

# Managed Health Care Table of Contents

**John R. Kasich, Governor**

**John B. McCarthy, Director**

## Ohio Department of Medicaid

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# Managed Care Transmittal Letters (MCTLs)

# MCTL 45 (OAC Chapter 5160-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 45

March 20, 2015

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5160-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating Ohio Administrative Code (OAC) rule revisions for Medicaid managed health care programs. The effective date for the enactment of these rule revisions is April 1, 2015.

### **General Provisions**

The amended rule identified below has been revised in order to comply with five year rule review requirements and update and clarify provisions for Medicaid managed care plans (MCPs).

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

### **Instructions**

Remove and file as obsolete rule 5160-26-02, effective 07-01-2013, and replace with rule [5160-26-02](#), effective 04-01-2015.

### **Access to Rules and Related Materials**

The main Ohio Department of Job and Family Services (ODJFS) web page includes links to valuable information about its services and programs; the address is <http://www.ifs.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) may be accessed through the ODJFS main page or directly at <http://www.medicaid.ohio.gov> ODJFS maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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The Legal/Policy Central - Calendar site, <http://www.odjfs.state.oh.us/lpc/calendar/>, is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS and Medicaid letters, <http://www.odjfs.state.oh.us/lpc/mtl/>. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document. To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Medicaid

Bureau of Managed Care

P.O. Box 182709

Columbus, OH 43218-2709

# MCTL 44 (OAC Chapter 5160-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 44

March 3, 2015

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5160-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating Ohio Administrative Code (OAC) rule revisions for Medicaid managed health care programs. The effective date for the enactment of these rule revisions is March 6, 2015.

### **General Provisions**

The amended rule identified below has been revised in order to comply with five year rule review requirements and update and clarify provisions for Medicaid managed care plans (MCPs). Additionally, the creation of the Ohio Department of Medicaid in Am. Sub. H.B. 59 (130th General Assembly) requires the department references in rule to change from "Ohio Department of Job and Family Services (ODJFS)" to the "Ohio Department of Medicaid (ODM)" and applicable rule citations in the Ohio Administrative Code to change from 5101 to 5160.

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

### **Instructions**

Remove and file as obsolete rule 5160-26-08.4, effective 01-01-2012, and replace with rule 5160-26-08.4, effective 03-06-2015.

### **Access to Rules and Related Materials**

The main Ohio Department of Job and Family Services (ODJFS) web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid (ODM) may be accessed through the ODJFS main page or directly at <http://www.medicaid.ohio.gov>

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## **Questions**

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Bureau of Managed Care

P.O. Box 182709

Columbus, OH 43218-2709

# MCTL 43 (OAC Chapter 5160-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 43

January 13, 2015

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5160-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating Ohio Administrative Code (OAC) rule revisions for Medicaid managed health care programs. The effective date for the enactment of these rule revisions is February 1, 2015.

### **General Provisions**

The amended and rescinded rules identified below are being proposed in order to comply with five year rule review requirements and update and clarify provisions for Medicaid managed care plans (MCPs). Additionally, the creation of the Ohio Department of Medicaid in Am. Sub. H.B. 59 (130th General Assembly) requires the department references in rule to change from "Ohio Department of Job and Family Services (ODJFS)" to the "Ohio Department of Medicaid (ODM)" and applicable rule citations in the Ohio Administrative Code to change from 5101 to 5160.

Rule [5160-26-01](#), entitled Managed health care programs: definitions, is being proposed for amendment due to five year rule review. The rule sets forth definitions related to the administration of the Medicaid managed care program and managed care plans (MCPs). Changes to the rule add definitions for subcontractor and authorized representative, and update the definitions of Medicaid consumer hotline, intermediate care facility, nursing facility, Ohio Department of Medicaid, oral interpretation services, oral translation services, program of all-inclusive care, primary care provider and subcontract. Other amendments to the rule delete references to automatic termination, corrective action plan, case, external quality review organization, quality assessment and performance improvement program, and termination. Additional amendments to the rule update legal citations and cross-references.

Rule [5160-26-04](#), entitled Managed health care programs: procurement and plan selection, is being proposed for rescission due to five year rule review. The rule sets forth the process for procurement and for selection of MCPs.

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

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

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

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

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

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

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

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

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

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

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

## **Instructions**

Remove and file as obsolete rule 5160-26-01, effective 07-01-2013, and replace with rule [5160-26-01](#), effective 02-01-2015.

Remove and file as obsolete rule [5160-26-04](#), effective 02-01-2015.

Remove and file as obsolete rule 5160-26-06, effective 07-01-2013, and replace with rule [5160-26-06](#), effective 02-01-2015.

Remove and file as obsolete rule [5160-26-07](#), effective 02-01-2015.

Remove and file as obsolete rule [5160-26-07.1](#), effective 02-01-2015.

Remove and file as obsolete rule 5160-26-08, effective 04-14-2009, and replace with rule [5160-26-08](#), effective 02-01-2015.

Remove and file as obsolete rule [5160-26-08.1](#), effective 02-01-2015.

Remove and file as obsolete rule 5160-26-08.2, effective 01-01-2012, and replace with rule [5160-26-08.2](#), effective 02-01-2015.

Remove and file as obsolete rule 5160-26-08.3, effective 07-01-2013, and replace with rule [5160-26-08.3](#), effective 02-01-2015.

Remove and file as obsolete rule [5160-26-08.5](#) effective 02-01-2015.

Remove and file as obsolete rule 5160-26-09, effective 04-14-2009, and replace with rule [5160-26-09](#), effective 02-01-2015.

Remove and file as obsolete rule 5160-26-11, effective 07-01-2013, and replace with rule [5160-26-11](#), effective 02-01-2015.

Remove and file as obsolete rule 5160-26-12, effective 10-1-2011, and replace with rule [5160-26-12](#), effective 02-01-2015.

### **Access to Rules and Related Materials**

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### **Questions**

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Ohio Department of Medicaid

Bureau of Managed Care

P.O. Box 182709

Columbus, OH 43218-2709

# MCTL 42 (OAC Chapter 5160-58 Rules for Mycare Ohio Plans)

## Managed Care Transmittal Letter No. 42

November 18, 2014

TO: Chief Executive Officers, MyCare Ohio Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5160-58 RULES FOR MYCARE OHIO PLANS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating Ohio Administrative Code (OAC) rule revisions for Medicaid managed health care programs. The effective date for the amendment of the rule listed below is December 1, 2014.

### **General Provisions**

Rule [5160-58-08.4](#), entitled Appeals and grievances for MyCare Ohio, sets forth the appeals, grievances and state hearing provisions for MyCare Ohio plan members. This rule requires a MyCare Ohio plan to have three avenues allowing a member to challenge certain actions taken by the MyCare Ohio plan: (1) a grievance process, (2) an appeal to the MyCare Ohio plan, and (3) a process allowing members to access the State's hearing system through the Ohio Department of Job and Family Services (ODJFS). The rule sets forth detailed requirements for each of these three avenues, and prescribes the manner in which members must be advised of actions by the MyCare Ohio plan, so that the members receive clear and timely notice of plan actions that will affect the services they receive. It also describes the circumstances under which benefits may be continued while an appeal is pending. Changes to the rule update language regarding the obligations of the MCPs with respect to the State hearings system. Additional amendments to the rule update a cross-reference and form references.

### **Instructions**

Remove and file as obsolete rule 5160-58-08.4, effective 03-01-2014, and replace with rule 5160-58-08.4, effective 12-01-2014.

### **Electronic Distribution**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the Ohio Department of Medicaid's rules, manuals, and handbooks. The URL is as follows:

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At the "electronic manuals" web page, this MCTL, and any attachments, may be viewed as follows:

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- (2) Select "Managed Health Care."
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- (5) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

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### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Medicaid

Bureau of Managed Care

P.O. Box 182709

Columbus, OH 43218-2709

# MCTL 41 (OAC Chapter 5160-58 Rules for MyCare Ohio Plans)

## Managed Care Transmittal Letter No. 41

February 19, 2014

TO: Chief Executive Officers, MyCare Ohio Plans  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5160-58 RULES FOR MYCARE OHIO PLANS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating Ohio Administrative Code (OAC) rule revisions for Medicaid managed health care programs. The effective date for the enactment of the rules listed below is March 1, 2014.

### **General Provisions**

The rules identified below implement a Medicare-Medicaid Integrated Care Delivery System (ICDS), which will be known as MyCare Ohio. The goal of the MyCare Ohio program is to manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees.

Rule [5160-58-01](#), entitled MyCare Ohio plans: definitions, is a proposed new rule that sets forth operational definitions for MyCare Ohio plans. With some exceptions, the definitions set forth in rule 5160-26-01 of the Administrative Code also apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code. The proposed rule explains the definitions that will be different for MyCare Ohio, and sets forth additional definitions that will only apply to MyCare Ohio.

Rule [5160-58-01.1](#), entitled MyCare Ohio plans: application of general managed care rules, describes the manner in which the general Medicaid managed care rules in Chapter 5160-26 of the Administrative Code will apply to MyCare Ohio. Since MyCare Ohio plans are also Medicaid managed care plans, most of the provisions in Chapter 5160-26 will apply to them. Some requirements will be different for MyCare Ohio plans, and the proposed rule explains those differences.

Rule [5160-58-02](#), entitled MyCare Ohio plans: eligibility, membership, and automatic renewal of membership describes the categories of individuals who are eligible for enrollment in MyCare Ohio plans. The proposed new rule also describes the process by which eligible individuals will be enrolled in MyCare Ohio plans, including the assignment of individuals who do not choose a MyCare Ohio plan after a notice of mandatory selection is sent to them.

Rule [5160-58-02.1](#), entitled MyCare Ohio plans: termination of membership establishes reasons for membership termination from a MyCare Ohio plan and the processes to be used when a member is terminated from a plan. The proposed rule describes circumstances that will be considered just cause when a member either requests a different plan or, where enrollment is not mandatory, requests disenrollment from the MyCare Ohio program. The proposed rule also includes grounds for termination when a plan seeks to terminate a member.

Rule [5160-58-02.2](#), entitled MyCare Ohio waiver: eligibility and enrollment, sets forth waiver eligibility requirements. The proposed new rule sets forth the eligibility and enrollment criteria for individuals participating in the MyCare Ohio Waiver. The rule also sets forth the circumstances under which a MyCare Ohio Waiver applicant may be denied enrollment, and under which a member may be disenrolled from the waiver.

Rule [5160-58-03](#), entitled MyCare Ohio plans: covered services, sets forth the Medicaid benefit package for beneficiaries served by MyCare Ohio plans. The proposed new rule describes the obligations of MyCare Ohio plans for ensuring that their members have access to all medically-necessary services covered by Medicaid. When services are provided for an emergency medical condition, a MyCare Ohio plan may be obligated to pay service providers that do not contract with the plan. Such payment may be required for the emergency services themselves, and for subsequent services after an emergency medical condition has been stabilized.

Rule [5160-58-03.2](#), entitled MyCare Ohio HCBS Waiver Program: Member Choice, Control, Responsibilities and Participant Direction, sets forth the choices and accompanying responsibilities of members enrolled in the MyCare Ohio Waiver. This rule also outlines the support that MyCare Ohio plans shall provide to members enrolled in the waiver including assistance with participant direction.

Rule [5160-58-04](#), entitled MyCare Ohio HCBS Waiver Program Covered Services and Providers, sets forth the services that are covered by the MyCare Ohio Waiver and the providers eligible to furnish those services. The waiver's covered services include adult day health, alternative meals, assisted living, Choices home care attendant, chore, community transition, emergency response, enhanced community living, homemaker, home care attendant, home delivered meals, home medical equipment and supplemental adaptive and assistive devices, home modification, maintenance and repair, independent living assistance, nutrition consultation, out-of-home respite, personal care, pest control, social work counseling, waiver nursing and waiver transportation services. Providers seeking to furnish services in the MyCare Ohio Waiver must meet the requirements of Chapters 173-39 or 5160-45 of the Administrative Code, as appropriate, prior to furnishing waiver services. They must also meet the provider requirements for the specific service they wish to provide. The rule also establishes that participant direction may be available to a member for Choices home care attendant, personal care, alternative meals, home modification, maintenance and repair, pest control and home medical equipment and supplemental adaptive and assistive devices.

Rule [5160-58-05.3](#), entitled MyCare Ohio waiver: Incident Management System, sets forth that ODM and its designees (including MyCare Ohio plans) must assure the health and welfare of MyCare Ohio waiver members by protecting them from abuse, neglect, and exploitation and other threats to their well-being. The rule establishes an "incident management system" that applies to Ohio Department of Medicaid (ODM), MyCare Ohio plans, their designees, service providers and MyCare Ohio Waiver members. The incident management system includes responsibilities for reporting, responding to, investigating and remediating incidents involving members. ODM has the authority to designate other agencies or entities to perform one or more of the incident management functions set forth in the rule.

Rule [5160-58-08.4](#), entitled Appeals and grievances for MyCare Ohio, sets forth the appeals, grievances and state hearing provisions for MyCare Ohio plan members. The proposed new rule requires a MyCare Ohio plan to have three avenues allowing a member to challenge certain actions taken by the MyCare Ohio plan: (1) a grievance process, (2) an appeal to the MyCare Ohio plan, and (3) a process allowing members to access the State's hearing system through the Ohio Department of Job and Family Services (ODJFS). The proposed rule sets forth detailed requirements for each of these three avenues, and prescribes the manner in which members must be advised of actions by the MyCare Ohio plan, so that the members receive clear and timely notice of plan actions that will affect the services they receive. It also describes the circumstances under which benefits may be continued while an appeal is pending.

## **Instructions**

Insert new rules 5160-58-01 to 5160-58-08.4

## **Electronic Distribution**

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**Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Medicaid

Bureau of Managed Care

P.O. Box 182709

Columbus, OH 43218-2709

# MCTL 40 (OAC Chapter 5160-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 40

January 9, 2014

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5160-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating Ohio Administrative Code (OAC) rule changes for Medicaid managed health care programs. The effective date for the enactment of the rule changes is January 1, 2014.

*Please note that with the establishment of the Ohio Department of Medicaid as an independent entity, administrative rules affecting providers have been renumbered: Rule numbers formerly beginning with 5101:3 now begin with 5160. It is likely, however, that these rules will continue to be referred to for some time by their old 5101:3 numbers, especially in online sources.*

### **General Provisions**

Rule [5160-26-03](#) entitled Managed health care programs: covered services, is being proposed for amendment, to update policy relating to the administration of the Medicaid program. This rule sets forth the covered services that Medicaid managed care plans are required to provide to Medicaid managed care members. The rule is being amended to add respite services for Medicaid children enrolled in Medicaid managed care plans who are under the age of 21 years and eligible for Supplemental Security Income (SSI). "Respite services" are services that provide short-term, temporary relief to an informal unpaid caregiver of an individual under the age of 21 in order to support and preserve the primary caregiving relationship. Other amendments clarify language describing the obligations of MCPs regarding payment for emergency conditions and update cross-references and legal citations.

Rule [5160-26-09.1](#), entitled Managed health care programs: third party recovery is being proposed for amendment, to update policy relating to the administration of the Medicaid program and comply with five year rule review requirements. The amendments to this rule address an MCP's obligation to report all cases of suspected fraud and abuse by providers subcontracting with the MCP, and specify the circumstances under which an MCP may keep the funds recovered as the result of the identification of fraud and abuse. Other amendments clarify the coordination of benefits for prenatal and preventive pediatric services, update cross-references and legal citations, and change the agency's name from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM).

### **Instructions**

Remove and file as obsolete rule [5160-26-03](#), effective 07-01-2013, and replace with rule 5160-26-03, effective 01-01-2014.

Remove and file as obsolete rule [5160-26-09.1](#), effective 08-01-2011, and replace with rule 5160-26-09.1, effective 01-01-2014.

### **Electronic Distribution**

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### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Medicaid  
Bureau of Managed Care  
P.O. Box 182709  
Columbus, OH 43218-2709

# MCTL 39 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 39

September 25, 2013

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating an Ohio Administrative Code (OAC) rule change for Medicaid managed health care programs. The effective date for the enactment of the rule change is October 1, 2013.

### **General Provisions**

Rule [5101:3-26-03.1](#), entitled Managed health care programs: care coordination, is being proposed for amendment. This rule sets forth care coordination requirements for Medicaid managed care plans (MCPs). This rule is being amended to comply with five year rule review requirements. Changes to the rule update and simplify a federal law citation, change the term "care treatment plan" to "care plan" and clarify the duties of a primary care provider in developing a care plan. Additionally, the rule changes the department's name from the "Ohio Department of Job and Family Services (ODJFS)" to the "Ohio Department of Medicaid (ODM)."

### **Instructions**

Remove and file as obsolete rule 5101:3-26-03.1, effective 01-01-2012, and replace with rule [5101:3-26-03.1](#), effective 10-01-2013.

### **Electronic Distribution**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the Ohio Department of Medicaid's rules, manuals, and handbooks. The URL is as follows:

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- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Managed Health Care."
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### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Medicaid  
Bureau of Managed Care  
P.O. Box 182709  
Columbus, OH 43218-2709

# MCTL 38 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 38

July 1, 2013

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, State Medicaid Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating Ohio Administrative Code (OAC) rule changes for Medicaid managed health care programs. The effective date for the enactment of these changes is July 1, 2013.

### **General Provisions**

The rules identified below are being amended in order to comply with five year rule review requirements, update and clarify provisions for Medicaid managed care plans (MCPs) and change the department's name from the "Ohio Department of Job and Family Services (ODJFS)" to the "Ohio Department of Medicaid (ODM)" in anticipation of the new department being established on July 1, 2013.

Rule [5101:3-26-01](#), entitled Managed health care programs: definitions, is being proposed for amendment. This rule sets forth definitions related to the Medicaid managed care program and MCPs. Proposed changes to the rule update the definitions of care plan, HealthChek and MCEC (managed care enrollment center), add a reference for the new "Ohio Department of Mental Health and Addiction Services" being established on July 1, 2013; and delete references to the "Ohio Department of Mental Health" and "Ohio Department of Alcohol and Drug Addiction Services."

Rule [5101:3-26-02](#), entitled Managed health care programs: eligibility, membership, and automatic renewal of membership, is being proposed for amendment. This rule sets forth the eligibility and membership provisions for MCPs. Proposed changes to the rule affect language to identify the groups eligible for Medicaid MCP enrollment, remove the option delaying the effective date of MCP coverage for persons hospitalized on their effective date of coverage, delete the requirement that an assistance group must always be enrolled in the same MCP, and update the prohibitions against discrimination.

Rule [5101:3-26-02.1](#), entitled Managed health care programs: termination of membership, is being proposed for amendment. This rule sets forth membership termination provisions for MCP members. Proposed changes to the rule add language clarifying when members with nursing facility stays will be disenrolled from the MCP.

Rule [5101:3-26-03](#), entitled Managed health care programs: covered services, is being proposed for amendment. This rule sets forth the covered services that Medicaid MCPs are required to provide to Medicaid managed care members. This rule is being amended to comply with five year rule review requirements. Proposed changes to the rule clarify and update the requirements surrounding the medical necessity criteria and the coverage of nursing facility short-term rehabilitative stays for managed care members. The rule amendments also reference the new "Ohio Department of Mental Health and Addiction Services" being established on July 1, 2013.

Rule [5101:3-26-05.1](#), entitled Managed health care programs: provider services, is being proposed for amendment. This rule sets forth MCP responsibilities to subcontracting providers. This rule is being amended to comply with five year rule review requirements.

Rule [5101:3-26-06](#), entitled Managed health care programs: program integrity - fraud and abuse, audits, reporting and record retention, is being proposed for amendment. This rule sets forth provisions for Medicaid MCP program integrity, including specific requirements on MCPs to guard against fraud and abuse, audits, the submission of reports, and record retention. Proposed changes to the rule add language to increase the length of time for record retention and require MCPs to provide readily available access to electronic records.

Rule [5101:3-26-08.3](#), entitled Managed health care programs: member rights, is being proposed for amendment. This rule sets forth the members' rights requirements for MCPs. This rule is being amended to comply with five year rule review requirements.

Rule [5101:3-26-11](#), entitled Managed health care programs: managed care plan non-contracting providers, is being proposed for amendment. This rule sets forth requirements for Medicaid MCP non-contracting providers. This rule is being amended to comply with five year rule review requirements.

