days from the date that the NOA was issued.

(1) An oral appeal filing must be followed by a written appeal. An MCOP will:

(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 will provide the member's written consent to file an appeal. MCOPs will begin processing the appeal upon receipt of the written consent.

(3) An MCOP acknowledges receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment is made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment is made by an MCOP within three business days of receipt of the appeal.

(4) An MCOP provides members a 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 or member's authorized representative is provided, free of charge and sufficiently in advance of the resolution time frame, the case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon or generated by an MCOP, or at the direction of an MCOP, in connection with the appeal of the adverse benefit determination.

(5) An MCOP considers the member, the member's authorized representative, and an estate representative of a deceased member as parties to the appeal.

(6) An MCOP reviews and resolves each appeal as expeditiously as the member's

health condition requires, but the resolution time frame may not exceed fifteen calendar days from the receipt of the appeal unless the resolution time frame is extended.

(7) An MCOP provides 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 includes the resolution decision and date of the resolution.

(8) For medicaid appeal resolutions not resolved wholly in the member's favor, the written notice to the member also includes 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; and

(ii) How to request the continuation of benefits.

(c) Oral interpretation is available for any language;

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

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

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

(9) For medicare or hybrid services, the MCOP provides information explaining the steps involved for a second level appeal in accordance with 42 CFR 422.633, as applicable.

(10) For appeal resolutions decided in favor of the member, an MCOP:

(a) Authorizes or provides 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) Pays for the disputed services if the member received the services while the appeal was pending.

(11) Standard appeals for integrated services are determined in accordance with 42 CFR 422.633, as applicable.

(E) Expedited appeals to an MCOP.

(1) An MCOP establishes and maintains an expedited review process to resolve appeals when the member requests and the MCOP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(2) In utilizing an expedited appeal process, an MCOP complies with the standard appeal process specified in paragraph (F) of this rule, except that the MCOP:

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

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

(c) Informs 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) Resolves the appeal as expeditiously as the member's health condition requires, but the resolution time frame cannot exceed seventy-two hours from the date the MCOP received the appeal unless the resolution time frame is extended as outlined in paragraph (F) of this rule;

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

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

(3) If an MCOP denies the request for expedited resolution of an appeal, the MCOP:

(a) Transfers 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; and

(b) Makes 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.

(4) Expedited appeals for integrated services are processed in accordance with 42

CFR 422.633, as applicable.

(F) Grievance and appeal resolution extensions.

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

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

(a) The MCOP seeks such an extension from ODM prior to the expiration of the standard or expedited appeal or grievance resolution time frame;

(b) The MCOP request is 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 MCOP immediately gives the member written notice of the extension, and includes the following components in the notice:

(i) The MCOP's reason for needing the extension;

(ii) The date a decision will be made; and

(iii) Informs the member of their right to file a grievance if the member disagrees with the extension.

(3) The MCOP maintains documentation of any extension request.

(4) The MCOP processes extensions for Part B drugs in accordance with 42 CFR 422.590, as applicable.

(G) Access to state's hearing system.

(1) In accordance with 42 CFR 438.402 (October 1, 2025), members may request a state hearing only after exhausting the MCOP's appeal process for hybrid services or medicaid-only services. If an MCOP fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the MCOP appeal process and may request a state hearing.

(2) When required by paragraph (C)(3) of this rule, and in accordance with division 5101:6 of the Administrative Code, an MCOP notifies members, and any authorized representatives on file with the MCOP, of the right to a state hearing subject to the following requirements:

(a) If an MCOP appeal resolution upholds the denial of a request for the authorization of a service, in whole or in part, the MCOP simultaneously issues the "Notice of Denial of Medical Services By Your Managed Care Entity" (ODM 04043).

(b) If an MCOP appeal resolution upholds the decision to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the MCOP, the MCOP issues the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Entity" (ODM 04066).

(c) If an MCOP learns a member was billed for services received by the member due to the MCOP's denial of payment, and the MCOP upholds the denial of payment, the MCOP immediately issues the "Notice of Denial of Payment for Medical Services By Your Managed Care Entity" (ODM 04046).

(3) The member or the 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).