### **Instructions**

Remove and file as obsolete rule 5101:3-26-01, effective 01-01-12, and replace with rule 5101:3-26-01, effective 07-01-2013.

Remove and file as obsolete rule 5101:3-26-02, effective 08-01-2011, and replace with rule 5101:3-26-02, effective 07-01-2013.

Remove and file as obsolete rule 5101:3-26-02.1, effective 08-01-2010, and replace with rule 5101:3-26-02.1, effective 07-01-2013.

Remove and file as obsolete rule 5101:3-26-03, effective 10-1-2011, and replace with rule 5101:3-26-03, effective 07-01-2013.

Remove and file as obsolete rule 5101:3-26-05.1, effective 09-15-2008, and replace with rule 5101:3-26-05.1, effective 07-01-2013.

Remove and file as obsolete rule 5101:3-26-06, effective 04-14-2009, and replace with rule 5101:3-26-06, effective 07-01-2013.

Remove and file as obsolete rule 5101:3-26-08.3, effective 01-01-2008, and replace with rule 5101:3-26-08.3, effective 07-01-2013.

Remove and file as obsolete rule 5101:3-26-11, effective 01-01-2008, and replace with rule 5101:3-26-11, effective 07-01-2013.

### **Electronic Distribution**

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- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Managed Health Care."
- (3) Select " Managed Care Transmittal Letters (MCTLs)."
- (4) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired MCTL number.
- (5) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

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### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Office of Medical Assistance  
Bureau of Managed Care  
P.O. Box 182709  
Columbus, OH 43218-2709

# **MCTL 37 (OAC Chapter 5101:3-25 Rules for Children's Buy-In Program)**

## **Managed Care Transmittal Letter No. 37**

December 20, 2011

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-25 RULES FOR CHILDREN'S BUY-IN PROGRAM

By issuing this letter, the Bureau of Policy and Health Plan Services (BPHPS) is communicating Ohio Administrative Code (OAC) rule changes for the Children's buy-in program.

### **General Provisions**

Ohio Administrative Code Chapter 5101:3-25 for the Children's Buy-in (CBI) program is being rescinded in accordance with Section 309.33.60 of Am. Sub. H.B. 153, 129th General Assembly, which repealed the CBI program, effective October 1, 2011. Eligible persons may receive services under the CBI program through December 31, 2011. The Department has no liability to reimburse any provider or person for claims for services rendered on or after January 1, 2012. Rules [5101:3-25-01](#) to [5101:3-25-12](#) are rescinded.

**The effective date for the enactment of the rescinded rules is January 1, 2012.**

### **Instructions**

Delete rules [5101:3-25-01](#) to [5101:3-25-12](#).

### **Electronic Distribution**

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### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Policy and Health Plan Services  
P.O. Box 182709  
Columbus, OH 43218-2709

# MCTL 36 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 36

December 22, 2011

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Policy and Health Plan Services (BPHPS) is communicating Ohio Administrative Code (OAC) rule changes for Medicaid managed health care programs. The effective date for the enactment of these changes is January 1, 2012.

### **General Provisions**

The rules identified below are being amended to set forth managed care plan (MCP) requirements for the Coordinated Services Program (CSP). The CSP replaces two existing programs, the Primary Alternative Care and Treatment (PACT) program, which applies to consumers who are not enrolled in managed care, and the Controlled Substances and Member Management (CSSM) program, which currently applies to managed care consumers. CSP requires Medicaid consumers whose use of Medicaid services demonstrates a pattern of receiving services at a frequency or in an amount that exceeds medical necessity to obtain certain services from only one pharmacy or only one primary provider of physician services.

Rule [5101:3-26-01](#), entitled Managed health care programs: definitions, has been amended. The changes to the rule remove the reference to the Controlled Substances and Member Management (CSMM) program and replaces it with the Coordinated Services Program (CSP). Additionally, the rule updates the definition for the Ohio Department of Developmental Disabilities.

Rule [5101:3-26-03.1](#), entitled Managed health care programs: care coordination has been amended. The changes to the rule add language requiring MCPs to implement the Coordinated Services Program (CSP) and provide clarification regarding state hearing rights for MCP members. The changes to the rule also clarify language regarding care coordination with designated providers.

Rule [5101:3-26-08.2](#), entitled Managed health care programs: member services, has been amended. Changes to the rule include the deletion of a reference to the Controlled Substances and Member Management (CSMM) program, which is being replaced with a reference to the Coordinated Services Program (CSP). Additionally there are two changes to the rule to update cross-references, and the correction of a citation to a federal regulation.

Rule [5101:3-26-08.4](#), entitled Managed health care programs: MCP grievance system, has been amended. The changes to the rule delete language regarding the Controlled Substances and Member Management (CSMM) program and substitute references to the Coordinated Services Program (CSP). Additionally, the rule updates references to forms.

Rule [5101:3-26-08.5](#), entitled Managed health care programs: responsibilities for state hearings has been amended. The changes to the rule replace the reference to the Controlled Substances and Member Management (CSMM) with CSP.

### **Instructions**

Remove and file as obsolete rule [5101:3-26-01](#), effective 07-01-09, and replace with rule [5101:3-26-01](#), effective 01-01-12.

Remove and file as obsolete rule [5101:3-26-03.1](#), effective 08-01-10, and replace with rule [5101:3-26-03.1](#), effective 01-01-12.

Remove and file as obsolete rule [5101:3-26-08.2](#), effective 08-01-10, and replace with rule [5101:3-26-08.2](#), effective 01-01-12.

Remove and file as obsolete rule [5101:3-26-08.4](#), effective 08-01-10, and replace with rule [5101:3-26-08.4](#), effective 01-01-12.

Remove and file as obsolete rule [5101:3-26-08.5](#), effective 08-01-10, and replace with rule [5101:3-26-08.5](#), effective 01-01-12.

### **Electronic Distribution**

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### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Policy and Health Plan Services

P.O. Box 182709

Columbus, OH 43218-2709

# MCTL 35 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 35

October 4, 2011

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Policy and Health Plan Services (BPHPS) is communicating Ohio Administrative Code (OAC) rule changes for Medicaid managed health care programs.

### General Provisions

The rules identified below are being proposed for amendment, rescission or adoption in order to update and clarify provisions related to Medicaid managed care annual external quality reviews and the carve-in of the Medicaid pharmacy benefit through Medicaid managed care plans (MCPs) pursuant to ORC 5111.172, adopted under Am. Sub. H.B. 153, 129th General Assembly. The effective date for the enactment of these changes is October 1, 2011.

Rule [5101:3-26-03](#), entitled Managed health care programs: covered services, is being amended to remove the language that excluded the reimbursement of the pharmacy benefit by Medicaid managed care plans (MCPs) as a result of the pharmacy benefit carve-out in February 1, 2010. Effective October 1, 2011, MCPs will again be responsible for the payment and provision of the pharmacy benefit. The changes to the rule also add clarifying language regarding the self-referral of MCP members to community behavioral health services.

Rule [5101:3-26-07](#) entitled Managed health care programs: annual external quality review survey is being rescinded and adopted as a new rule. This rule was established to comply with 42 CFR 438.204 and 42 CFR 438.358, which require states to arrange for annual, independent reviews of contracted managed care plans and to ensure specific external quality review activities are performed, respectively. The rescinded rule deletes language related to the specific activities that will be conducted by the external quality review organization (EQRO), and the resulting non-compliance actions if deficiencies are identified as a result of the reviews and adds this language to the contract between ODJFS and the MCPs. The adopted rule establishes MCP responsibilities regarding the annual external survey. The intent of the rescinded and adopted rules remains the same.

Rule [5101:3-26-12](#), entitled Managed health care programs: co-payments, is being amended. The rule sets forth provisions for MCP member co-payments. The changes to the rule add language allowing MCPs to impose pharmacy co-payments in accordance with fee-for-service co-payment requirements. The change is also being made to comply with five year rule review provisions required by ORC 119.032.

### Instructions

Remove and file as obsolete rule 5101:3-26-03, effective 02-01-10, and replace with rule [5101:3-26-03](#), effective 10-01-11.

Remove and file as obsolete rule 5101:3-26-07, effective 09-15-08, and replace with rule [5101:3-26-07](#), effective 10-01-11.

Remove and file as obsolete rule 5101:3-26-12, effective 02-01-10, and replace with rule [5101:3-26-12](#), effective 10-01-11.

### Electronic Distribution

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### **Questions**

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Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Policy and Health Plan Services  
P.O. Box 182709  
Columbus, OH 43218-2709

# MCTL 34 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 34

July 27, 2011

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26  
*RULES FOR MANAGED HEALTHCARE PROGRAMS*

By issuing this letter, the Bureau of Policy and Health Plan Services (BPHPS) is communicating Ohio Administrative Code (OAC) rule changes for Medicaid managed health care programs. The effective date for the enactment of these changes is August 1, 2011.

### **General Provisions**

The rules identified below are being amended in order to update and clarify provisions for managed care plan (MCP) newborn coverage, third party liability, delegated entity and subcontracting requirements.

Rule [5101:3-26-02](#), entitled Managed health care programs: eligibility, membership, and automatic renewal of membership, sets forth eligibility, membership, and automatic renewal of membership provisions for Medicaid managed care plans (MCPs). In order to comply with a federal directive, the changes to the rule delete provisions in the rule requiring mothers of Medicaid newborns to contact the county department of job and family services (CDJFS) regarding the newborn. Additionally, the changes to rule 5101:3-26-02 delete language that would require a newborn to be disenrolled from an MCP after 90 days if the child's eligibility status is not updated within the State's eligibility system. Covered families and children (CFC) newborns born to mothers enrolled in an MCP are eligible for enrollment in an MCP from their date of birth through the end of the month of the child's first birthday.

Rule [5101:3-26-05](#), entitled Managed health care programs: provider panel and subcontracting requirements, sets forth provisions for Medicaid managed care plan (MCP) provider panel and subcontracting requirements. The changes to the rule add clarifying language regarding the review of sanctioned providers by MCPs and the submission of hospital, federally qualified health center (FQHC) and rural health center (RHC) subcontracts to the Ohio Department of Job and Family Services (ODJFS). Additionally, the rule adds clarifying language regarding the MCP's submission of the annual assessment of a delegated entity's performance to ODJFS and modifies the notification requirements for primary care provider (PCP) and hospital subcontract expirations, nonrenewals or terminations. In paragraph (D)(36), the rule adds a provision that MCP subcontracts include an agreement by the subcontractor to supply the business transaction information required under 42 CFR 455.105.

Rule [5101:3-26-09.1](#), entitled Managed health care programs: third party recovery, sets forth the provisions for Medicaid managed care plan (MCP) third party recovery. The amendments to this rule add clarifying language regarding the processing of third party claims. The changes in paragraph (B)(6)(a)(i) reduce administrative burden by requiring documentation of the submission of only one claim to a third-party payor rather than three submissions. In new paragraph (B)(10), the amended rule includes a timely filing deadline of at least 90 days from the date of a remittance advice that indicates adjudication or adjustment of the third party claim.

Please note that JFS 03245 and 03246 forms have been revised to reference the correct paragraphs of rule 5101:3-26-09.1. The revised forms are located at the Ohio Department of Job and Family Services Forms Central: <http://www.odjfs.state.oh.us/forms/results1.asp>.

### **Instructions**

Remove and file as obsolete rule 5101:3-26-02, effective 06-19-2009, and replace with rule 5101:3-26-02, effective 08-01-2011.

Remove and file as obsolete rule 5101:3-26-05, effective 07-01-2009, and replace with rule 5101:3-26-05, effective 08-01-2011.

Remove and file as obsolete rule 5101:3-26-09.1, effective 09-15-2008, and replace with rule 5101:3-26-09.1, effective 08-01-2011

### **Electronic Distribution**

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### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Policy and Health Plan Services  
P.O. Box 182709  
Columbus, OH 43218-2709

# MCTL 33 (Ohio Administrative Code (OAC) Chapter 5101:3-26 Rules For Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 33

August 10, 2010

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 *RULES FOR MANAGED HEALTHCARE PROGRAMS*

By issuing this letter, the Bureau of Policy and Health Plan Services (BPHPS) is communicating Ohio Administrative Code (OAC) rule changes for Medicaid managed health care programs. The effective date for the enactment of these changes is August 1, 2010.

### General Provisions

The rules identified below are being amended in order to update and clarify provisions for managed care plan (MCP) state hearings, utilization management and just cause requests.

Rule [5101:3-26-02.1](#), entitled Managed health care programs: termination of membership, is being amended. The changes to the rule update language regarding processing timeframes for just cause requests.

Rule [5101:3-26-03.1](#), entitled Managed health care programs: care coordination, is being amended. The changes to the rule add language clarifying that in addition to maintaining prior authorization data, MCPs will submit the data as directed by ODJFS.

Rule [5101:3-26-08.2](#), entitled Managed health care programs: member services, is being amended. The changes to the rule add federally-required language regarding MCP member notification for standard and expedited state hearing resolution timeframes.

Rule [5101:3-26-08.4](#), entitled Managed health care programs: MCP grievance system, is being amended. The changes to the rule add federally-required language regarding information that must be contained on managed care plan (MCP) member appeal notifications. The changes to the rule also include clarification that the ninety day period for member appeals begins the day after the mailing date of the notice of action and that MCPs are to submit information regarding grievance and appeal activity as directed by ODJFS.

Rule [5101:3-26-08.5](#), entitled Managed health care programs: responsibilities for state hearings, is being amended. The changes to the rule add language clarifying that the ninety day notification period for a member's right to a state hearing begins on the day after the mailing date on the state hearing form consistent with OAC rule 5101:6-3-02(B)(2).

### Instructions

Remove and file as obsolete rule 5101:3-26-02.1, effective 02-01-10, and replace with rule [5101:3-26-02.1](#), effective 08-01-10.

Remove and file as obsolete rule 5101:3-26-03.1, effective 07-01-09, and replace with rule [5101:3-26-03.1](#), effective 08-01-10.

Remove and file as obsolete rule 5101:3-26-08.2, effective 07-01-09, and replace with rule [5101:3-26-08.2](#), effective 08-01-10.

Remove and file as obsolete rule 5101:3-26-08.4, effective 07-01-09, and replace with rule [5101:3-26-08.4](#), effective 08-01-10.

Remove and file as obsolete rule 5101:3-26-08.5, effective 07-01-09, and replace with rule [5101:3-26-08.5](#), effective 08-01-10.

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- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

**Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Policy and Health Plan Services

P.O. Box 182709

Columbus, OH 43218-2709

# MCTL 32 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 32

February 4, 2010

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating rule changes for Medicaid managed health care programs. The proposed effective date for the enactment of these changes is February 1, 2010.

### General Provisions

The rules identified below are being proposed for amendment or rescission in order to update cross-references, update and clarify provisions, and remove language related to a franchise permit fee imposed on the MCPs.

Rule [5101:3-26-02.1](#), entitled Managed health care programs: termination of membership, is being amended. The changes to the rule update cross references.

Rule [5101:3-26-03](#), entitled Managed health care programs: covered services, is being amended. The changes to the rule add services provided through Medicaid School Program (MSP) providers, certain medical supplies provided at pharmacies, and drugs covered under the Ohio Medicaid pharmacy benefit to the list of coverage exclusions under Medicaid managed health care programs. The changes to the rule also revise a term and update a cross reference.

Rule [5101:3-26-09.2](#), entitled Managed health care programs: franchise permit fee, is being rescinded. The rule is being rescinded because the statutory authority for the rule, section 5111.176 of the Ohio Revised Code, was ended for quarters on and after October 1, 2009, in Amended Substitute HB 1, 128 GA.

Rule [5101:3-26-12](#), entitled Managed health care programs: co-payments, is being amended. The changes to the rule delete language permitting MCPs to impose pharmacy co-payments.

### Instructions

Remove and file as obsolete rule [5101:3-26-02.1](#), effective 07-01-09, and replace with rule [5101:3-26-02.1](#), effective 02-01-10.

Remove and file as obsolete rule [5101:3-26-03](#), effective 09-15-08, and replace with rule [5101:3-26-03](#), effective 02-01-10.

Remove and file as obsolete rule [5101:3-26-09.2](#), effective 09-15-08.

Remove and file as obsolete rule [5101:3-26-12](#), effective 07-01-09, and replace with rule [5101:3-26-12](#), effective 02-01-10.

### Electronic Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this MCTL, and any attachments, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Managed Health Care."

- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired MCTL number.
- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

**Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Managed Care

P.O. Box 182709

Columbus, OH 43218-2709

614-466-4693

# MCTL 31 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 31

June 30, 2009

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTHCARE PROGRAMS

By issuing this letter, the Bureau of Managed Care (BMC) is communicating rule changes for Medicaid managed health care programs. The proposed effective date for the enactment of these changes is July 1, 2009.

### **General Provisions**

The rules identified below are being proposed for amendment in order to revise a definition, update and clarify provisions, and update cross-references and JFS forms, and make grammatical corrections.

Rule [5101:3-26-01](#), entitled Managed health care programs: definitions, is being amended. The changes to the rule revise the definition of 'intermediate care facility for the mentally retarded,' update cross-references, and make grammatical corrections.

Rule [5101:3-26-02](#), entitled Managed health care programs: eligibility, membership and automatic renewal of membership, is being amended. The changes to the rule revise the definition of an 'eligible individual'; replace the word 'membership' with the word 'enrollment'; revise provisions applicable to MCP enrollment, newborn notification and membership, and commencement of coverage; and update internal cross references.

Rule [5101:3-26-02.1](#), entitled Managed health care programs: termination of membership, is being amended. The changes to the rule revise provisions for automatic termination of coverage when a member is placed in a nursing facility, revise the timeframes for MCP member-initiated change requests or terminations, and update cross references.

Rule [5101:3-26-03.1](#), entitled Managed health care programs: care coordination, is being amended. The changes to the rule clarify MCP care coordination responsibilities and revise requirements for MCP care management programs.

Rule [5101:3-26-04](#), entitled Managed health care programs: procurement and plan selection, is being amended. The changes to the rule delete the word 'separate' in reference to ODJFS procurement processes.

Rule [5101:3-26-05](#), entitled Managed health care programs: provider panel and subcontracting requirements, is being amended. The changes to the rule remove the requirement that an MCP obtain ODJFS prior-approval of the MCP's panel providers, and update a cross reference.

Rule [5101:3-26-08.1](#), entitled Managed health care programs: information and selection services, is being amended. The changes to the rule replace the word 'selection' with the word 'enrollment.'

Rule [5101:3-26-08.2](#), entitled Managed health care programs: member services, is being amended. The changes to the rule revise requirements for MCP member materials (identification cards, letters, and handbooks) and the issuance of MCP provider directories, and update internal cross references.

Rule [5101:3-26-08.4](#), entitled Managed health care programs: MCP grievance system, is being amended. The changes to the rule revise requirements for MCP notification to members of their right to a state hearing, and update cross references to JFS state hearing forms.

Rule [5101:3-26-08.5](#), entitled Managed health care programs: responsibilities for state hearings, is being amended. The changes to the rule revise procedures for members to follow in requesting a state hearing and revise MCP responsibilities upon being notified that a member has requested a state hearing.

Rule [5101:3-26-12](#), entitled Managed health care programs: member co-payments, is being amended. The changes to the rule revise the family planning exclusion language for the member co-payment program for consistency with federal language, and update cross references.

### **Instructions**

Remove and file as obsolete rule 5101:3-26-01, effective 09-15-08, and replace with rule [5101:3-26-01](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-02, effective 10-09-08, and replace with rule [5101:3-26-02](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-02.1, effective 10-09-08, and replace with rule [5101:3-26-02.1](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-03.1, effective 09-15-08, and replace with rule [5101:3-26-03.1](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-04, effective 06-01-06, and replace with rule [5101:3-26-04](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-05, effective 01-01-08, and replace with rule [5101:3-26-05](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-08.1, effective 10-31-05, and replace with rule [5101:3-26-08.1](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-08.2, effective 09-15-08, and replace with rule [5101:3-26-08.2](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-08.4, effective 09-15-08, and replace with rule [5101:3-26-08.4](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-08.5, effective 09-15-08, and replace with rule [5101:3-26-08.5](#), effective 07-01-09.

Remove and file as obsolete rule 5101:3-26-12, effective 01-01-07, and replace with rule [5101:3-26-12](#), effective 07-01-09.

### **Electronic Distribution**

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- (2) Select "Managed Health Care."
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- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Managed Care  
P.O. Box 182709  
Columbus, OH 43218-2709

c: BMC Chiefs  
Tammy Simon  
Rafiat Eshett

# MCTL 30 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 30

September 11, 2008

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTH CARE PROGRAMS

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for Medicaid managed health care programs. The proposed effective date for the enactment of changes to rules [5101:3-26-02](#), [5101:3-26-02.1](#), and [5101:3-26-10](#) is October 9, 2008. The proposed effective date for the enactment of changes to all other rules listed below is September 15, 2008.

### General Provisions

The rules identified below are being proposed for adoption, amendment, or rescission in order to add and revise definitions, update and clarify provisions, update cross-references, and correct typographical errors.

Rule [5101:3-26-01](#), entitled Managed health care programs: definitions, is being amended. The changes to the rule revise language for consistency throughout the rule, revise the definition of "third party payer," change the term "case management" to "care management," and add and define the following terms: "coordination of benefit claim," "controlled substances and member management program," "explanation of benefits," "protected health information," "third party," "third party benefit," "third party claim," "third party liability," and "Title V."

Rule [5101:3-26-02](#), entitled Managed health care programs: eligibility, membership and automatic renewal of membership, is being amended. The changes to the rule revise language to clarify managed care plan responsibilities for hospital in-patient coverage upon termination of a member's managed care plan membership.

Rule [5101:3-26-02.1](#), entitled Managed health care programs: termination of membership, is being amended. The changes to the rule revise language to clarify managed care plan responsibilities for hospital in-patient coverage upon termination of a member's managed care plan membership.

Rule [5101:3-26-03](#), entitled Managed health care programs: covered services, is being amended. The changes to the rule update cross-references and change the term "case management" to "care management."

Rule [5101:3-26-03.1](#), entitled Managed health care programs: care coordination, is being amended. The changes to the rule add language to allow managed care plans to implement controlled substances and member management programs, and change the term "case management" to "care management."

Rule [5101:3-26-05.1](#), entitled Managed health care programs: provider services, is being amended. The changes to the rule change the term "case management" to "care management."

Rule [5101:3-26-07](#), entitled Managed health care programs: annual external quality review survey, is being amended. The changes to the rule change the term "case management" to "care management."

Rule [5101:3-26-07.1](#), entitled Managed health care programs: quality assessment and performance improvement program, is being amended. The changes to the rule revise language to clarify the required components of managed care plan performance improvement projects.

Rule [5101:3-26-08.2](#), entitled Managed health care programs: member services, is being amended. The changes to the rule change the term "case management" to "care management."

Rule [5101:3-26-08.4](#), entitled Managed health care programs: MCP grievance system, is being amended. The changes to the rule revise language to clarify the definition of a managed care plan "action" for member appeals, and add additional managed care plan state hearing member notification requirements.

Rule [5101:3-26-08.5](#), entitled Managed health care programs: responsibilities for state hearings, is being amended. The changes to the rule update references to Ohio Department of Job and Family Services (ODJFS) forms, and add language to clarify managed care plan responsibilities when a member requests a hearing as a result of proposed enrollment in the controlled substances and member management program.

Rule 5101:3-26-09.1, entitled Managed health care programs: third party recovery, is being rescinded. This rule will be replaced by new rule 5101:3-26-09.1.

Rule [5101:3-26-09.1](#), entitled Managed health care programs: third party recovery, is being adopted. This rule will set forth provisions for managed care plan responsibilities with regard to ODJFS recovery from third party payers of the cost of medical services rendered to managed care plan members. This rule will replace rescinded rule 5101:3-26-09.1. The difference between the rescinded rule and the new rule is the addition of language to the new rule that clarifies managed care plan responsibilities for the coordination of benefits. The new rule also corrects typographical errors, and updates cross-references.

Rule [5101:3-26-09.2](#), entitled Managed health care programs: franchise permit fee, is being adopted. This rule will establish the percentage to be used in calculating the franchise permit fee to be paid by Medicaid health insuring corporations pursuant to section 5111.176 of the Revised Code.

Rule [5101:3-26-10](#), entitled Managed health care programs: sanctions and provider agreement actions, is being amended. The changes to the rule revise language to clarify managed care plan responsibilities following the amendment, termination, or nonrenewal of the managed care plan's provider agreement.

### **Instructions**

Remove and file as obsolete rule 5101:3-26-01, effective 01-01-08, and replace with rule [5101:3-26-01](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-03, effective 01-01-08, and replace with rule [5101:3-26-03](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-03.1, effective 01-01-08, and replace with rule [5101:3-26-03.1](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-05.1, effective 01-01-08, and replace with rule [5101:3-26-05.1](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-07, effective 01-01-08, and replace with rule [5101:3-26-07](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-07.1, effective 07-01-03, and replace with rule [5101:3-26-07.1](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-08.2, effective 01-01-08, and replace with rule [5101:3-26-08.2](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-08.4, effective 06-01-06, and replace with rule [5101:3-26-08.4](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-08.5, effective 06-01-06, and replace with rule [5101:3-26-08.5](#), effective 09-15-08.

Remove and file as obsolete rule 5101:3-26-09.1, effective 07-01-07.

File new rule [5101:3-26-09.1](#), effective 09-15-08.

File new rule [5101:3-26-09.2](#), effective 09-15-08.

### **Electronic Distribution**

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- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

**Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Managed Health Care

P.O. Box 182709

Columbus, OH 43218-2709

614-466-4693

# MCTL 29 (OAC Chapter 5101:3-26 Rules for Managed Healthcare Programs)

## Managed Care Transmittal Letter No. 29

September 11, 2008

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTH CARE PROGRAMS

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for Medicaid managed health care programs. The rules were filed on an emergency basis effective August 26, 2008.

### General Provisions

The rules identified below were amended in order to update and clarify provisions and correct cross-references.

Rule [5101:3-26-02](#), entitled Managed health care programs: eligibility, membership and automatic renewal of membership, establishes provisions for membership in a managed care plan under the Medicaid Program. The changes to the rule revise language regarding managed care plan liability for the coverage of inpatient hospital facility services when the managed care plan exits the Ohio Medicaid Managed Care Program.

Rule [5101:3-26-02.1](#), entitled Managed health care programs: termination of membership, establishes provisions for the termination of membership in a managed care plan under the Medicaid Program. The changes to the rule revise language regarding managed care plan liability for the coverage of inpatient hospital facility services when the managed care plan exits the Ohio Medicaid Managed Care Program.

Rule [5101:3-26-10](#), entitled Managed health care programs: sanctions and provider agreement actions, establishes sanctions and provider agreement actions for managed care plans that fail to fulfill duties and obligations under the Medicaid Program. The changes to the rule delete language regarding a limitation on the duties and obligations of managed care plans when exiting the Ohio Medicaid Managed Care Program (to maintain consistency with amendments to rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code).

### Instructions

Remove and file as obsolete rule 5101:3-26-02, effective 01-01-08, and replace with rule [5101:3-26-02](#), effective 08-26-08.

Remove and file as obsolete rule 5101:3-26-02.1, effective 01-01-08, and replace with rule [5101:3-26-02.1](#), effective 08-26-08.

Remove and file as obsolete rule 5101:3-26-10, effective 01-01-08, and replace with rule [5101:3-26-10](#), effective 08-26-08.

### Electronic Distribution

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**Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Managed Health Care

P.O. Box 182709

Columbus, Ohio 43218-2709

614-466-4693

# MCTL 28 (OAC Chapter 5101:3-25 Rules for Children's Buy-In Program)

## Managed Care Transmittal Letter No. 28

June 27, 2008

TO: Executive Director, CareSource  
FROM: Helen E. Jones-Kelley, Director  
SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101: 3-25 RULES FOR CHILDREN'S BUY-IN PROGRAM

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating the proposed adoption of new rules for the Children's Buy-In Program, contained in Ohio Administrative Code Chapter 5101:3-25. The proposed effective date for the adoption of these rules is June 30, 2008.

### **General Provisions**

The rules identified below are being filed in order to implement a Children's Buy-In Program, as mandated by Amended Substitute H.B. 119 (127 G.A., sections 5101.5211 to 5101.5216). This program is one of the Turn-Around Ohio (TAO) health care initiatives to be implemented in the SFY 2008-2009 biennium.

Rule [5101:3-25-01](#), entitled Children's buy-in program: definitions, sets forth operational definitions for the children's buy-in program.

Rule [5101:3-25-02](#), entitled Children's buy-in program: managed care plan membership, sets forth provisions for membership in a managed care plan under the children's buy-in program.

Rule [5101:3-25-02.1](#), entitled Children's buy-in program: termination of membership, sets forth provisions for the termination of membership in the children's buy-in program.

Rule [5101:3-25-03](#), entitled Children's buy-in program: covered services, sets forth the benefit package covered under the children's buy-in program.

Rule [5101:3-25-03.1](#), entitled Children's buy-in program: care coordination, sets forth care coordination responsibilities under the children's buy-in program.

Rule [5101:3-25-05](#), entitled Children's buy-in program: provider panel and subcontracting requirements, sets forth provider panel and subcontracting requirements for the children's buy-in program.

Rule [5101:3-25-05.1](#), entitled Children's buy-in program: provider services, sets forth requirements for provider services under the children's buy-in program.

Rule [5101:3-25-06](#), entitled Children's buy-in program: program integrity - fraud and abuse, audits, reporting, and record retention, sets forth provisions to guard against fraud and abuse, and provisions for audits, reporting, and record retention for the children's buy-in program.

Rule [5101:3-25-07](#), entitled Children's buy-in program: quality review activities, sets forth quality review activities and requirements under the children's buy-in program.

Rule [5101:3-25-07.1](#), entitled Children's buy-in program: quality assessment and performance improvement program (QAPI), sets forth a QAPI program for the children's buy-in program.

Rule [5101:3-25-08](#), entitled Children's buy-in program: marketing, sets forth provisions for marketing activities under the children's buy-in program.

Rule [5101:3-25-08.2](#), entitled Children's buy-in program: member services, sets forth provisions for member services and member materials for the children's buy-in program.

Rule [5101:3-25-08.3](#), entitled Children's buy-in program: member rights, sets forth member rights under the children's buy-in program.

Rule [5101:3-25-08.4](#), entitled Children's buy-in program: responsibilities for member grievances and appeals, sets forth provisions for member grievances and appeals under the children's buy-in program.

Rule [5101:3-25-08.5](#), entitled Children's buy-in program: reconsideration process, sets forth provisions for an independent external review of service denials under the children's buy-in program.

Rule [5101:3-25-09](#), entitled Children's buy-in program: reimbursement and financial responsibility, sets forth provisions for reimbursement and financial responsibility under the children's buy-in program.

Rule [5101:3-25-09.1](#), entitled Children's buy-in program: third party recovery, sets forth provisions for third party liability and the recovery of payment from third party payers under the children's buy-in program.

Rule [5101:3-25-10](#), entitled Children's buy-in program: sanctions and grant agreement actions, sets forth sanctions and grant agreement actions for failure to fulfill duties and obligations under the children's buy-in program.

Rule [5101:3-25-11](#), entitled Children's buy-in program: managed care plan non-contracting providers, sets forth provisions for services delivered by non-contracting providers under the children's buy-in program.

Rule [5101:3-25-12](#), entitled Children's buy-in program: member cost sharing obligations, sets forth provisions for member cost sharing requirements under the children's buy-in program.

### **Instructions**

Insert new rules 5101:3-25-01 to 5101:3-25-12.

### **Electronic Distribution**

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- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Managed Health Care  
P.O. Box 182709  
Columbus, Ohio 43218-2709  
614-466-4693

# MCTL 27 (OAC Chapter 5101: 3-25 Rules for Children's Buy-In Program)

## Managed Care Transmittal Letter No. 27

April 14, 2008

TO: Executive Director, CareSource  
FROM: Helen E. Jones-Kelley, Director  
SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101: 3-25 RULES FOR CHILDREN'S BUY-IN PROGRAM

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating the enactment of a new chapter of the Ohio Administrative Code (5101:3-25) containing rules for the Children's Buy-In Program. The rules were filed on an emergency basis effective April 1, 2008.

### **General Provisions**

The rules identified below were filed in order to implement a Children's Buy-In Program, as mandated by Amended Substitute H.B. 119 (127 G.A.), sections 5101.5211 to 5101.5216. This program is one of the Turn-Around Ohio (TAO) health care initiatives to be implemented in the SFY 2008-2009 biennium.

Rule [5101:3-25-01](#), entitled Children's buy-in program: definitions, sets forth operational definitions for the children's buy-in program.

Rule [5101:3-25-02](#), entitled Children's buy-in program: managed care plan membership, sets forth provisions for membership in a managed care plan under the children's buy-in program.

Rule [5101:3-25-02.1](#), entitled Children's buy-in program: termination of membership, sets forth provisions for the termination of membership in the children's buy-in program.

Rule [5101:3-25-03](#), entitled Children's buy-in program: covered services, sets forth the benefit package covered under the children's buy-in program.

Rule [5101:3-25-03.1](#), entitled Children's buy-in program: care coordination, sets forth care coordination responsibilities under the children's buy-in program.

Rule [5101:3-25-05](#), entitled Children's buy-in program: provider panel and subcontracting requirements, sets forth provider panel and subcontracting requirements for the children's buy-in program.

Rule [5101:3-25-05.1](#), entitled Children's buy-in program: provider services, sets forth requirements for provider services under the children's buy-in program.

Rule [5101:3-25-06](#), entitled Children's buy-in program: program integrity - fraud and abuse, audits, reporting, and record retention, sets forth provisions to guard against fraud and abuse, and provisions for audits, reporting, and record retention for the children's buy-in program.

Rule [5101:3-25-07](#), entitled Children's buy-in program: quality review activities, sets forth quality review activities and requirements under the children's buy-in program.

Rule [5101:3-25-07.1](#), entitled Children's buy-in program: quality assessment and performance improvement program (QAPI), sets forth a QAPI program for the children's buy-in program.

Rule [5101:3-25-08](#), entitled Children's buy-in program: marketing, sets forth provisions for marketing activities under the children's buy-in program.

Rule [5101:3-25-08.2](#), entitled Children's buy-in program: member services, sets forth provisions for member services and member materials for the children's buy-in program.

Rule [5101:3-25-08.3](#), entitled Children's buy-in program: member rights, sets forth member rights under the children's buy-in program.

Rule [5101:3-25-08.4](#), entitled Children's buy-in program: responsibilities for member grievances and appeals, sets forth provisions for member grievances and appeals under the children's buy-in program.

Rule [5101:3-25-08.5](#), entitled Children's buy-in program: reconsideration process, sets forth provisions for an independent external review of service denials under the children's buy-in program.

Rule [5101:3-25-09](#), entitled Children's buy-in program: reimbursement and financial responsibility, sets forth provisions for reimbursement and financial responsibility under the children's buy-in program.

Rule [5101:3-25-09.1](#), entitled Children's buy-in program: third party recovery, sets forth provisions for third party liability and the recovery of payment from third party payers under the children's buy-in program.

Rule [5101:3-25-10](#), entitled Children's buy-in program: sanctions and grant agreement actions, sets forth sanctions and grant agreement actions for failure to fulfill duties and obligations under the children's buy-in program.

Rule [5101:3-25-11](#), entitled Children's buy-in program: managed care plan non-contracting providers, sets forth provisions for services delivered by non-contracting providers under the children's buy-in program.

Rule [5101:3-25-12](#), entitled Children's buy-in program: member cost sharing obligations, sets forth provisions for member cost sharing requirements under the children's buy-in program.

### **Instructions**

Insert new rules 5101:3-25-01 to 5101:3-25-12.

### **Electronic Distribution**

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- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Managed Health Care  
P.O. Box 182709  
Columbus, Ohio 43218-2709  
614-466-4693

# MCTL 26 (OAC Chapter 5101:3-26 Rules for Managed Health Care Programs)

## Managed Care Transmittal Letter No. 26

January 3, 2008

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTH CARE PROGRAMS

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for Medicaid managed health care programs. The proposed effective date for the enactment of these changes is January 1, 2008.

### General Provisions

The rules identified below are being proposed for amendment in order to update and clarify provisions.

**Rule 5101:3-26-01**, entitled Managed health care programs: definitions, is being amended. The changes to the rule add and define the terms “care treatment plan” and “pending member,” change the term “primary care physician” to “primary care provider” and revise the definition to include advanced practice nurses, add clarifying language to the definition of a “member” and revise the definition of an “inpatient facility.” The changes to the rule also revise language for consistency throughout the rule, and update internal references.

**Rule 5101:3-26-02**, entitled Managed health care programs: eligibility, membership and automatic renewal of membership, is being amended. The changes to the rule revise language to clarify individuals who are not required to enroll in a managed care plan, revise language to clarify provisions for the commencement of coverage, and update internal references.

**Rule 5101:3-26-02.1**, entitled Managed health care programs: termination of membership, is being amended. The changes to the rule revise language to clarify the reasons for which automatic termination of MCP membership occurs, and provisions for MCP member-initiated change requests and terminations.

**Rule 5101:3-26-03**, entitled Managed health care programs: covered services, is being amended. The changes to the rule revise language to clarify managed care plan responsibility for the payment of covered services when a managed care plan member is placed in a nursing facility. The changes to the rule also update internal references.

**Rule 5101:3-26-03.1**, entitled Managed health care programs: care coordination, is being amended. The changes to the rule revise language to clarify requirements for managed care plan utilization management program policies and procedures. The changes to the rule also add language for consistency with changes being made to rule 5101:3-26-01.

**Rule 5101:3-26-05**, entitled Managed health care programs: provider panel and subcontracting requirements, is being amended. The changes to the rule update internal references.

**Rule 5101:3-26-05.1**, entitled Managed health care programs: provider services, is being amended. The changes to the rule add an additional component of written information that managed care plans must provide to their contracting providers.

**Rule 5101:3-26-07**, entitled Managed health care programs: annual external quality review survey, is being amended. The changes to the rule remove clinical and non-clinical focused quality of care studies from the components of the external quality review.

**Rule 5101:3-26-08**, entitled Managed health care programs: marketing, is being amended. The changes to the rule remove language requiring managed care plans to submit the following to ODJFS: a list of their current Medicaid marketing representatives, a copy of each representative's Ohio Department of Insurance

licensure, and written documentation verifying the successful completion of a marketing representative training program. Language requiring managed care plans to receive written approval from ODJFS prior to performing marketing presentations was also removed.

[Rule 5101:3-26-08.2](#), entitled Managed health care programs: member services, is being amended. The changes to the rule replace the word "sex" with the word "gender," and update internal references.

[Rule 5101:3-26-08.3](#), entitled Managed health care programs: member rights, is being amended. The changes to the rule replace the word "sex" with the word "gender."

[Rule 5101:3-26-10](#), entitled Managed health care programs: sanctions and provider agreement actions, is being amended. The changes to the rule correct a typographical error and update internal references.

[Rule 5101:3-26-11](#), entitled Managed health care programs: managed care plan non-contracting providers, is being amended. The changes to the rule correct typographical errors and update internal references.

### **Instructions**

Remove and file as obsolete rule 5101:3-26-01, effective 07-01-07, and replace with rule [5101:3-26-01](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-02, effective 07-01-07, and replace with rule [5101:3-26-02](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-02.1, effective 07-01-07, and replace with rule [5101:3-26-02.1](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-03, effective 07-01-07, and replace with rule [5101:3-26-03](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-03.1, effective 06-01-06, and replace with rule [5101:3-26-03.1](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-05, effective 07-01-07, and replace with rule [5101:3-26-05](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-05.1, effective 06-01-06, and replace with rule [5101:3-26-05.1](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-07, effective 01-01-07, and replace with rule [5101:3-26-07](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-08, effective 07-01-07, and replace with rule [5101:3-26-08](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-08.2, effective 06-01-06, and replace with rule [5101:3-26-08.2](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-08.3, effective 07-01-03, and replace with rule [5101:3-26-08.3](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-10, effective 10-31-05, and replace with rule [5101:3-26-10](#), effective 01-01-08.

Remove and file as obsolete rule 5101:3-26-11, effective 01-01-07, and replace with rule [5101:3-26-11](#), effective 01-01-08.

### **Electronic Distribution**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this MCTL, and any attachments, may be viewed as follows:

(1) Select "Ohio Health Plans - Provider."