(4) There are no state hearing rights for a member disenrolled from an MCOP pursuant to an MCOP-initiated membership disenrollment in accordance with rule 5160-58-02.1 of the Administrative Code.

(5) Following the bureau of state hearing's notification to an MCOP that a member requested a state hearing, the MCOP:

(a) Completes the "Appeal Summary for Managed Care Entities" (ODM 01959) with appropriate supporting attachments, and files it with the bureau of state hearings, at least three business days prior to the scheduled hearing date. The appeal summary includes all facts and documents relevant to the issue and is sufficient to demonstrate the basis for the MCOP's adverse benefit determination;

(b) Sends 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 then the MCOP continues or reinstates the benefit(s) if the MCOP is notified the member's state hearing request was received within fifteen calendar days from the date of the appeal resolution.

(6) An MCOP participates in the state hearing, in person or by telephone, on the

date indicated on the "Notice to Appear for a Scheduled Hearing" (JFS 04002) sent to the MCOP by the bureau of state hearings.

(7) An MCOP complies with the state hearing decision provided to the MCOP via the "State Hearing Decision" (JFS 04005). If the state hearing decision sustains the member's appeal, the MCOP submits the information required by the "Order of Compliance" (JFS 04068) 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 MCOP:

(a) Authorizes or provides 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) Pays for the disputed services if the member received the services while the appeal was pending.

(H) Continuation of benefits while the appeal to an MCOP or state hearing is pending.

(1) Unless a member requests that previously authorized benefits not be continued, an MCOP continues a member's benefits when all the following conditions are met:

(a) The member requests an appeal within fifteen calendar days of the MCOP issuing the NOA;

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

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

(d) The authorization period has not expired.

(2) If an MCOP continues or reinstates the member's benefits while the appeal or state hearing are pending, the benefits are 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 calendar days after the MCOP issues an adverse appeal resolution; or

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

(3) If the final resolution of the appeal or state hearing upholds an MCOP's original adverse benefit determination the MCOP may recover the cost of the services furnished to the member while the appeal and/or state hearing was pending.

(I) Other duties of an MCOP regarding appeals and grievances.

(1) An MCOP gives members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:

(a) Explaining the MCOP'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 grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) An MCOP ensures 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 MCOP takes into account all comments, documents, records, and other information submitted by the member and their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

TO BE RESCINDED

5160-58-08.4 **Appeals and grievances for "MyCare Ohio".**

(A) Notice of action (NOA) by a MyCare Ohio plan (MCOP).

(1) When an MCOP adverse benefit determination has or will occur, the MCOP shall provide the affected member with a NOA.

(2) The NOA shall explain:

(a) The adverse benefit determination the MCOP 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 MCOP;

(d) Information related to exhausting the MCOP appeal;

(e) The member's right to request a state hearing through the state's hearing system upon exhausting the MCOP 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 those services;

(i) The date the notice is issued;

(3) The following language and format requirements apply to a NOA issued by an MCOP:

(a) It shall be provided in a manner and format that may be easily understood;

(b) It shall explain that oral interpretation is available for any language, written translation is available in prevalent non-English languages as applicable, and written alternative formats may be available as needed;

(c) It shall explain how to access the MCOP's interpretation and translation services as well as alternative formats that can be provided by the MCOP;

(d) When directed by ODM, it shall be printed in the prevalent non-English languages of members in the MCOP's service area; and

(e) It shall be available in alternative formats, and in an appropriate manner, taking into consideration the special needs of members, including but not limited to members who are visually limited and members who have limited reading proficiency.

(4) An MCOP shall issue a NOA within the following time frames:

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

(b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCOP, the MCOP 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 MCOP 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, 2022), the MCOP 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 MCOP shall give notice simultaneously with the MCOP's action to deny the claim, in whole or part, for a service that is not covered by medicaid, including a service that was determined through the MCOP's prior authorization process as not medically necessary.

(d) For untimely prior authorization, appeal, or grievance resolution, the MCOP shall give notice simultaneously with the MCOP becoming aware of the untimely resolution. Service authorization decisions not reached within the time frames specified in rules 5160-26-03.1 and 5160-58-01.1 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.

(B) Grievances to an MCOP.

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

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

(3) An MCOP 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 all other grievances that are not regarding access to services.

(4) At a minimum, an MCOP shall provide oral notification to the member of a grievance resolution. If an MCOP 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 MCOP's resolution.

(5) If an MCOP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service, or billing of a member due to the MCOP's denial of payment for that service, the MCOP 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.

(C) Standard appeal to an MCOP.

(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 by a written appeal. An MCOP shall:

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

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

(2) Any provider acting on the member's behalf shall have the member's written consent to file an appeal. An MCOP must begin processing the appeal upon receipt of the written consent.

(3) An MCOP shall acknowledge receipt of each appeal to the member filing the appeal. At a minimum, acknowledgment shall be made in the same manner the appeal was filed. If an appeal is filed in writing, written acknowledgment shall be made by an MCOP within three business days of receipt of the appeal.

(4) An MCOP shall provide members a 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, and any other documents and records, and any new or additional evidence considered, relied upon or generated by an MCOP, or at the direction of an MCOP, in connection with the appeal of the adverse benefit determination.

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

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

(7) An MCOP 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; and

(ii) How to request the continuation of benefits.

(c) Oral interpretation is available for any language;

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

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

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

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

(D) Expedited appeals to an MCOP.

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

(2) In utilizing an expedited appeal process, an MCOP shall comply with the standard appeal process specified in paragraph (C) of this rule, except the MCOP 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 MCOP received the appeal unless the resolution time frame is extended as outlined in paragraph (E) 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 an MCOP denies the request for expedited resolution of an appeal, the MCOP 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 (E) of this rule; and

(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.

(E) Grievance and appeal resolution extensions.

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

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

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

(b) The MCOP 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 MCOP shall immediately give the member written notice of the extension, and include the following components in the notice:

(i) The MCOP's reason for needing the extension;

(ii) The date a decision will be made; and

(iii) Inform the member of their right to file a grievance if the member disagrees with the extension.

(3) The MCOP shall maintain documentation of any extension request.

(F) Access to state's hearing system.

(1) In accordance with 42 CFR 438.402 (October 1, 2022), members may request a state hearing only after exhausting the MCOP's appeal process. If an MCOP fails to adhere to the notice and timing requirements for appeals set forth in this rule, the member is deemed to have exhausted the MCOP appeal process and may request a state hearing.

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

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

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

(c) If an MCOP learns a member has been billed for services received by the member due to the MCOP's denial of payment, and the MCOP upholds the denial of payment, the MCOP shall immediately issue the "Notice of Denial of Payment for Medical Services By Your Managed Care Entity" (ODM 04046).

(3) The member or the member's authorized representative may request a state hearing within ninety 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).

(4) There are no state hearing rights for a member terminated from an MCOP pursuant to an MCOP-initiated membership termination in accordance with rule 5160-58-02.1 of the Administrative Code.

(5) Following the bureau of state hearing's notification to an MCOP that a member has requested a state hearing, the MCOP shall:

(a) Complete the "Appeal Summary for Managed Care Entities" (ODM 01959) 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 MCOP'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 (G)(1) of this rule, continue or reinstate the benefit(s) if the MCOP is notified the member's state hearing request was received within fifteen days from the date of the appeal resolution.

(6) An MCOP 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) sent to the MCOP by the bureau of state hearings.

(7) An MCOP shall comply with the state hearing decision provided to the MCOP via the "State Hearing Decision" (JFS 04005). If the state hearing decision sustains the member's appeal, the MCOP shall submit the information required by the "Order of Compliance" (JFS 04068) 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 MCOP 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.

(G) Continuation of benefits while the appeal to an MCOP or state hearing are pending.

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

(a) The member requests an appeal within fifteen days of the MCOP issuing the NOA;

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

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

(d) The authorization period has not expired.

(2) If an MCOP 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 MCOP issues an adverse appeal resolution; or

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

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

(H) Other duties of an MCOP regarding appeals and grievances.

(1) An MCOP shall give members all reasonable assistance filing a grievance, an appeal, or a state hearing request including but not limited to:

(a) Explaining the MCOP'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 grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) An MCOP 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 MCOP shall take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

Effective:

Five Year Review (FYR) Dates:

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Certification

_____

Date

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