- (2) Select "Managed Health Care."
- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired MCTL number.
- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

**Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Managed Health Care

P.O. Box 182709

Columbus, OH 43218-2709

614-466-4693

# MCTL 25

## Managed Care Transmittal Letter No. 25

June 29, 2007

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101:3-26 RULES FOR MANAGED HEALTH CARE PROGRAMS

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for Medicaid managed health care programs. The proposed effective date for the enactment of these changes is July 1, 2007.

### General Provisions

The rules identified below are being proposed for amendment in order to update and clarify provisions.

Rule [5101:3-26-01](#), entitled Managed health care programs: definitions, is being amended. The changes to the rule replace the term and definition for a "selection services entity (SSE)" with the term and definition for a "managed care enrollment center (MCEC)," add clarifying language to the definition of "coordination of benefits (COB)," and correct typographical errors.

Rule [5101:3-26-02](#), entitled Managed health care programs: eligibility, membership and automatic renewal of membership, is being amended. The changes to the rule replace references to a "selection services entity (SSE)" with references to a "managed care enrollment center (MCEC)," and remove language regarding requests for exclusion from managed care plan membership made by eligible individuals or MCP members.

Rule [5101:3-26-02.1](#), entitled Managed health care programs: termination of membership, is being amended. The changes to the rule add language to clarify when automatic termination of MCP membership occurs, replace the words "open selection" with the words "open enrollment," and replace references to a "selection services entity (SSE)" with references to a "managed care enrollment center (MCEC)."

Rule [5101:3-26-03](#), entitled Managed health care programs: covered services, is being amended. The changes to the rule revise language to clarify managed care plan responsibility for the payment of covered services when a managed care plan member is placed in a nursing facility.

Rule [5101:3-26-05](#), entitled Managed health care programs: provider panel and subcontracting requirements, is being amended. The changes to the rule add language to clarify the required elements of MCP subcontract Medicaid addendums, update internal references, and correct typographical errors.

Rule [5101:3-26-08](#), entitled Managed health care programs: marketing, is being amended. The changes to the rule revise language regarding the return address on mailings to eligible individuals when such mailings are processed by ODJFS, and correct a typographical error.

Rule [5101:3-26-09.1](#), entitled Managed health care programs: third party recovery, is being amended. The changes to the rule add language to clarify the primary payer for Medicaid-covered services rendered by Title V programs, replace the word "enrollee" with "member," and correct a typographical error.

### Instructions

Remove and file as obsolete rule 5101:3-26-01, effective 01-01-07, and replace with rule 5101:3-26-01, effective 07-01-07.

Remove and file as obsolete rule 5101:3-26-02, effective 01-01-07, and replace with rule 5101:3-26-02, effective 07-01-07.

Remove and file as obsolete rule 5101:3-26-02.1, effective 06-01-06, and replace with rule 5101:3-26-02.1, effective 07-01-07.

Remove and file as obsolete rule 5101:3-26-03, effective 01-01-07, and replace with rule 5101:3-26-03, effective 07-01-07.

Remove and file as obsolete rule 5101:3-26-05, effective 01-01-07, and replace with rule 5101:3-26-05, effective 07-01-07.

Remove and file as obsolete rule 5101:3-26-08, effective 06-01-06, and replace with rule 5101:3-26-08, effective 07-01-07.

Remove and file as obsolete rule 5101:3-26-09.1, effective 06-01-06, and replace with rule 5101:3-26-09.1, effective 07-01-07.

### **Electronic Distribution**

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- (2) Select "Managed Health Care."
- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired MCTL number.
- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Managed Health Care  
P.O. Box 182709  
Columbus, OH 43218-2709  
614-466-4693

# MCTL 24

## Managed Care Transmittal Letter No. 24

January 3, 2007

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Ohio Administrative Code (OAC) Chapter 5101:3-26  
Rules for Managed Health Care Programs

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for the Medicaid managed care program. The proposed effective date for the enactment of these changes is January 1, 2007.

### General Provisions

The rules identified below are being proposed for amendment in order to update and clarify provisions and to implement section 6085 of the federal Deficit Reduction Act (DRA) of 2005; section 5111.0112 of the Revised Code, as amended under Am. Sub. H.B. 530; section 5111.163 of the Revised Code, as adopted under Am. Sub. H.B. 530; and 42 C.F.R. 438.106 and 438.60.

Rule [5101:3-26-01](#), entitled Managed Health Care Programs: Definitions, is being amended. The changes to the rule modify the definition of a managed care plan (MCP).

Rule [5101:3-26-02](#), entitled Managed Health Care Programs: Eligibility, Membership and Automatic Renewal of Membership, is being amended. The changes to the rule correct an OAC citation and revise language to clarify individuals not required to enroll in an MCP.

Rule [5101:3-26-03](#), entitled Managed Health Care Programs: Covered Services, is being amended. The changes to the rule add language to clarify MCP reimbursement for emergency services delivered by a non-contracting provider as stipulated in section 6085 of the DRA and section 5111.163 of the Revised Code, as adopted under Am. Sub. H.B. 530.

Rule [5101:3-26-05](#), entitled Managed Health Care Programs: Provider Panel and Subcontracting Requirements, is being amended. The changes to the rule revise language regarding MCP subcontract requirements, to mirror federal language contained in 42 C.F.R. 438.106 and 438.60.

Rule [5101:3-26-07](#), entitled Managed Health Care Programs: Annual External Quality Review Survey, is being amended. The changes to the rule revise how an MCP is held accountable for external quality review (EQR) survey results and how an MCP may address EQR deficiencies.

Rule [5101:3-26-11](#), entitled Managed Health Care Programs: Managed Care Plan Non-Contracting Providers, is being amended. The changes to the rule add language to clarify MCP reimbursement for emergency services delivered by a non-contracting provider as stipulated in section 6085 of the DRA and section 5111.163 of the Revised Code, as adopted under Am. Sub. H.B. 530.

Rule [5101:3-26-12](#), entitled Managed Health Care Programs: Member Co-Payments, is being amended. The changes to the rule add language from section 5111.0112 of the Revised Code, as amended under Am. Sub. H.B. 530, which specifies the circumstances in which a hospital provider may waive a member's obligation to pay the provider a co-payment.

### Instructions

Remove and file as obsolete rule 5101:3-26-01, effective 06-01-06, and replace with rule [5101:3-26-01](#), effective 01-01-07.

Remove and file as obsolete rule 5101:3-26-02, effective 06-01-06, and replace with rule [5101:3-26-02](#), effective 01-01-07.

Remove and file as obsolete rule 5101:3-26-03, effective 06-01-06, and replace with rule [5101:3-26-03](#), effective 01-01-07.

Remove and file as obsolete rule 5101:3-26-05, effective 06-01-06, and replace with rule [5101:3-26-05](#), effective 01-01-07.

Remove and file as obsolete rule 5101:3-26-07, effective 06-01-06, and replace with rule [5101:3-26-07](#), effective 01-01-07.

Remove and file as obsolete rule 5101:3-26-11, effective 06-01-06, and replace with rule [5101:3-26-11](#), effective 01-01-07.

Remove and file as obsolete rule 5101:3-26-12, effective 06-01-06, and replace with rule [5101:3-26-12](#), effective 01-01-07.

### **Electronic Distribution**

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- (2) Select "Managed Health Care."
- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired MCTL number.
- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Managed Health Care  
255 E. Main Street, 2nd floor  
Columbus, OH 43215-5222  
614-466-4693

# MCTL 23

## Managed Care Transmittal Letter No. 23

June 1, 2006

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101: 3-26 RULES FOR MANAGED HEALTH CARE PROGRAMS

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for the Medicaid managed care program. The proposed effective date for the enactment of these changes is June 1, 2006.

### General Provisions

The rules identified below are being proposed for amendment in order to implement a statewide expansion of the Ohio Medicaid full-risk managed care program. As mandated by Amended Substitute HB 66, all Covered Families and Children (CFC) consumers with limited exceptions and certain Aged, Blind, and Disabled (ABD) consumers must be enrolled in the full-risk managed care program by December 31, 2006.

Rule 5101:3-26-01, entitled Managed health care programs: definitions, is being amended. The changes to the rule add language to clarify certain definitions relevant to statewide managed care expansion.

Rule 5101:3-26-02, entitled Managed health care programs: eligibility, membership and automatic renewal of membership, is being amended. The changes to the rule add language to describe CFC and ABD individuals eligible for mandatory enrollment. References to preferred option and continuity of care deferrals have also been deleted.

Rule 5101:3-26-02.1, entitled Managed health care programs: termination of membership, is being amended. The changes to the rule add language regarding termination of MCP membership, from the perspective of MCP members in the ABD and CFC categories of assistance.

Rule 5101:3-26-03, entitled Managed health care programs: covered services, is being amended. The changes to the rule add language to clarify MCP responsibilities for nursing facility stays and reflect the exclusion of habilitation services and coverage of services outside the United States.

Rule 5101:3-26-03.1, entitled Managed health care programs: care coordination, is being amended. The changes to the rule clarify MCP care coordination responsibilities, add language to clarify the dispensing of prior-authorized drugs in an emergency situation, and add a provision which allows prior authorization timeframes to be increased from five working days to fourteen calendar days (except for prior-authorizations of covered outpatient drugs).

Rule 5101:3-26-04, entitled Managed health care programs: procurement and plan selection, is being amended. The changes to the rule remove outdated references to the comprehensive managed care (CMC) program and add a federal citation pertaining to the MCP procurement process.

Rule 5101:3-26-05, entitled Managed health care programs: provider panel and subcontracting requirements, is being amended. The changes to the rule add language stating that unless otherwise specified by ODJFS, any information submitted to ODJFS regarding services rendered by a delegated entity, must be submitted directly by the MCP. Revisions were also made to the provider subcontracting section of the rule.

Rule 5101:3-26-05.1, entitled Managed health care programs: provider services, is being amended. The changes to the rule add language to clarify MCP responsibilities to subcontracting providers. Language was also added to clarify MCP and provider responsibilities for oral translation, oral interpretation, and sign language services.

Rule 5101:3-26-07, entitled Managed health care programs: annual external quality review survey, is being amended. The changes to the rule clarify federal requirements regarding non-duplication of mandatory activities and exemption from external quality review activities.

Rule 5101:3-26-08, entitled Managed health care programs: marketing, is being amended. The changes to the rule add new terminology related to statewide managed care expansion.

Rule 5101:3-26-08.2, entitled Managed health care programs: member services, is being amended. The changes to the rule modify member services requirements to include provisions such as the issuance of new member letters by MCPs.

Rule 5101:3-26-08.4, entitled Managed health care programs: MCP grievance system, is being amended. The changes to the rule add language to clarify standard appeal and state hearing procedures.

Rule 5101:3-26-08.5, entitled Managed health care programs: responsibilities for state hearings, is being amended. The changes to the rule add language to clarify the distribution of forms for state hearings notifications.

Rule 5101:3-26-09, entitled Managed health care programs: reimbursement and financial responsibility, is being amended. The changes to the rule add language to clarify that maternal delivery payments are made separately for the CFC category of assistance only.

Rule 5101:3-26-11, entitled Managed health care programs: managed care plan non-contracting providers, is being amended. The changes to the rule add language to clarify that if an MCP has chosen to require applicable co-payments for certain services, those co-payments will also apply to services provided by non-subcontracting providers. Clarifying language was also added specifying record retention requirements.

The rules identified below are being proposed for amendment, adoption, or rescission in order to update and clarify provisions and/or renumber the rule.

Rule 5101:3-26-06, entitled Managed health care programs: program integrity-fraud and abuse, audits, reporting, and record retention, is being amended. The changes to the rule add language to clarify MCP record retention requirements.

Rule 5101:3-26-09.1, entitled Managed health care programs: third party recovery, is being amended. The changes to the rule add a Revised Code citation and remove an Administrative Code citation.

Rule 5101:3-26-12, entitled Managed health care programs: member co-payments, is being adopted. This rule is being adopted with language from rescinded rule 5101:3-26-13, to keep this rule set in numerical order. A typographical error and an erroneous OAC citation have been corrected. Language was added to clarify the application of MCP member co-payments for pharmacy services.

Rule 5101:3-26-13, entitled Managed health care programs: member co-payments, is being rescinded. This rule is being rescinded and filed as new rule 5101:3-26-12, to keep this rule set in numerical order.

### **Instructions**

Remove and file as obsolete rule 5101:3-26-01, effective 10-31-05, and replace with rule 5101:3-26-01, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-02, effective 10-31-05, and replace with rule 5101:3-26-02, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-02.1, effective 10-31-05, and replace with rule 5101:3-26-02.1, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-03, effective 01-01-06, and replace with rule 5101:3-26-03, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-03.1, effective 07-01-03, and replace with rule 5101:3-26-03.1, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-04, effective 10-31-05, and replace with rule 5101:3-26-04, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-05, effective 01-01-06, and replace with rule 5101:3-26-05, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-05.1, effective 07-01-03, and replace with rule 5101:3-26-05.1, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-06, effective 10-31-05, and replace with rule 5101:3-26-06, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-07, effective 10-31-05, and replace with rule 5101:3-26-07, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-08, effective 10-31-05, and replace with rule 5101:3-26-08, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-08.2, effective 10-31-05, and replace with rule 5101:3-26-08.2, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-08.4, effective 07-01-03, and replace with rule 5101:3-26-08.4, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-08.5, effective 07-01-03, and replace with rule 5101:3-26-08.5, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-09, effective 10-31-05, and replace with rule 5101:3-26-09, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-09.1, effective 07-01-03, and replace with rule 5101:3-26-09.1, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-11, effective 01-01-06, and replace with rule 5101:3-26-11, effective 06-01-06.

File new rule 5101:3-26-12, effective 06-01-06.

Remove and file as obsolete rule 5101:3-26-13, effective 01-01-06.

### **Electronic Distribution**

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- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Managed Health Care."
- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired MCTL number.
- (4) Scroll through the MCTL to the desired rule number highlighted in blue and select the rule number.

### **Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Managed Health Care

255 E. Main Street, 2nd floor

Columbus, OH 43215-5222

614-466-4693

# MCTL 22

## Managed Care Transmittal Letter No. 22

December 27, 2005

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101: 3-26 RULES FOR MANAGED HEALTH CARE PROGRAMS

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for the Medicaid managed care program. The effective date for the proposed rule changes is January 1, 2006.

### **General Provisions**

Rule 5101:3-26-03, entitled Managed health care programs: Covered services, is being amended. The changes to the rule add language requiring non-contracting hospitals to accept the Medicaid fee-for-service rate for non-emergency hospital services when authorized by ODJFS. A provision was also added to this rule to require MCPs to pay non-contracting hospitals for all emergency services regardless of whether the services meet an emergency medical condition definition.

Rule 5101:3-26-05, entitled Managed health care programs: Provider panel and subcontracting requirements, is being amended. The changes to the rule add language clarifying the compensation amount for Medicaid-covered non-emergency hospital services. The rule also permits the subcontractor to collect a co-payment if the MCP has elected to implement a member co-payment program.

Rule 5101:3-26-11, entitled Managed health care programs: Managed care plan non-contracting providers, is being amended. The changes to the rule add language to outline the conditions under which a non-contracting hospital must accept the Medicaid rate for non-emergency hospital services when ODJFS has authorized the MCP's membership to be sent to the non-contracting hospital.

Rule 5101:3-26-13, entitled Managed health care programs: Member co-payments is being adopted. This is a new rule that sets forth provisions and conditions for a member co-payment program permitted by Amended Substitute HB 66 for those MCPs that elect to implement a member co-payment program for dental services, vision services, non-emergency emergency department services and prescription drugs, other than generic drugs.

### **Instructions**

Remove and file as obsolete rule 5101:3-26-03, effective 7-1-03, and replace with rule 5101:3-26-03, effective 01-01-06.

Remove and file as obsolete rule 5101:3-26-05, effective 7-1-03, and replace with rule 5101:3-26-05, effective 01-01-06.

Remove and file as obsolete rule 5101:3-26-11, effective 7-1-03, and replace with rule 5101:3-26-11, effective 01-01-06.

File new rule 5101:3-26-13, effective 1-1-06.

### **Electronic Distribution**

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<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter, and the proposed rules cited in this transmittal letter, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column),

- (2) Select "Managed Health Care" (right column),
- (3) Select "Managed Care Transmittal Letter" or "MHC Rules" (left column).

**Questions**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Managed Health Care

Program Development and Analysis Section

30 East Broad Street, 27th floor

Columbus, OH 43215-3414

614-466-4693

# MCTL 21

## Managed Care Transmittal Letter No. 21

October 27, 2005

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OHIO ADMINISTRATIVE CODE (OAC) CHAPTER 5101: 3-26 RULES FOR MANAGED HEALTH CARE PROGRAMS

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating rule changes for the Medicaid managed care program. The effective date for the enactment of these changes is October 31, 2005.

The rules identified below are being amended or rescinded in order to terminate the enhanced care management program effective October 31, 2005. The program is being terminated subsequent to amendments in Amended Substitute HB 66 which require the statewide implementation of a full-risk managed care program for certain Aged, Blind, and Disabled Medicaid consumers, including ECM eligibles.

### **General Provisions**

Rule 5101:3-26-01, entitled Managed health care programs: definitions, is being amended. The changes to the rule remove language referencing the enhanced care management program (ECM) and/or enhanced care management plans (ECMP).

Rule 5101:3-26-02, entitled Managed health care programs: eligibility, membership and automatic renewal of membership, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-02.1, entitled Managed health care programs: termination of membership, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-04, entitled Managed health care programs: procurement and plan selection, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-06, entitled Managed health care programs: program integrity-fraud and abuse, audits, reporting, and record retention, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-07, entitled Managed health care programs: annual external quality review survey, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-08, entitled Managed health care programs: marketing, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-08.1, entitled Managed health care programs: information and selection services, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-08.2, entitled Managed health care programs: member services, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-09, entitled Managed health care programs: reimbursement and financial responsibility, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs, and add a Revised Code reference.

Rule 5101:3-26-10, entitled Managed health care programs: sanctions and provider agreement actions, is being amended. The changes to the rule remove language referencing ECM and/or ECMPs.

Rule 5101:3-26-12, entitled Managed health care programs: ECMP obligations, is being rescinded. This rule sets forth obligations of enhanced care management plans contracted with ODJFS for the provision of

services to Medicaid individuals. The rule is being rescinded due to the termination of the enhanced care management program.

**Instructions:**

Remove and file as obsolete rule 5101:3-26-01, effective 7-1-04, and replace with rule 5101:3-26-01, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-02, effective 7-1-04, and replace with rule 5101:3-26-02, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-02.1, effective 7-1-04, and replace with rule 5101:3-26-02.1, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-04, effective 7-1-04, and replace with rule 5101:3-26-04, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-06, effective 7-1-04, and replace with rule 5101:3-26-06, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-07, effective 7-1-04, and replace with rule 5101:3-26-07, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-08, effective 7-1-04, and replace with rule 5101:3-26-08, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-08.1, effective 7-1-04, and replace with rule 5101:3-26-08.1, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-08.2, effective 7-1-04, and replace with rule 5101:3-26-08.2, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-09, effective 7-1-04, and replace with rule 5101:3-26-09, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-10, effective 7-1-04, and replace with rule 5101:3-26-10, effective 10-31-05.

Remove and file as obsolete rule 5101:3-26-12, effective 7-1-04.

**Electronic Distribution:**

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter, and the proposed rules cited in this transmittal letter, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column),
- (2) Select "Managed Health Care" (right column),
- (3) Select "Managed Care Transmittal Letter" or "MHC Rules" (left column).

**Questions:**

Questions regarding this transmittal letter should be directed to the following:

Ohio Department of Job and Family Services  
Office of Ohio Health Plans  
Bureau of Managed Health Care  
Program Development and Analysis Section  
30 East Broad Street, 27th floor  
Columbus, OH 43215-3414

614-466-4693

# MCTL 20

## Managed Care Transmittal Letter # 20

June 25, 2004

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, District Offices  
Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Chapter 5101: 3-26 Ohio Administrative Code (OAC) Rules For Enhanced Care Management

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating proposed rule changes for the implementation of the Enhanced Care Management (ECM) program.

Rule 5101: 3-26-01 entitled "Managed health care programs: Definitions" is being amended to revise current terms and include new terms relating to the ECM program.

Rule 5101:3-26-02 entitled "Managed health care programs: Eligibility, MCP membership and automatic renewal of MCP membership" is being amended to include new language concerning the selection of membership into an enhanced care management plan.

Rule 5101:3-26-02.1 entitled "Managed health care programs: Termination of MCP membership" is being amended to include new language to address the termination of a member(s) from an enhanced care management plan.

Rule 5101:3-26-04 entitled "Managed health care programs: Procurement and plan selection" is being rescinded and adopted as new to address issues relating to the selection of an enhanced care management plan by ODJFS for program participation.

Rule 5101:3-26-06 entitled "Managed health care programs: Program integrity - fraud and abuse, audits, reporting, and record retention" is being amended to include the term "ECMP."

Rule 5101:3-26-07 entitled "Managed health care programs: Annual external quality review survey" is being amended to include the responsibilities of the external quality review organization and enhanced care management plan concerning quality surveys.

Rule 5101:3-26-08 entitled "Managed health care programs: Marketing" is being amended to include language concerning enhanced care management plan marketing activities and materials.

Rule 5101:3-26-08.1 entitled "Managed health care programs: Information and selection services" is being amended to include the term "ECMP."

Rule 5101:3-26-08.2 entitled "Managed health care programs: Member services" is being amended to address services and materials that must be provided by an enhanced care management plan to its members.

Rule 5101:3-26-09 entitled "Managed health care programs: Reimbursement and financial responsibility" is being amended to include new language stating the financial requirements of enhanced care management plans and documents that must be submitted by them.

Rule 5101:3-26-10 entitled "Managed health care programs: Sanctions and provider agreement actions" is being amended to address "best interest" as it relates to a decision by ODJFS to terminate, deny, not renew or amend a provider agreement with a managed care plan or enhanced care management plan.

Rule 5101:3-26-12 entitled "Managed health care programs: ECMP obligations" is a new rule to address enhanced care management plan responsibilities concerning provider subcontracts, care coordination and other services that must be provided.

**The effective date for the enactment of these OAC rules is July 1, 2004.**

Should you have any questions regarding these rules, please contact the BMHC at (614) 466-4693.

# MCTL 19

## Managed Care Transmittal Letter # 19

September 22, 2003

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, District Offices  
Directors, County Departments of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: Chapter 5101:3-26-03.2 Ohio Administrative Code (OAC) Rule For Managed Care Plans (MCPs)

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating proposed rule changes for the Medicaid managed care program.

Rule 5101: 3-26-03.2 entitled "Managed health care programs: Substance abuse screening and referral procedures for managed care plans and prenatal medical service providers in mandatory managed care counties" is being rescinded as required by House Bill 95 of the 125<sup>th</sup> General Assembly.

**The effective date for the enactment of this rescission is October 1, 2003.**

Should you have any questions regarding these rule, please contact the BMHC at (614) 466-4693.

c: BMHC Chiefs  
Contract Administrators  
Dan Arnold

# MCTL 18

## Managed Care Transmittal Letter # 18

June 26, 2003

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, District Officers  
Directors, County Departments of Human Services

FROM: Thomas J. Hayes, Director

SUBJECT: Chapter 5101:3-26 Ohio Administrative Code (OAC) Rules For Managed Care Plans (MCPs)

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating proposed rule changes for the Medicaid managed care program.

Rule 5101:3-26-01 entitled "Managed health care programs: Definitions" (attached) is being amended to update terms, add new ones, and remove unnecessary definitions.

Rule 5101:3-26-02 entitled "Managed health care programs: Eligibility, enrollment and automatic reenrollment" (attached) is being rescinded and adopted as new to include applicable Balanced Budget Act (BBA) requirements and to revise language dealing with commencement of coverage.

Rule 5101: 3-26-02.1 entitled "Managed health care programs: Disenrollment" (attached) is being amended to include applicable BBA language and to include level of care and waiver language previously found in another rule.

Rule 5101:3-26-03 entitled "Managed health care programs: Covered services" (attached) is being rescinded and adopted as new to incorporate federally-required covered-services provisions of the BBA, delete an obsolete requirement, and to move several requirements to other rules in this Chapter.

Rule 5101: 3-26-03.1 entitled "Managed health care programs: Care coordination" (attached) is being rescinded and adopted as new to include federal requirements specified in the BBA and revised language concerning care coordination related issues.

Rule 5101: 3-26-04 entitled "Managed health care programs: Eligible MCP providers" (attached) is being amended to more specifically differentiate between currently-contracting MCPs and entities wishing to receive an MCP contract from the Ohio Department of Job and Family Services (ODJFS).

Rule 5101:3-26-05 entitled "Managed health care programs: Provider panel and subcontracting requirements" (attached) is being amended to clarify current requirements and to include federal requirements specified under the structure and operation standards, information requirements, provider discrimination, provider-enrollee communications, and availability of services sections of the BBA.

Rule 5101: 3-26-05.1 entitled "Managed health care programs: Provider services" (attached) is a new rule which has been developed to implement a number of federally-required provisions of the BBA specific to information and services that MCPs must provide to their contracting providers, and to incorporate requirements previously contained in other rules in the Chapter.

Rule 5101:3-26-06 entitled "Managed health care programs: Program Integrity - fraud and abuse, audits, reporting, and record retention" (attached) is being rescinded and adopted as new due to the substantial revisions made to this rule. The rule was reorganized and revised to include new language on fraud and abuse, as required by BBA, and also includes revisions to the reporting requirement language.

Rule 5101:3-26-07 entitled "Managed health care programs: Annual external quality review survey" (attached) is being amended to include federal requirements specified in the BBA.

Rule 5101: 3-26-07.1 entitled "Managed health care programs: Quality Assessment and Performance Improvement Program" (attached) is being rescinded and adopted as new to include federal requirements specified in the BBA.

Rule 5101:3-26-08 entitled "Managed health care programs: Marketing" (attached) is being amended to update terms and include federal requirements specified under the marketing activities and information requirements sections of the BBA.

Rule 5101: 3-26-08.1 entitled "Managed health care programs: Enrollment and information services" (attached) is being revised to insert clarifying language.

Rule 5101: 3-26-08.2 entitled "Managed health care programs: Member services" (attached) is being amended to update terms, include federal requirements specified under the information requirements section of the BBA, and include certain requirements previously covered under commencement of coverage in rule 5101:3-26-02 of the Administrative Code.

Rule 5101: 3-26-08.3 entitled "Managed health care programs: Member rights" (attached) is being rescinded and adopted as new to separate the list of member rights from the MCP grievance process. The new rule includes the applicable federal requirements specified in the BBA and revises language addressing MCPs and the state hearing process.

Rule 5101: 3-26-08.4 entitled "Managed health care programs: MCP grievance system" (attached) is a new rule that outlines the federal requirements specified under the grievance system section of the BBA for MCPs to have a grievance system that includes an appeals process, a grievance process, and a process to access the state's hearing system.

Rule 5101: 3-26-08.5 entitled "Managed health care programs: Responsibilities for state hearings" (attached) is a new rule that includes in the managed care program rules the responsibilities identified in Chapter 5101:6 of the Administrative Code regarding the forms the MCP must utilize for state hearings.

Rule 5101: 3-26-09 entitled "Managed health care programs: Reimbursement and financial responsibility" (attached) is being amended in order to consolidate all the financial related language into one rule.

Rule 5101: 3-26-09.1 entitled "Managed health care programs: Third party recovery" (attached) is being amended to correct a couple of typographical errors.

Rule 5101: 3-26-10 entitled "Managed health care programs: Sanctions and provider agreement actions" (attached) is being amended to incorporate federally-required sanction provisions of the BBA.

Rule 5101: 3-26-11 entitled "Managed health care programs: MCP non-contracting providers" (attached) is being amended to incorporate the definition of an MCP non-contracting provider which previously was only found in the definition rule (5101: 3-26-01).

**The effective date for the enactment of these OAC rules is July 1, 2003.**

Should you have any questions regarding these OAC rules, please contact the BMHC at (614) 466-4693.

# MCTL 17

## Managed Care Transmittal Letter 17

May 14, 2002

TO: Chief Executive Officers, Managed Care Plans (MCPs)  
Directors, District Officers  
Directors, County Departments of Human Services

FROM: Tom Hayes, Director

SUBJECT: Chapter 5101:3-26 Ohio Administrative Code (OAC) Rules For Managed Care Plans (MCPS)

By issuing this letter, the Bureau of Managed Health Care (BMHC) is communicating proposed rule changes for the Medicaid managed care program.

Rule 5101:3-26-01 entitled "Managed health care programs: Definitions" (attached) is being amended to update terms and remove unnecessary definitions.

Rule 5101:3-26-02 entitled "Managed health care programs: Eligibility, enrollment and automatic reenrollment" (attached) is being rescinded and adopted as new to reorganize the rule and to include new language concerning the Consumer Contact Record.

Rule 5101:3-26-02.1 entitled "Managed health care programs: Disenrollment" (attached) includes revisions dealing with MCP and enrollee initiated disenrollments, and automatic disenrollments.

Rule 5101:3-26-03 entitled "Managed health care programs: Covered services" (attached) includes new language concerning Healthchek exams and record keeping requirements for prior authorizations.

Rule 5101:3-26-04 entitled "Managed health care programs: Eligible MCP providers" (attached) contains revisions concerning MCP provider agreements and the MCP procurement process.

Rule 5101:3-26-05 entitled "Managed health care programs: Provider panel and subcontracting requirements" (attached) is being amended to revise language concerning MCP notification about provider panel deletions and to make changes in the provider subcontracting section of the rule.

Rule 5101:3-26-07 entitled "Managed health care programs: Annual external quality review survey" (attached) contains revisions concerning MCP deeming for accreditation.

Rule 5101:3-26-08 entitled "Managed health care programs: Marketing" (attached) is being rescinded and adopted as new to reorganize the rule and to remove language concerning initial mailers.

Rule 5101: 3-26-08.1 entitled "Managed health care programs: Enrollment and information services" (attached) is being revised to insert clarifying language.

**The effective date for the enactment of these OAC rules is July 1, 2002.**

Should you have any questions regarding these OAC rules, please contact the BMHC at (614) 466-4693.

# Miscellaneous Medicaid Handbook Transmittal Letters

## **MHTL 3334-10-02**

**Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02** (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

[Click here to view MHTL 3334-10-02, New 2010 HCPCS and CPT Codes and Policy Updates](#)

## **MHTL 3336-10-01**

**Medicaid Handbook Transmittal Letter (MHTL) No. 3336-10-01** (Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule), is maintained in the Physician Services e-book.

[Click here to view MHTL 3336-10-01, Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule](#)

# Managed Care Medical Assistance Letters (MALs)

## **MAL 522**

**Medical Assistance Letter No 522** (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

## **MAL 516**

**Medical Assistance Letter No 516** (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

# MAL 494

## Medical Assistance Letter (MAL) No. 494

December 15, 2005

TO: Community Mental Health Agencies Certified by the Ohio Department of Mental Health to Provide Medication Somatic Services  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators  
Medicaid-contracting Managed Care Plans

FROM: Barbara E. Riley, Director

SUBJECT: Billing Instructions for Risperdal Consta provided to Medicaid-contracting managed care plan (MCP) members

This medical assistance letter (MAL) is to be used as a supplement to MALs [464](#) and [476](#) previously issued by the Ohio Department of Job and Family Services (ODJFS) regarding billing for Risperdal Consta when provided to Medicaid consumers. As described in MAL 464, through collaborative efforts between ODJFS and the Ohio Department of Mental Health (ODMH), Risperdal Consta has been available since April 1, 2004 as a Medicaid-covered physician-administered injection given every two weeks to those clients who have one of the following diagnoses: schizophrenia, schizoaffective disorder, delusional disorder and psychosis NOS. Only certain community mental health centers (CMHCs) which meet the required criteria outlined in MALs 464 and 476 are permitted to bill ODJFS or Medicaid-contracting managed care plans (MCPs). Because the prior MALs did not provide instructions on the billing process for Medicaid consumers enrolled in MCPs, ODJFS is providing the necessary instructions in this MAL.

CMHCs are to follow each MCP's claims processing procedures and directly bill the MCP for the drug when Risperdal Consta is provided to someone enrolled in an MCP. Only those CMHCs that are certified by ODMH to provide medication/somatic services and have been issued provider type 51 by ODJFS may directly bill the MCP for Risperdal Consta when the drug is administered to a Medicaid consumer enrolled in an MCP. Due to federal regulations, ODJFS cannot pay fee-for-service (FFS) claims for services provided to someone enrolled in an MCP, unless those services are carved out of the MCP's premium rate. The coverage of prescription drugs has not been carved out of the MCP's premium rate. Therefore, MCPs are required to cover this drug when MCP members receive the drug at a CMHC. Claims submitted to ODJFS for Risperdal Consta administered to MCP members will be denied.

While Risperdal Consta will be paid for by MCPs when administered to their members, the administration of the drug and/or the office visit will not be paid for by the MCPs. The administration of the drug and/or the office visit must be billed to the local Alcohol, Drug and Mental Health Services (ADAMHS)/CMH board per the regular billing process through the multi-agency community services information system (MACSIS).

Please note that MCPs have different billing and authorization policies that may not mirror FFS policies and requirements. For example, certain MCPs may require that the CMHC submit a prior authorization request before rendering payment to the CMHC for Risperdal Consta. Per Ohio Administrative Code (OAC) rule 5101:3-26-03.1 (A) (4), MCPs are required to share information regarding their billing policies, including any prior authorization requirements with CMHCs. MCPs are also required to follow federal regulations specified in Section 1927(d) (5) of the Social Security Act which require prescription drug prior authorization decisions to be made by the MCP within 24 hours of the initial request. To avoid any unintended deleterious consequences from not having the drug administered promptly, MCPs that utilize prescription drug prior authorization requirements must make all efforts to have prior authorization decisions for Risperdal Consta rendered as quickly as possible while the member is still at the CMHC. This will eliminate the need for the member to leave the CMHC and then return later for another office visit, prior to having the drug administered.

Except for the above-outlined billing exception for Risperdal Consta (currently billable under procedure code J2794), all other claims for community mental health services provided in conjunction with this drug should continue to be billed to the local ADAMHS/CMH Board through MACSIS. To determine whether a Medicaid

consumer is enrolled in an MCP or receiving services through the FFS system, CMHCs can confirm eligibility via the Provider Network Management Interactive Voice Response System at 1-800-686-1516.

For further information about current Medicaid-contracting MCPs and to obtain the contact information for each MCP, CMHCs can refer to the Bureau of Managed Health Care page of the ODJFS website at <http://ifs.ohio.gov/ohp/bmhc>. An electronic version of this MAL may be accessed at the ODJFS electronic manuals website <http://emanuals.odjfs.state.oh.us/emanuals> by clicking the link "Ohio Health Plans - Provider" (left column), "Managed Health Care" (right column), "Medical Assistance Letters" (left column).

CMHCs that have any further questions about ODJFS billing policies for Risperdal Consta should contact:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-1516

# **MAL 406**

## **Medical Assistance Letter (MAL) No. 406**

January 22, 2002

TO: All Medicaid Providers  
Directors, County Departments of Job and Family Services  
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Ohio Administrative Code Rule 5101:3-26-11

The purpose of this Medical Assistance Letter (MAL) is to inform Medicaid providers of the requirements in Ohio Administrative Code (OAC) rule 5101:3-26-11 as this rule contains some new language applicable to Medicaid providers who provide services to a managed care plan's (MCP's) enrollees, even if the Medicaid provider does not contract with the MCP (i.e., MCP non-contracting providers). As you may be aware, the Ohio Medicaid program has a managed care component which has primarily enrolled Covered Families and Children (CFC), including Healthy Start and Healthy Families eligibles, into participating MCPs in several counties.

On July 20, 2001, OAC rule 5101:3-26-11 was promulgated by the Ohio Department of Job and Family Services (ODJFS). This rule specifically addresses requirements for MCP non-contracting providers and is being forwarded to all providers currently participating in the fee-for-service (FFS) program (see attached). Although certain similar language may have existed elsewhere in the OAC, the language has now been inserted in OAC rule 5101:3-26-11 to consolidate the requirements for non-contracting providers in terms of managed health care programs.

A summary of the requirements in OAC rule 5101:3-26-11 is as follows:

- the rule requires MCP non-contracting providers to accept the lesser of one hundred percent of the current Medicaid provider rate or billed charges as payment in full for emergency services and qualified family planning services since MCPs are federally required to cover such services outside their provider network.
- the rule contains recipient liability language which similarly exists in OAC rule 5101: 3-1-131.
- the rule describes how MCP non-contracting providers should contact MCPs for the provision of post-stabilization care services.
- the rule requires MCP non-contracting providers to allow MCPs and/or ODJFS or its designee access to enrollee medical records.

For a list of current MCPs and their counties of service, please visit our website at <http://www.state.oh.us/odjfs/ohp/bmhc/index.stm>

**Questions pertaining to this MAL should be addressed to:**

**The Ohio Department of Job and Family Services**

**Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, OH 43216-1461**

**In-state toll free telephone number 1-800-686-6108**

**Out-of-state telephone number 1-614-724-3288**

Thanks for your attention to this matter.

**Attachment**



# Medicaid Managed Health Care Program Rules

MCTL 43

**Effective Date: February 1, 2015**

**Most Current Prior Effective Date: July 1, 2013**

As used in Chapter ~~5101:35160~~ 5160-26 of the Administrative Code:

- (A) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes consumer practices that result in unnecessary cost to the medicaid program.
- (B) "Advance directive" means written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.
- ~~(C) "Assignment" means the process as described in rule 5101:3-26-02 of the Administrative Code by which the MCEC, ODM, or other ODM-approved entity selects an MCP for eligible individuals in service areas where MCP selection is required.~~
- ~~(D)~~(C) "Assistance group" means a group of consumers receiving benefits together under a specific category of assistance.
- ~~(D)~~ "Authorized representative" has the same meaning as in rule 5160:1-1-55.1 of the Administrative Code.
- ~~(E) "Automatic renewal" means the process by which an eligible individual automatically terminated from managed care membership has membership in the same MCP renewed without the individual having to contact the MCEC or ODM.~~
- ~~(F) "Automatic termination" means the process as described in rule 5101:3-26-02.1 of the Administrative Code by which a member's managed care membership is terminated not at the request of the member or the MCP, but for reasons described in that rule.~~
- ~~(G) "CAP" means corrective action plan.~~
- ~~(H)~~(E) "Care plan" means a written document developed by the managed care plan for a member receiving care management services. The care plan is based on the assessment and includes measureable goals, interventions and outcomes with completion timeframes that address the member's clinical and non-clinical needs.
- ~~(I) "Case" means one or more assistance groups living in the same household.~~
- ~~(J)~~(F) "Care management" means activities performed on behalf of members that include services described in ~~paragraph (A)(8) of~~ rule ~~5101:35160~~ 5160-26-03.1 of the Administrative Code.
- ~~(K)~~(G) "CCR" means the consumer contact record. The CCR contains demographic health-related information provided by an eligible individual, managed care member, or ODM that is utilized by the ~~MCEC~~ medicaid consumer hotline to process membership transactions.
- ~~(L)~~(H) "CDJFS" means a county department of job and family services.
- ~~(M)~~(I) "C.F.R." means the Code of Federal Regulations, as amended, unless otherwise specified.
- ~~(N)~~(J) "CLIA" means the clinical laboratory improvement amendments regulated by CMS under 42 C.F.R. part 493 (~~May 1, 2013~~ October 1, 2013), laboratory requirements.
- ~~(O)~~(K) "CMS" means the centers for medicare and medicaid services.
- ~~(P)~~(L) "COB (coordination of benefits)" means a procedure establishing the order in which health care entities pay their claims.
- ~~(Q)~~(M) "COB claim" means any claim that meets the definition of a third party claim as established in this rule.

- ~~(R)~~(N) "Covered services" means those medical services set forth in rule ~~5101:35160-26-03~~ of the Administrative Code or a subset of those medical services.
- ~~(S)~~(O) "CSP" means coordinated services program as defined in rule ~~5101:35160-20-01~~ of the Administrative Code.
- ~~(T)~~(P) "DBA" means doing business as, in accordance with ODI's designation.
- ~~(U)~~(Q) "DEA" means drug enforcement administration.
- ~~(V)~~(R) "Eligible individual" means any medicaid consumer who is a legal resident of the managed care service area and is in one of the categories specified in the MCP's provider agreement with ODM.
- ~~(W)~~(S) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
- ~~(X)~~(T) "Emergency services" means covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition ~~as defined in paragraph (W) of this rule~~. As used in this chapter, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCP.
- ~~(Y)~~(U) "EOB (explanation of benefits)," otherwise known as "EOP (explanation of payment)," or "RA (remittance advice)," means the information sent to providers and/or members by any other third party payer, or managed care plan (MCP), to explain the adjudication of a claim.
- ~~(Z)~~ ~~"EQRO" means external quality review organization.~~
- ~~(AA)~~(V) "FQHC-" means a federally qualified health center as defined in rule ~~5101:35160-28-01~~ of the Administrative Code.
- ~~(BB)~~(W) "Fraud" means any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes fraud under applicable federal or state law. Member fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's identification card to obtain services or supplies.
- ~~(CC)~~(X) "Healthchek," services otherwise known as early and periodic screening, diagnosis, and treatment (EPSDT) services, are comprehensive preventive health services available to medicaid consumers from birth through twenty years of age.
- ~~(DD)~~(Y) "HIC" means a "health insuring corporation" as defined in section 1751.01 of the Revised Code.
- ~~(EE)~~(Z) "Hospital" means an institution located at a single site that is engaged primarily in providing to inpatients, by or under the supervision of an organized medical staff of physicians licensed under Chapter 4731. of the Revised Code, diagnostic services and therapeutic services for medical diagnosis and treatment or rehabilitation of injured, disabled, or sick persons. "Hospital" does not mean an institution that is operated by the United States government or the Ohio department of mental health and addiction services.
- ~~(FF)~~(AA) "Hospital services" means those inpatient and outpatient services that are generally and customarily provided by hospitals.
- ~~(GG)~~(BB) "Inpatient facility" means an acute or general hospital.
- ~~(HH)~~(CC) "Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" has the same meaning as in rule 5123:2-7-01 of the Administrative Code~~"Intermediate care facility for the mentally retarded (ICF-MR)" means a long-term care facility, or part of a facility, for the mentally retarded,~~

~~currently certified by the Ohio department of health as being in compliance with the ICF-MR standards and medicaid conditions of participation.~~

- ~~(H)~~(DD) "LEP" means limited-English proficiency.
- ~~(J)~~(EE) "LRP" means limited-reading proficiency.
- ~~(K)~~(FF) "~~MCEC (managed care enrollment center)~~" otherwise known as the "~~Ohio medicaid consumer hotline~~" "Medicaid consumer hotline" means an organization or individual under contract with or designated by ODM to provide medicaid managed care information and selection enrollment services to eligible individuals.
- ~~(L)~~(GG) "MCP (managed care plan)," otherwise known as "plan," means a HIC licensed in the state of Ohio that enters into a provider agreement with ODM in the managed health care program ~~pursuant to rule 5101:3-26-04 of the Administrative Code~~. For the purpose of this chapter, MCP does not include entities approved to operate as a PACE site, as defined in paragraph ~~(E)~~(VV) of this rule.
- ~~(M)~~(HH) "Medicaid" means medical assistance as defined in section ~~5111.01~~5162.01 of the Revised Code.
- ~~(N)~~(II) "Medically necessary," otherwise known as "medical necessity," as used in this chapter is the same as defined in ~~paragraph (A) of rule 5101:3~~5160-1-01 of the Administrative Code.
- ~~(O)~~(JJ) "Medicare" means the federally financed medical assistance program defined in 42 U.S.C. 1395 (~~April 15, 2013~~as in effect December 1, 2014).
- ~~(P)~~(KK) "Member," otherwise known as "enrollee," means a medicaid consumer who has selected MCP membership or has been assigned to an MCP for the purpose of receiving health care services.
- ~~(Q)~~(LL) "MFCU (medicaid fraud control unit)" means an identifiable entity of a state or federal governmental~~government~~ agency charged with the investigation and prosecution of fraud and related offenses within medicaid.
- ~~(R)~~(MM) "MHAS" means the Ohio department of mental health and addiction services.
- ~~(S)~~ "~~MR/DD~~" ~~means mental retardation or developmental disabilities.~~
- ~~(T)~~(NN) "NF (nursing facility)" ~~means any long-term care facility (excluding intermediate care facilities for the mentally retarded/developmentally disabled), or part of a facility, currently certified by the Ohio department of health as being in compliance with the nursing facility standards and medicaid conditions of participation~~ has the same meaning as in section 5165.01 of the Revised Code.
- ~~(U)~~(OO) "ODA" means the Ohio department of aging.
- ~~(V)~~(PP) "ODI" means the Ohio department of insurance.
- ~~(W)~~(QQ) "ODM" means the Ohio department of medicaid or its designee.
- ~~(X)~~(RR) "ODM approval" means written approval by ODM and does not constitute approval by any other state or federal agency.
- ~~(Y)~~ "~~ODM-approved entity~~" ~~means any entity other than the CDJFS that is under contract with or designated by ODM to perform the functions set forth in rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code.~~
- ~~(Z)~~(SS) "ODODD" means the Ohio department of developmental disabilities.
- ~~(AAA)~~(TT) "Oral interpretation services" means services provided to a limited-reading proficient eligible individual or member to ensure that he or she receives MCP information in a format and manner that is easily understood by the eligible individual or member~~means services provided to LRP consumers to ensure that they receive MCP information in a format and manner that is easily understood by those consumers.~~
- ~~(BBB)~~(UU) "Oral translation services" ~~means services provided to LEP consumers to ensure that they receive MCP information translated into the primary language of the consumer~~means services

provided to a limited-English proficient eligible individual or member to ensure that he or she receives MCP information translated into the primary language of the eligible individual or member.

- ~~(CCC)~~(VV) "PACE" has the same meaning as in rule 5160-36-01 of the Administrative Code ~~means the program of all inclusive care for the elderly. The PACE program integrates the provision of acute and long-term care across settings for frail older adults who have been determined to require at least an intermediate level of care as defined in rule 5101:3-3-06 of the Administrative Code.~~
- ~~(DDD)~~(WW) "PCP (primary care provider)" means an individual physician (M.D. or D.O.), ~~certain~~a physician group practice, ~~or an advanced practice registered nurse as defined in section 4723.434723.01 of the Revised Code, or an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Administrative Code~~ contracting with an MCP to provide services as specified in ~~paragraph (B) of rule 5101:35160-26-03.1 of the Administrative Code.~~ Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).
- ~~(EEE)~~(XX) "Pending member," otherwise known as "pending enrollee," means an eligible individual who has selected or been assigned to an MCP but whose MCP membership is not yet effective.
- ~~(FFF)~~(YY) "PHI (protected health information)" means information received from or on behalf of ODM that meets the definition of PHI as defined by 45 C.F.R. 160.103 (~~May 1, 2013~~October 1, 2013).
- ~~(GGG)~~(ZZ) "Post-stabilization care services" means covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (~~May 1, 2013~~October 1, 2013) to improve or resolve the member's condition.
- ~~(HHH)~~(AAA) "Premium" means the monthly payment amount per member to which the MCP is entitled as compensation for performing its obligations in accordance with Chapter ~~5101:35160-26 of the Administrative Code and/or the provider agreement with ODM.~~
- ~~(III)~~(BBB) "Provider" means a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed, or certified, ~~or other~~ appropriate individual or entity, that is authorized to or may be entitled to reimbursement for health care services rendered to an MCP's member.
- ~~(JJJ)~~(CCC) "Provider agreement" means a formal agreement between ODM and an MCP for the provision of medically necessary services to medicaid consumers who are enrolled in the MCP.
- ~~(KKK)~~(DDD) "Provider panel," otherwise known as "panel," means ~~an~~ the MCP's contracted providers available to the MCP's general membership ~~as specified in paragraph (A)(3) of rule 5101:3-26-05 of the Administrative Code.~~
- ~~(LLL)~~ "~~QAPI~~" ~~means a quality assessment and performance improvement program as described in rule 5101:3-26-07.1 of the Administrative Code.~~
- ~~(MMM)~~(EEE) "QFPP (qualified family planning provider)" means any public or nonprofit health care provider that complies with guidelines/standards set forth in 42 U.S.C. 300 (~~April 15, 2013~~as in effect December 1, 2014), and receives either Title X funding or family planning funding from the Ohio department of health.
- ~~(NNN)~~ "~~Quality indicators~~" ~~means measurable variables relating to a specified clinical or health services delivery area that are reviewed over a period of time to monitor the process or outcome of care delivered in that area.~~
- ~~(OOO)~~(FFF) "Risk" or "underwriting risk" means the possibility that an MCP may incur a loss because the cost of providing services may exceed the payments made by ODM to the contractor for services covered under the provider agreement.
- ~~(PPP)~~(GGG) "RHC" means a rural health clinic as defined in rule ~~5101:35160-16-01 of the Administrative Code.~~
- ~~(QQQ)~~(HHH) "Self-referral" means the process by which an MCP member may access certain services without ~~the PCP's and/or MCP's~~ prior approval from the PCP or the MCP.

- ~~(RRR)~~(III) "Service area" means the geographic area specified in the MCP's provider agreement.
- ~~(SSS)~~(JJJ) "SFY (state fiscal year)" means the period July first through June thirtieth, corresponding to the state of Ohio's fiscal year.
- ~~(TTT)~~(KKK) "State cut-off" means the eighth state working day prior to the end of a calendar month.
- ~~(UUU)~~(LLL) "Subcontract" means a written contract between an MCP and a third party, including the MCP's parent company or any subsidiary corporation owned by the MCP's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the MCP's provider agreement with ODM.
- ~~(MMM)~~ "Subcontractor" means any party that has entered into a subcontract to perform a specific part of the obligations specified under the MCP's provider agreement with ODM.
- ~~(VVV)~~ "~~Termination" means the process by which an individual's managed care membership is terminated. Terminations may be automatic, member-initiated, or plan-initiated as described in rule 5101:3-26-02.1 of the Administrative Code.~~
- ~~(WWW)~~(NNN) "Third party benefit" means any health care service(s) available to members through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the TPP or in part the obligation of the member, the TPP, and/or the MCP.
- ~~(XXX)~~(OOO) "Third party claim" means any claim submitted to the MCP for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by the MCP:
- (1) Any claim received by the MCP that shows no prior payment by a TPP, but the MCP's records indicate that the member has third party benefits.
  - (2) Any claim received by the MCP that shows no prior payment by a TPP, but the provider's records indicate that the member has third party benefits.
- ~~(YYY)~~(PPP) "TP (third party)" is as defined in section ~~5101.571~~5160.35 of the Revised Code.
- ~~(ZZZ)~~(QQQ) "TPA (third party administrator)" means any entity utilized in accordance with the provisions of this chapter to manage or administer a portion of services in fulfillment of the provider agreement with ODM.
- ~~(AAA)~~(RRR) "TPL (third party liability)" means the payment obligations of the TPP for health care services rendered to a member when the member also has third party benefits as described in paragraph ~~(YYY)~~(NNN) of this rule.
- ~~(BBB)~~(SSS) "TPP (third party payer)" means an individual, an entity, or a program responsible for adjudicating and paying claims for third party benefits rendered to an eligible member.
- ~~(CCC)~~(TTT) "Title V," otherwise known as the "program for medically handicapped children," means the program established under sections 3701.021 to 3701.0210 of the Revised Code.
- ~~(DDD)~~(UUU) "Title X services" means services and supplies allowed under 42 U.S.C. 300 (~~April 15, 2013~~as in effect December 1, 2014), and provided by a qualified family planning provider.
- ~~(EEE)~~(VVV) "Tort action," otherwise known as "subrogation," means the right of ODM to recover payment received from a third party payer who may be liable for the cost of medical services and care arising out of an injury, disease, or disability to the member.
- ~~(FFF)~~(WWW) "United States" means the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Effective: 02/01/2015

Five Year Review (FYR) Dates: 10/30/2014 and 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

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**MCTL 45****Effective Date: April 1, 2015****Most Current Prior Effective Date: July 1, 2013**

- (A) ~~For the purpose of this rule, "authorized representative" means an individual eighteen years of age or older who stands in the place of the consumer. The authorized representative may act on behalf of individuals inside or outside of the household in which the authorized representative lives. For the purpose of this rule, the authorized representative may be the primary information person of the household, another member of the same assistance group, a custodial parent, or a person designated by custodial parent.~~ This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code. The eligibility, membership, and automatic renewal provisions for MyCare Ohio plans are described in rule 5160-58-02 of the Administrative Code.
- (B) Eligibility.
- (1) ~~For the purpose of this rule, an eligible individual is a medicaid consumer who is either subject to mandatory MCP membership or has the option to select MCP membership, and is~~ In mandatory service areas as permitted by 42 CFR 438.52 (October 1, 2013), an individual must be enrolled in an MCP if he or she meets the following criteria and paragraphs (B)(2) to (B)(5) of this rule do not apply:
- (a) ~~Found eligible~~ Eligible for covered families and children (CFC) medicaid in accordance with Chapter ~~5101:1-40~~ 5160:1-4 of the Administrative Code or modified adjusted gross income (MAGI)-based medicaid eligibility in accordance with division 5160:1 of the Administrative Code, ~~and paragraphs (B)(2) to (B)(4) of this rule do not apply; and~~ or
- (b) ~~Found eligible~~ Eligible for aged, blind, or disabled (ABD) medicaid in accordance with Chapter ~~5101:1-39~~ 5160:1-3 of the Administrative Code, ~~and paragraphs (B)(2), (B)(4), and (B)(5) of this rule do not apply.~~
- (2) Individuals who are dually eligible under both the medicaid and medicare programs are excluded from medicaid MCP membership.
- (3) The following individuals are not required to enroll in an MCP:
- (a) Children under nineteen years of age and receiving Title IV-E federal foster care maintenance through an agreement between the local children services board and the foster care provider;
- (b) Children under nineteen years of age and receiving Title IV-E adoption assistance through an agreement between the local children services board and the adoptive parent;
- (c) Children under nineteen years of age and in foster care or other out-of-home placement; ~~and~~
- (d) Children under nineteen years of age and receiving services through the Ohio department of health's bureau for children with medical handicaps (BCMh) or any other family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act, 42 U.S.C. 701(a)(1)(D) (as in effect December 1, 2014) and is defined by the state in terms of either program participation or special health care needs; ~~and~~
- (e) Indians who are members of federally recognized tribes.
- ~~(4) Indians who are members of federally recognized tribes are not required to enroll in an MCP, except as permitted under 42 C.F.R. 438.50(d)(2) (May 1, 2013).~~
- ~~(5)~~ (4) Eligible individuals for ABD described in paragraph (B)(1)(b) of this rule are excluded from MCP membership if they are:
- (a) Institutionalized;

- (b) Eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements; or
- (c) Individuals receiving medicaid services through a medicaid waiver component, as defined in section ~~5111.85~~5166.02 of the Revised Code.

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

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

~~(8)~~(6) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for other non-medicaid benefits to which he or she may be entitled.

(C) ~~MCP enrollment~~Enrollment.

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

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

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

(a) The MCP membership must accept eligible individuals ~~occur~~ without regard to an eligible individual's race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services. The MCP will not use any discriminatory policy or practice ~~as specified~~ in accordance with 42 C.F.R. 438.6(d)(4) (May 1, 2013)October 1, 2013.

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

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

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

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

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

~~(f)~~ The MCEC shall document via the CCR all information provided by the eligible individual or the authorized representative of each eligible assistance group requesting MCP membership. ~~The MCEC shall document via the CCR that oral authorization of MCP membership was given and the date of the authorization.~~

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

~~(h)~~(d) In the event that an MCP member loses medicaid eligibility and is automatically terminated from the MCP, but regains medicaid eligibility within a period of sixty days or less, his or her membership in the same MCP shall automatically be ~~renewed~~re-instated.

- (f)(e) ODM shall confirm the eligible individual's MCP membership to the MCP via an ODM-produced roster of new members, continuing members, and terminating members.
- (f)(f) The MCP shall not be required to provide coverage until MCP membership is confirmed via an ODM-produced roster except as provided in paragraph (C)(6)(3) of this rule or upon mutual agreement between ODM and the MCP.

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

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

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

~~(b)(a) When a service area is initially designated by ODM as mandatory for eligible individuals specified in paragraph (B)(1) of this rule, ODM shall confirm the eligibility of each eligible individual as prescribed in paragraph (C)(3)(i)(C)(1)(e) of this rule. Upon the confirmation of eligibility:~~

- ~~(i) Eligible individuals residing in the service area who are currently MCP members are deemed participants in the mandatory program; and~~
- ~~(ii) All other eligible individuals residing in the mandatory service area may request MCP membership at any time but must select an MCP following receipt of a notification of mandatory selection (NMS) issued by ODM.~~

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

- ~~(i) An eligible assistance group individual that does not make a choice following issuance of an NMS by ODM and one additional notice will be assigned to an MCP by ODM, the MCEC medicaid consumer hotline, or other ODM-approved entity.~~
- ~~(ii) ODM or the MCEC medicaid consumer hotline shall assign the assistance group individual to an MCP based on prior medicaid fee-for-service and/or MCP membership history, whenever available, or at the discretion of ODM.~~
- ~~(iii) In the event that an eligible assistance group does not identify to the MCEC those individuals who are not required to enroll in an MCP because they meet the criteria as specified in paragraphs (B)(3) and (B)(4) of this rule, such individuals shall be enrolled in the same MCP as the rest of the assistance group until such time as the assistance group notifies the MCEC.~~

~~(6)(3) Newborn notification and membership.~~

- ~~(a) The MCP must notify ODM, or its designee, as directed by ODM of the birth of any newborn whose mother is enrolled in an MCP.~~
- ~~(b) Newborns born to mothers enrolled in an MCP are enrolled in an MCP from their date of birth through the end of the month of the child's first birthday, in accordance with the enrollment and disenrollment criteria specified in Chapter 5160-26 unless the newborn is a case addition due to the mother's eligibility for ABD medicaid as described in paragraph (B)(1)(b) of this rule. Enrollment and disenrollment of newborns shall be in accordance with Chapter 5101:3-26 of the Administrative Code.~~

(D) Commencement of coverage.

- (1) Coverage of MCP members will be effective at the beginning of the first day of the calendar month following the confirmation of the eligible individual's effective date of MCP membership via an ODM-produced roster to the MCP, except as identified in paragraph (C)(6)(3) of this rule.

- (2) The following coverage responsibilities shall apply for a new member admitted to an inpatient facility prior to the effective date of managed care coverage who remains an inpatient on the effective date of coverage in accordance with the following:
- (a) The new member must be enrolling in the MCP from medicaid fee-for-service. In the event the member is transferring membership from one MCP to another, the provisions of paragraphs (D)(3) and (D)(4) of this rule apply.
  - (b) The MCP shall assume responsibility for all medically necessary medicaid covered services including professional and ancillary services related to the inpatient stay beginning with the effective date of membership in the MCP, except for the inpatient facility charges. Medicaid fee-for-service shall remain responsible for the inpatient facility charges through the date of discharge pursuant to rule ~~5101:3~~5160-2-07.11 of the Administrative Code.
- (3) The coverage responsibilities listed in paragraph (D)(4) of this rule shall apply to a member who meets the following criteria:
- (a) The member's current MCP membership is changed or terminated for any reason, including, but not limited to, any of the reasons set forth in rule ~~5101:3~~5160-26-02.1 of the Administrative Code, except if the member becomes ineligible for medicaid ~~for the reason specified in paragraph (C)(2)(a) of rule 5101:3-26-02.1 of the Administrative Code~~; and
  - (b) The member is admitted to an inpatient facility prior to the effective date of the MCP change or termination; and
  - (c) The member remains an inpatient in an inpatient facility after the date that membership in the current MCP ends.
- (4) The following coverage responsibilities shall apply to a member who meets the criteria listed in paragraph (D)(3) of this rule:
- (a) The disenrolling MCP shall remain responsible for providing all medically necessary medicaid covered services through the last day of the month in which the membership is changed or terminated, and shall remain responsible for all inpatient facility charges through the date of discharge. For retroactive disenrollments authorized by ODM, where the date of inpatient admission is prior to the last day of MCP coverage, the disenrolling MCP is responsible for inpatient facility charges through the date of discharge.
  - (b) The disenrolling MCP shall receive capitation through the end of the month in which membership is changed or terminated regardless of the length of the inpatient stay. Additional capitation payments will not be made by ODM regardless of the length of the inpatient stay.
  - (c) If the member will be enrolling in a new MCP, the disenrolling MCP shall notify the enrolling MCP of the inpatient status of the member following verification of the change or termination by the MGEC medicaid consumer hotline via the consumer contact record and the disenrollment by ODM via the monthly member roster.
  - (d) The disenrolling MCP shall notify the inpatient facility of the change or termination in MCP enrollment including the name of the enrolling MCP, if applicable, following verification of the disenrollment by ODM via the monthly membership roster, but advise the inpatient facility that the disenrolling MCP shall remain responsible for the inpatient facility charges through the date of discharge.
  - (e) If the member will be enrolling in a new MCP, the enrolling MCP shall assume responsibility for all medically necessary medicaid covered services including professional and ancillary services related to the inpatient stay beginning with the effective date of membership in the MCP, except for the inpatient facility charges.
  - (f) If the member will be enrolling in a new MCP, the enrolling MCP shall receive capitation beginning with the effective date of MCP membership.

- (g) If the member will be enrolling in a new MCP, then upon notification of the inpatient status of the new member as specified in paragraph (D)(4)(c) of this rule, the enrolling MCP shall contact the inpatient facility to verify responsibility for all services following discharge for the member, and to assure that discharge plans are arranged through the MCP's panel. The enrolling MCP shall also verify the MCP's responsibility for all professional and ancillary charges related to the inpatient stay beginning with the effective date of MCP membership.
- (h) If the member will be enrolling in a new MCP, and if the enrolling MCP fails to contact the inpatient facility prior to discharge, the enrolling MCP must honor discharge arrangements until such time that the MCP can transition the member to the MCP's participating providers.

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**MCTL 38**

**Effective Date: July 1, 2013**

**Most current prior effective date: August 1, 2010**

- (A) For the purpose of this rule, "authorized representative" means an individual eighteen years of age or older who stands in the place of the consumer. The authorized representative may act on behalf of individuals inside or outside of the household in which the authorized representative lives. For the purpose of this rule, the authorized representative may be the primary information person of the household, another member of the same assistance group, a custodial parent, or a person designated by a custodial parent.
- (B) Termination of MCP membership occurs through one of the following:
- (1) Automatic termination occurs due to a change in MCP member medicaid eligibility, residence, or other circumstance, as set forth in paragraph (C) of this rule.
  - (2) Member-initiated termination occurs as set forth in paragraph (D) of this rule.
  - (3) MCP-initiated termination occurs as set forth in paragraph (E) of this rule.
- (C) The following applies to all automatic terminations of MCP membership in voluntary and mandatory service areas:
- (1) Automatic termination occurs at the individual level.
  - (2) Automatic termination occurs for one of the following reasons:
    - (a) The member becomes ineligible for medicaid.
    - (b) The member's permanent place of residence is moved outside the MCP membership service area.
    - (c) The member dies, in which case the period of MCP membership ends on the date of death.
    - (d) An MCP member is placed in a residential facility for the treatment of behavioral or developmental health issues and ODJFSODM determines following investigation, that ongoing receipt of health care through the MCP may not be in the best interest of the member or meet the rules of MCP enrollment. Upon ODJFSODM approval, termination is effective the last day of the month preceding placement.
    - (e) A member is incarcerated for either more than fifteen working days or is incarcerated and has accessed non-emergent medical care. When this occurs and following MCP, CDJFS, or other public agency notification to ODJFSODM, termination is effective the last day of the month prior to incarceration.
    - (f) A member is found by ODJFSODM to meet the criteria for an ICF-MR level of care and is then placed in an ICF-MR facility. When this occurs and following MCP notification to ODJFSODM, membership termination is effective the last day of the month preceding placement in the ICF-MR facility.
    - (g) A member is placed in a nursing facility (NF):
      - (i) Prior to the membership effective date and the member remains in the NF on the membership effective date. Following MCP notification to ODJFSODM, the membership termination is effective the last day of the month preceding placement in the NF. When this occurs, the MCP must submit required documentation which includes, but is not limited to, a copy of the approved level of care (LOC) obtained pursuant to division 5101:3 of the Administrative Code and a copy of the NF admission form or other proof of NF admission.

- (ii) After the membership effective date, and the member remains authorized by the MCP for NF services ~~in the NF~~ past the last day of the second calendar month following the month of NF admission. Following MCP notification to ODJFSODM, membership termination is effective the last day of the second calendar month following the month of NF admission. When this occurs, the MCP must submit required documentation which includes, but is not limited to, a copy of the approved level of care (LOC) obtained pursuant to division 5101:3 of the Administrative Code and a copy of the NF admission form or other proof of NF admission.
  - (h) A member is enrolled in a home and community-based waiver program administered by ODJFSODM, Ohio department of aging (ODA), or Ohio department of developmental disabilities (ODODD). When this occurs, termination is effective no later than the last day of the month preceding enrollment in the home and community-based waiver program.
  - (i) A minor MCP member's custody has been legally transferred from the legal parent or guardian to another entity. When this occurs, following appropriate notification to ODJFSODM, membership termination is effective the last day of the month preceding the transfer.
  - (j) A member becomes ineligible in an MCP medicaid-eligible category.
  - (k) A member's eligibility changes from either the ABD category of assistance as described in paragraph (B)(1)(b) of rule 5101:3-26-02 of the Administrative Code to the CFC category of assistance as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code or from the CFC category of assistance as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code to the ABD category of assistance as described in paragraph (B)(1)(b) of rule 5101:3-26-02 of the Administrative Code.
  - (l) A member has third party coverage and ODJFSODM determines, following MCP, member, or other public agency notification to ODJFSODM and based on the type of coverage and the existence of conflicts between provider panels and access requirements, that continuing MCP membership may not be in the best interest of the member. When this occurs the effective date of termination shall be determined by ODJFSODM but in no event shall the termination date be later than the last day of the month in which ODJFSODM approves the termination.
  - (m) The provider agreement between ODJFSODM and the MCP is terminated or ODJFSODM takes action as specified in paragraphs (G) and (H) of rule 5101:3-26-10 of the Administrative Code.
- (3) Automatic terminations of MCP membership do not require completion of a CCR.
  - (4) Except as specified in paragraphs (C)(2)(c) to (C)(2)(i) of this rule, automatic membership termination will be effective at the end of the last day of the month in which the change in eligibility, residence, or other circumstance occurred.
  - (5) If ODJFSODM fails to notify the MCP of a member's termination from an MCP, ODJFSODM shall continue to pay the MCP the monthly premium rate with respect to such member, subject to the provisions of rule 5101:3-26-09 of the Administrative Code. The MCP shall remain liable for the provision of covered services as set forth in rule 5101:3-26-03 of the Administrative Code, until such time as ODJFSODM provides the MCP with documentation of the member's termination.
  - (6) ODJFSODM shall recover from the MCP any premium paid for retroactive membership termination occurring as a result of paragraphs (C)(2)(c) to (C)(2)(i) of this rule.
  - (7) In the event that an MCP member loses medicaid eligibility during an annual open enrollment period resulting in the temporary inability to change managed care plans, the member may

request to change managed care plans within thirty days following automatic renewal of MCP membership.

- (D) The following applies to MCP member-initiated change requests or terminations:
- (1) MCP member-initiated change requests or terminations must occur at the assistance group level except as provided in paragraph (B)(1)(b) of rule 5101:3-26-02 of the Administrative Code and paragraphs (D)(2)(d) and (D)(9)(e) of this rule. All individuals within an assistance group must be terminated at the same time.
  - (2) MCP member-initiated change requests in mandatory service areas or MCP member-initiated terminations in voluntary service areas may occur:
    - (a) From the date of enrollment through the initial three months of MCP membership; or
    - (b) During an open enrollment month for the member's service area as described in paragraph (D)(8) of this rule; or
    - (c) If the just cause request meets one of the reasons for just cause as specified in paragraph (D)(9)(a) of this rule; or
    - (d) Upon notification to the MCEC if the member meets the criteria as specified in paragraphs (B)(2) to (B)(4) of rule 5101:3-26-02 of the Administrative Code, MCP membership is terminated in mandatory and voluntary counties.
  - (3) When requesting MCP member-initiated change requests in mandatory service areas, members must select membership in another participating MCP except as specified in paragraph (D)(2)(d) of this rule.
  - (4) When requesting MCP member-initiated terminations in voluntary service areas, members will be returned to medicaid fee-for-service or may select membership in another participating MCP, if available.
  - (5) The MCEC shall document via the consumer contact record (CCR) all information provided by the member or authorized representative of each eligible assistance group requesting termination. The MCEC shall document via the CCR that oral authorization was given and the date of the authorization.
  - (6) MCP member-initiated terminations in voluntary service areas, and MCP member-initiated change requests in mandatory service areas, will be effective the last day of the calendar month or the succeeding calendar month, subject to state cut-off.
  - (7) MCPs must:
    - (a) Provide information on MCP membership change or termination options, including reasons for just cause requests as described in paragraph (D)(9)(a) of this rule, to eligible individuals and members as required in rules 5101:3-26-08 and 5101:3-26-08.2 of the Administrative Code.
    - (b) Continue to recognize the MCP identification card and not request its return from the member until the MCP receives documentation from ODJFSODM that the change or termination is effective. ODJFSODM shall continue to pay the MCP the monthly premium until the change or termination is effective.
  - (8) Open enrollment months will be designated for each voluntary and mandatory service area by ODJFSODM or its designee at least annually. ODJFSODM shall notify each assistance group by mail at least sixty days prior to the designated open enrollment month of the opportunity to change or terminate MCP membership and where to obtain further information. During open enrollment months, consumers not in their initial three months of membership as described in paragraph (D)(2)(a) of this rule or meeting the criteria described in paragraphs (D)(2)(c) and (D)(2)(d) of this rule will be limited to only a one month time period to change MCPs.
  - (9) MCP members or authorized representatives may request to change or terminate MCP membership for just cause when the members' or authorized representatives' contacts to the

MCPs are unsuccessful in identifying providers of services that would alleviate the members' need to make a just cause request.

- (a) Changing MCPs in mandatory service areas or terminating MCP membership in voluntary service areas for just cause includes the following:
    - (i) The member moves out of the MCP's service area and a non-emergency service must be provided out of the service area before the effective date of the member's automatic termination as described in paragraph (C)(2)(b) of this rule;
    - (ii) The MCP 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 MCP network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk;
    - (iv) Poor quality of care and the services are not available from another provider within the MCP's network;
    - (v) Lack of access to medically necessary medicaid-covered services or lack of access to the type of providers experienced in dealing with the member's health care needs;
    - (vi) The PCP selected by a member leaves the MCP's panel and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCP in the member's service area; and
    - (vii) A situation in which, as determined by ODJFSODM, continued membership in the MCP would be harmful to the interests of the member.
  - (b) Requests for just cause must be made directly to ODJFSODM or other ODJFSODM-approved entity orally or in writing.
  - (c) ODJFSODM shall review all requests for just cause within seven working days of receipt. ODJFSODM may request documentation as necessary from both the member and the MCP. ODJFSODM shall make a decision within forty-five days from the date ODJFSODM receives the just cause request. ODJFSODM may establish retroactive termination dates and/or recover premium payments as determined necessary and appropriate. 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. If ODJFSODM fails to make the determination within this timeframe, the just cause request is considered approved.
  - (d) If the just cause request is not approved, ODJFSODM shall notify the member or the authorized representative of the member's right to a state hearing.
  - (e) Requests for just cause may be processed at the individual level or the assistance group level as ODJFSODM determines necessary and appropriate.
  - (f) In the case of members who lose medicaid eligibility prior to ODJFSODM action to change or terminate membership for just cause, ODJFSODM shall assure that the member's MCP membership is not automatically renewed if eligibility for medicaid is reauthorized.
- (10) All MCP member-initiated changes or terminations must be voluntary. No member may be encouraged by an MCP to change or terminate due to an adverse change in the member's health status or need for health services, age, gender, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry. No policy or practice that has the effect of discrimination on the basis of race, color, or national origin shall be used.

- (E) The following applies to all MCP-initiated membership terminations:
- (1) In the following instances, the MCP may submit a request to ODJFSODM for the termination of a member:
    - (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 MCP's ability to provide services to either the member or other MCP members.
  - (2) All proposed MCP-initiated terminations of members must contain ODJFSODM-specified documentation.
  - (3) The MCP may not request termination due to a change in the member's health status or need for health services, age, gender, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry.
  - (4) There are no state hearing rights for a member(s) terminated from an MCP pursuant to paragraph (E)(1) of this rule.
  - (5) The MCP must provide medicaid-covered services to a terminated member(s) through the last day of the month in which the MCP membership is terminated, notwithstanding the date of ODJFSODM approval of the termination request. Inpatient facility services must be provided in accordance with paragraphs (D)(3) and (D)(4) of rule 5101:3-26-02 of the Administrative Code.
  - (6) For MCP-initiated termination of MCP membership:
    - (a) Termination must occur at the assistance group level with all members returning to the fee-for-service medicaid program, if eligible.
    - (b) If ODJFSODM approves the MCP's request for termination, ODJFSODM shall:
      - (i) Notify the member(s) or authorized representative, in writing, of the impending MCP-initiated termination of all members within the assistance group; and
      - (ii) Notify in writing the member(s) or authorized representative, the MCP, or other ODJFSODM-approved entity and the MCEC, when applicable, of the decision to terminate all members within the assistance group, and initiate the process for returning the individuals to the fee-for-service medicaid program.
- (F) The MCP must provide medicaid-covered services to a terminated member(s) through the last day of the month in which the MCP membership is terminated, with the exception of inpatient facility services that must be provided in accordance with paragraphs (D)(3) and (D)(4) of rule 5101:3-26-02 of the Administrative Code.

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**MCTL 40**

**Effective Date: January 1, 2014**

**Most Current Prior Effective Date: July 1, 2013**

- (A) Except as provided in this rule, managed care plans (MCPs) must ensure that members have access to all medically-necessary services covered by medicaid. The MCP must ensure that:
- (1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;
  - (2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;
  - (3) Coverage decisions are based on the coverage and medical necessity criteria published in ~~division agency 5101:3-5160~~ of the Administrative Code and practice guidelines specified in ~~paragraph (B) of rule 5101:3-5160~~ rule 5160-26-05.1 of the Administrative Code; and
  - (4) If a member is unable to obtain medically-necessary services offered by medicaid from a MCP panel provider, the MCP must adequately and timely cover the services out of panel, until the MCP is able to provide the services from a panel provider.
- (B) MCPs may place appropriate limits on a service;
- (1) On the basis of medical necessity; or
  - (2) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.
- (C) MCPs must cover annual physical examinations for adults.
- (D) At the request of the member, MCPs must provide for a second opinion from a qualified health care professional within the panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.
- (E) MCPs must assure that emergency care services as defined in rule ~~5101:3-5160~~-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:
- (1) MCPs may not deny payment for treatment obtained when a member had an emergency medical condition, as defined in rule 5160-26-01 of the Administrative Code ~~including cases in which the absence of immediate medical attention would not have resulted in the outcomes specified in paragraph (W) of rule 5101:3-26-01 of the Administrative Code.~~
  - (2) MCPs cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
  - (3) MCPs must cover all emergency services without requiring prior authorization.
  - (4) MCPs must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the MCP including but not limited to the member's PCP or the MCP's twenty-four-hour toll-free call-in-system.
  - (5) MCPs cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.
  - (6) For the purposes of this paragraph, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCP but provides emergency services to an MCP member, regardless of whether or not that provider has a medicaid provider

agreement with ODM. An MCP must cover emergency services as defined in ~~paragraph (X) of~~ rule ~~5101:35160-26-01~~ of the Administrative Code when the services are delivered by a non-contracting provider of emergency services and claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in ~~paragraph (W) of~~ rule ~~5101:35160-26-01~~ of the Administrative Code. Such services must be reimbursed by the MCP at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the MCP is required to reimburse at this rate only until the member can be transferred to a provider designated by the MCP.

- (7) MCPs must adhere to the judgment of the attending provider when requesting a member's transfer to another facility or discharge. MCPs may establish arrangements with hospitals whereby the MCP may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.
  - (8) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
- (F) MCPs must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (E)(6) of this rule. Such information must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. MCPs may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.
- (G) MCPs must assure that post-stabilization care services as defined in rule ~~5101:35160-26-01~~ of the Administrative Code are provided and covered twenty-four hours a day, seven days a week.
- (1) The MCP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day. MCPs must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The MCP must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time that the MCP communicated the decision in writing to the provider.
  - (2) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:
    - (a) MCPs must cover services obtained within or outside the MCP's panel that are pre-approved in writing to the requesting provider by a plan provider or other MCP representative.
    - (b) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain the member's stabilized condition within one hour of a request to the MCP for preapproval of further post-stabilization care services.
    - (c) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain, improve or resolve the member's stabilized condition if:
      - (i) The MCP fails to respond within one hour to a provider request for authorization to provide such services.
      - (ii) The MCP cannot be contacted.

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

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

- (a) A plan provider with privileges at the treating hospital assumes responsibility for the member's care;
- (b) A plan provider assumes responsibility for the member's care through transfer;
- (c) A MCP representative and the treating provider reach an agreement concerning the member's care; or
- (d) The member is discharged.

(H) Exclusions, limitations and clarifications.

(1) When an MCP member is placed in a nursing facility (NF) and is not using a hospice service, the MCP is responsible for payment of medically necessary NF services as described in rule ~~5101:35160-3-02.3~~ of the Administrative Code. MCP members may be disenrolled upon request to ODM by the MCP in accordance with ~~paragraph (C) of rule 5101:35160-26-02.1~~ of the Administrative Code if all of the following are met:

- (a) The MCP has authorized NF services for the month of NF admission and for one complete consecutive calendar month thereafter;
- (b) For the entire period in (a) above, the member has remained in the NF without any admission to an inpatient hospital or long-term acute care (LTAC) facility;
- (c) The member's discharge plan documents that NF discharge is not expected in the foreseeable future and the member has a need for long-term NF care.

(2) MCPs are not responsible for payment of services provided to a member that has been enrolled in a home and community-based waiver program administered by ODM, the Ohio department of aging (ODA), or the Ohio department of developmental disabilities (ODODD). MCP members enrolled in a waiver program will be disenrolled in accordance with ~~paragraph (C)(2)(h) of rule 5101:35160-26-02.1~~ of the Administrative Code.

(3) MCPs are not responsible for payment of habilitation services as described in 42 U.S.C. 1396n(c)(5) (~~April 15~~ August 9, 2013).

(4) MCP members are permitted to self-refer to mental health services and substance abuse services offered through the Ohio department of mental health and addiction services (MHA) community mental health centers and MHA-certified medicaid providers. MCPs must ensure access to medicaid-covered behavioral health services for members who are unable to timely access services or unwilling to access services through community providers.

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

(6) MCPs must permit members to self-refer to any women's health specialist within the MCP's panel for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.

- (7) MCPs must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- (8) Where available, MCPs must ensure access to covered services provided by a certified nurse practitioner.
- (9) ODM may approve an MCP's members to be referred to certain MCP non-contracting hospitals, as specified in rule ~~5401:3~~5160-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODM permits such authorization, ODM will notify the MCP and the MCP non-contracting hospital of the terms and conditions, including the duration, of the approval and the MCP must reimburse the MCP non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the MCP non-contracting hospital. ODM will base its determination of when an MCP's members can be referred to MCP non-contracting hospitals pursuant to the following:
  - (a) The MCP's submission of a written request to ODM for the approval to refer members to a hospital that has declined to contract with the MCP. The request must document the MCP's contracting efforts and why the MCP believes it will be necessary for members to be referred to this particular hospital; and
  - (b) ODM consultation with the MCP non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the MCP, including but not limited to whether the MCP's contracting efforts were unreasonable and/or that contracting with the MCP would have adversely impacted the hospital's business.
- (10) Paragraph (H)(9) of this rule is not applicable when an MCP and an MCP non-contracting hospital have mutually agreed to that hospital providing non-emergency hospital services to an MCP's members. MCPs must ensure that such arrangements comply with ~~paragraph (A)(9) of rule 5401:3~~5160-26-05 of the Administrative Code.
- (11) MCPs are not responsible for payment of services provided through medicaid school program (MSP) providers pursuant to Chapter ~~5401:3~~5160-35 of the Administrative Code. MCPs must ensure access to medicaid-covered services for members who are unable to timely access services or unwilling to access services through MSP providers.
- (12) MCPs are responsible for providing respite services to eligible members, as described in this paragraph. "Respite services" are services that provide short-term, temporary relief to the informal unpaid caregiver of an individual under the age of twenty-one in order to support and preserve the primary caregiving relationship. The service provides general supervision of the child, and meal preparation and hands-on assistance with personal care that are incidental to supervision of the child during the period of service delivery. Respite services can be provided on a planned or emergency basis and shall only be furnished in the child's home. The provider must be awake during the provision of respite services and the services shall not be provided overnight.
  - (a) To be eligible for respite services, the member must meet all of the following criteria:
    - (i) The member must reside with his or her informal, unpaid primary caregiver in a home or an apartment that is not owned, leased or controlled by a provider of any health-related treatment or support services.
    - (ii) The member must not be residing in foster care.
    - (iii) The member must be under the age of twenty-one and determined eligible for social security income for children with disabilities or supplemental security disability income for adults disabled since childhood.
    - (iv) The member must be enrolled in the MCP's care management program.
    - (v) The member must be determined by the MCP to meet an institutional level of care as set forth in rules 5160-3-07 and 5160-3-08 of the Administrative Code.

- (vi) The member must require skilled nursing or skilled rehabilitation services at least once per week.
- (vii) The member must have received at least fourteen hours per week of home health aide services for at least six consecutive months immediately preceding the date respite services are requested.
- (viii) The MCP must have determined that the child's primary caregiver has a need for temporary relief from the care of the child as a result of the child's long term services and support needs/disabilities, or in order to prevent the provision of institution or out-of-home placement.
- (b) Respite services are limited to no more than twenty-four hours per month and no more than two hundred fifty hours per calendar year.
- (c) Respite services must be provided by individuals employed by enrolled medicaid providers that are either medicare-certified home health agencies pursuant to Chapter 3701-60 of the Administrative Code, or otherwise-accredited agencies (i.e., accredited by the "Joint Commission", the "Community Health Accreditation Program", or the "Accreditation Commission for Health Care") as that term is defined in rule 5160-45-01 of the Administrative Code.
  - (i) Before commencing service delivery, the provider agency employee must:
    - (a) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under Section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 CFR 484.36 (August 14, 2013), and
    - (b) Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.
  - (ii) After commencing service delivery, the provider agency employee must:
    - (a) Maintain evidence of completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation, and
    - (b) Receive supervision from an Ohio-licensed RN and meet any other additional supervisory requirements pursuant to the agency's certification or accreditation.
- (d) Respite services must not be delivered by the child's legally responsible family member or foster caregiver.

- (12)(13) MCPs must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with the periodicity schedule identified in Chapter ~~5104:3~~5160-14 of the Administrative Code, to eligible individuals and assure that services are delivered and monitored as follows:
- (a) Healthchek exams must include those components specified in Chapter ~~5104:3~~5160-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual external quality review.
  - (b) The MCP or its contracting provider must notify members of the appropriate healthchek exam intervals as specified in Chapter ~~5104:3~~5160-14 of the Administrative Code.

- (c) Healthchek exams are to be completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.

- (l) Out-of-country coverage

MCPs are not required to cover services provided to members outside the United States.

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**MCTL 39**

**Effective Date: October 1, 2013**

**Most Current Prior Effective Date: January 1, 2012**

- (A) Managed care plan (MCP) care coordination responsibilities.
- (1) MCPs must ensure that each member has a primary care provider (PCP) who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member's needs. The care coordination responsibilities of a PCP are set forth in paragraph (B) of this rule.
  - (2) MCPs must ensure that PCPs are in compliance with the following triage requirements:
    - (a) Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site;
    - (b) Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site; and
    - (c) Members with requests for routine care must be seen within six weeks.
  - (3) At the request of the member, MCPs must provide for a second opinion from a qualified health care professional within the MCP's panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.
  - (4) Care coordination with ~~ODJFS~~ODM-designated providers.
    - (a) MCPs are required to share specific information with ~~ODJFS~~ODM-designated non-panel providers-. Such information includes, but is not limited to, the MCP's contact information, prior authorization procedures, and a list of panel laboratories and pharmacies.
    - (b) Upon request, MCPs must provide information to ~~ODJFS~~ODM to document the non-contracting providers identified by the MCP under paragraph (A)(4)(a) of this rule and the information the MCP provided to each provider.
  - (5) MCPs that require referrals to specialists must ensure that information on referral approvals and denials is made available to ~~ODJFS~~ODM upon request.
  - (6) MCPs must provide a centralized toll-free call-in system that is available nationwide twenty-four hours a day, seven days a week.
    - (a) The call-in system must be staffed by trained medical professionals who will provide members with medical advice and direct members to the appropriate care setting. Such system must also provide information to members and/or providers as necessary to assure access, including, but not limited to, membership status. MCPs may not require members to contact their PCP or any other entity prior to contacting the twenty-four-hour toll-free call-in system for advice or direction concerning emergency and/or after-hours services.
    - (b) A log for the twenty-four-hour toll-free call-in system must be maintained, and accessible, by the MCP and must include at a minimum:
      - (i) Identification of the member;
      - (ii) Date and time of call;
      - (iii) Member's question, concern, or presenting problem;
      - (iv) Disposition of call;
      - (v) PCP or other provider if contacted by MCP; and

- (vi) Name and title of person taking the call.
- (c) The twenty-four-hour toll-free call-in system must have services available to assist:
  - (i) Hearing impaired members; and
  - (ii) LEP members in the primary language of the member.
- (7) The MCP must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. MCPs must ensure that decisions rendered through the UM program are based on medical necessity.
  - (a) The UM program must be based on written policies and procedures that include, at a minimum, the following:
    - (i) The specification of the information sources used to make determinations of medical necessity;
    - (ii) The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria;
    - (iii) A specification that written utilization management criteria will be made available to both contracting and non-contracting providers; and
    - (iv) A description of how the MCP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.
  - (b) The MCP's UM program must also assure and document the following:
    - (i) An annual review and update of the UM program.
    - (ii) The involvement of a designated senior physician in the UM program.
    - (iii) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions.
    - (iv) The use of board-certified consultants to assist in making medical necessity determinations, as necessary.
    - (v) That UM decisions are consistent with clinical practice guidelines as specified in paragraph (B) of rule 5101:3-26-05.1 of the Administrative Code. MCPs may not impose conditions around the coverage of a medically necessary medicaid-covered service unless they are supported by such clinical practice guidelines.
    - (vi) The reason for each denial of a service, based on sound clinical evidence.
    - (vii) That compensation by the MCP to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member.
  - (c) MCPs must process requests for initial and continuing authorizations of services from their providers and members. MCPs must have written policies and procedures to process requests and, upon request, the MCP's policies and procedures must be made available for review by ~~ODJFS~~ ODJFS ODM. The MCP's written policies and procedures for initial and continuing authorizations of services must also be made available to contracting and non-contracting providers upon request. The MCPs must assure and document the following occurs when processing requests for initial and continuing authorizations of services:
    - (i) Consistent application of review criteria for authorization decisions.
    - (ii) Consultation with the requesting provider, when necessary.
    - (iii) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

- (iv) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must meet the requirements of rules 5101:6-2-35, 5101:3-26-08.4, and 5101:3-26-08.5 of the Administrative Code.
- (v) For standard authorization decisions, the MCP must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than fourteen calendar days following receipt of the request for service, except as specified in paragraph (A)(7)(c)(viii) of this rule. If requested by the member, provider, or MCP, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ~~ODJFS~~ODM for prior-approval, documentation as to how the extension is in the member's interest. If ~~ODJFS~~ODM approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- (vi) If a provider indicates or the MCP determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCP must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service. If requested by the member or MCP, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ~~ODJFS~~ODM for prior-approval, documentation as to how the extension is in the member's interest. If ~~ODJFS~~ODM approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- (vii) Service authorization decisions not reached within the timeframes specified in paragraphs (A)(7)(c)(v) and (A)(7)(c)(vi) of this rule constitute a denial, and the MCPs must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code.
- (viii) ~~Pursuant to Section 1927(d)(5) of the Social Security Act, prior~~ Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (~~January 1, 2007~~ May 1, 2013) must be made by telephone or other telecommunication device within twenty-four hours of the initial request. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the MCP is unable to obtain the information needed to make the prior-authorization decision within seventy-two hours, the decision timeframe has expired and the MCP must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code. All other pharmacy prior authorization decisions must be made by no later than the end of the second working day following receipt of the request, or as expeditiously as the member's condition warrants.
- (ix) MCPs must maintain and submit as directed by ~~ODJFS~~ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. MCP records must include member identifying information, service requested, date initial request received, any extension

requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

- (d) MCPs must implement the ~~ODJFS~~ODM-required emergency department diversion program for frequent users.
  - (e) Pursuant to section 5111.172 of the Revised Code, MCPs may, subject to ~~ODJFS~~ODM prior approval, implement strategies for the management of drug utilization. At a minimum, MCPs must implement a coordinated services program (CSP) as described in rule 5101:3-20-01 of the Administrative Code. MCPs must provide members with a notice of their right to a state hearing in accordance with rules 5101:3-26-08.5 and 5101:6-2-40 of the Administrative Code before enrolling or continuing the enrollment of a member in CSP. If a member requests a state hearing regarding CSP enrollment within the fifteen day prior notice period set forth in rule 5101:6-4-01 of the Administrative Code, an MCP shall enroll the member into CSP no sooner than the hearing decision mail date. If a member requests a timely hearing regarding continued enrollment in CSP, CSP enrollment shall continue until the hearing decision is rendered. MCPs must also provide care management services to any member enrolled in CSP.
  - (f) MCPs may develop other utilization management programs subject to ~~ODJFS~~ODM prior approval.
- (8) MCPs must provide care management (CM) services to coordinate and monitor treatment rendered to members with specific diagnoses or who require high-cost or extensive services.
- (a) MCPs must notify all members of the CM services they may be eligible to receive.
  - (b) The MCP's CM program must include and document the following, at a minimum:
    - (i) Identification of members who potentially meet the criteria for care management;
    - (ii) Assessment of the member ~~member's health conditions~~ to determine the need for care management;
    - (iii) Assignment of the member to a risk stratification level;
    - (iv) Notification to the member and his or her PCP of the member's enrollment in the MCP's care management program;
    - (v) Development, implementation, and ongoing monitoring of a care ~~treatment~~ plan for members in care management; and
    - (vi) Assignment of an accountable point of contact.
  - (c) MCPs must report care management program-related data to ~~ODJFS~~ODM, as required.
- (B) PCP care coordination responsibilities include at a minimum the following:
- (1) Assisting with coordination of the member's overall care, as appropriate for the member;
  - (2) Serving as the ongoing source of primary and preventive care;
  - (3) Recommending referrals to specialists, as required;
  - (4) Triaging members as described in paragraph (A)(2) of this rule;
  - (5) Participating in the development of care ~~management care treatment~~ plans as described in paragraph (A)(8) of this rule; and
  - (6) Notifying the MCP of members who may benefit from care management.

Effective:

R.C. 119.032 review dates: 07/16/2013

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.16, 5111.17, 5111.085

Rule Amplifies: 5111.01, 5111.16, 5111.17, 5111.172, 5111.179

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**MCTL 34**

**Effective Date: August 1, 2011**

**Most Current Prior Effective Date: July 1, 2009**

(A) Obligations.

- (1) Managed care plans (MCPs) must provide or arrange for the delivery of covered health care services and must assure that all the requirements of Chapter 5101:3-26 of the Administrative Code, the MCP provider agreement, and all applicable federal, state, and local regulations are met.
- (2) For the purposes of this rule the following terms are defined as follows:
  - (a) "Subcontractor" means providers and delegated entities contracted with the MCP and providers employed by the MCP.
  - (b) "Fully executed" means that the legal written agreement between an MCP and its subcontractors includes dated signatures by both parties. These signatures must be by persons legally authorized to represent those parties, including each signee's formal title.
- (3) For the direct provision of health care services, MCPs must meet the obligations specified in paragraph (A)(1) of this rule either through employment or through current fully-executed subcontracts with providers. All subcontracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6, as applicable.
- (4) For delegated entities used to meet any program requirement, other than the direct provision of health care services, MCPs must meet the obligations specified in paragraph (A)(1) of this rule by entering into fully executed subcontracts. All subcontracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6, as applicable. In addition, MCPs must do all of the following:
  - (a) Evaluate the entity prior to executing a subcontract to assure that the entity is capable of performing the delegated activity in accordance with all applicable program requirements and provide a copy of the evaluation summary to ODJFS upon request.
  - (b) Provide the delegated entity with all information, materials, and documentation the entity will need to meet the delegated program requirement(s).
  - (c) Require the delegated entity to submit a report to the MCP, at least monthly, summarizing the status of the delegated activity, and including at a minimum:
    - (i) A copy of any required reports or logs maintained by the delegated entity; and
    - (ii) Identification of any problems, concerns or potential compliance issues that may exist.
  - (d) Monitor the entity's performance on an ongoing basis, including a review of the report referenced in paragraph (A)(4)(c) of this rule, all relevant member grievances and appeals as specified in rule 5101:3-26-08.4 of the Administrative Code, and all member complaints reported to the Ohio department of job and family services (ODJFS) and forwarded to the MCP, to identify any deficiencies or areas for improvement. Upon request, provide documentation of the MCP's monitoring efforts and its findings to ODJFS.
  - (e) Submit an annual assessment of the delegated entity's performance with meeting the delegated program requirements throughout the year to ODJFS as directed by ODJFS ~~within thirty calendar days of the assessment.~~

- (f) Include in the contract between the MCP and the delegated entity the sanctions that will be imposed for inadequate performance. The sanctions must specify the MCP's authority to require corrective action for any deficiencies or areas of improvement identified and provide for the revocation of the delegation if the MCP or ODJFS determines that the delegation is not in the best interest of the enrollees.
- (g) Include in the contract between the MCP and the delegated entity the sanctions that will be imposed for unauthorized uses or disclosures of protected health information (PHI).
- (h) Include in the contract between the MCP and the delegated entity that, unless otherwise specified by ODJFS, all information required to be submitted to ODJFS must be submitted directly by the MCP.

- (5) For subcontracts that the MCP believes to be short-term, one-time, or infrequent activities, the MCP may request that ODJFS exempt them from the reporting, monitoring and assessment requirements specified in paragraphs (A)(4)(c) and (A)(4)(e) of this rule.
- (6) All subcontracts must fulfill the requirements of 42 C.F.R. 434.6 and 438.6 that are appropriate to the service or activity delegated under the subcontract.
- (7) The MCP's execution of a subcontract with a provider or delegated entity does not terminate the MCP's legal responsibility to ODJFS to assure that all of the MCP's activities and obligations are performed in accordance with Chapter 5101:3-26 of the Administrative Code and the MCP provider agreement.
- (8) MCP-executed subcontracts may not include language that conflicts with the specifications identified in paragraphs (C) and (D) of this rule.
- (9) MCPs that authorize the delivery of services from a provider who does not have an executed subcontract with the MCP must ensure that they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph (D) of this rule. For medicaid-covered non-emergency hospital services outlined in paragraph (H)(9) of rule 5101:3-26-03 of the Administrative Code, the compensation amount is identified in paragraph (C) of rule 5101:3-26-11 of the Administrative Code.

(B) Notification.

- (1) Notwithstanding paragraph (D)(13) of this rule, an MCP must notify ODJFS of the addition or deletion of subcontractors on an ongoing basis, and must follow the time restrictions contained in paragraphs (B)(2), (B)(3), (B)(5), and (B)(6) of this rule unless the explanation of extenuating circumstances is accepted by ODJFS.
- (2) At the direction of ODJFS, ~~when any providers of the designated types are to be added to the MCP's provider panel,~~ the MCP must submit evidence of the following:
  - (a) A copy of the subcontractor's current licensure if ODJFS provides notification that it cannot verify current licensure;
  - (b) Copies of written agreements with the subcontractor, including but not limited to fully executed subcontracts, amendments and the medicaid addendum as specified in paragraph (D) of this rule; ~~A copy of the dated and fully executed medicaid addendum as specified in paragraph (D) of this rule or, for all new subcontracting hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs), a copy of the complete subcontract, including the medicaid addendum;~~ and (c) Notification to ODJFS of any hospital subcontract for which a date of termination is specified; and
  - ~~(e)~~(d) The subcontractor's medicaid provider number or provider reporting number, as applicable.
- (3) When any program requirement is to be delegated as specified in paragraph (A)(4) of this rule, the MCP must submit a copy of the dated and fully executed medicaid addendum or amendment as applicable within thirty calendar days of the execution of the subcontract or subcontract amendment for prior approval of the delegation.

- (4) Upon ODJFS approval of the delegated entity, MCPs must provide the subcontractor with a copy of the fully executed subcontract and specification of the ODJFS approval date.
- (5) In the event any of the providers of the designated types are to be deleted from the MCP's provider panel due to the expiration, nonrenewal, or termination of said subcontract, the MCP must:
  - (a) If the subcontractor is a hospital or primary care provider (PCP):
    - (i) Inform ODJFS of the deletion of the subcontractor fifty-five calendar days prior to the expiration, nonrenewal, or termination of said subcontract;
    - (ii) If the MCP receives or issues less than fifty-five days notice, inform ODJFS within one working day of its awareness of this information; and
    - (iii) If the deletion is a PCP, include the number of members that will be affected by the change.
  - (b) Deletion of any other subcontractors referenced in paragraph (A)(3) of this rule must be reported to ODJFS no later than thirty calendar days prior to the expiration, nonrenewal, or termination of the subcontract. If the MCP receives or issues less than thirty-days notice, the MCP must inform ODJFS within one working day of its awareness of this information.
  - (c) If the subcontractor involved is a PCP, the MCP must notify, in writing, all members who use the subcontractor as a PCP.
    - (i) The form of the notice and its content must be prior-approved by ODJFS and must contain, at a minimum, all of the following information:
      - (a) The PCP's name and last date the PCP is available to provide care to the MCP's members;
      - (b) The name, location, telephone number, and effective date of the member's new PCP as selected by the MCP;
      - (c) Information regarding how members can select a different PCP; and
      - (d) An MCP telephone number members can call for further information and/or assistance.
    - (ii) The MCP shall send the notice at least forty-five calendar days prior to the effective date of the deletion to members who use the subcontractor as a PCP. If the MCP receives less than forty-five days prior notice, the MCP shall issue the notice within one working day of the MCP becoming aware of the PCP's deletion. ~~The MCP shall submit a copy of this member notification to ODJFS along with the MCP's notification of provider deletion.~~
  - (d) When the subcontractor is a hospital, the MCP must notify in writing all members in the service area, or in an area authorized by ODJFS, ~~in writing~~, of the impending expiration, nonrenewal, or termination of the subcontract and the last date the subcontractor will provide services to members under the MCP contract. If the subcontract is expiring or the MCP is initiating the nonrenewal or termination of the subcontract, the MCP must notify in writing all providers who have admitting privileges at the hospital of the impending expiration, nonrenewal, or termination of the subcontract and the last date the subcontractor will provide services to members under the MCP subcontract. If the subcontractor is initiating the nonrenewal or termination of the subcontract, as specified in paragraph (D)(35) of this rule, the subcontractor must notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the subcontract and the last date the subcontractor will provide services to members under the MCP subcontract.

- (i) The MCP shall send the notices to the members and providers who have admitting privileges at the hospital at least forty-five calendar days prior to the effective date of the deletion. If the MCP receives/issues less than forty-five days prior notice, the MCP shall send the notices within one working day of the MCP becoming aware of the hospital's deletion.
- (ii) The form and content of the member notice must be prior-approved by ODJFS and contain an ODJFS designated toll-free telephone number that members can call for information and assistance.
- (iii) When issued by the MCP, the form and content of the provider notice must be prior-approved by ODJFS.
- (iv) Notification to additional members and/or providers may also be required if the hospital's deletion adversely impacts additional members and/or providers.
- (v) The MCP shall submit copies of the member and provider notifications to ODJFS along with the MCP's notification of the hospital deletion.

- (e) Member and/or provider notification may also be required for certain other provider deletions that may adversely impact the MCP's members.
- (f) Regardless of the member notification timeframes specified in this paragraph, the MCP must make a good faith effort to give written notice of termination of a contracted provider, within fifteen calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

- (6) In the event of the expiration, nonrenewal, or termination of the subcontract with a delegated entity, as specified in paragraph (A)(4) of this rule, the MCP must take the following steps:
  - (a) Inform ODJFS fifty-five calendar days prior to the expiration, nonrenewal, or termination of the subcontract. If the MCP receives or issues less than fifty-five days notice, the MCP must inform ODJFS within one working day of its awareness of this information.
  - (b) In situations that may adversely impact members and/or providers, notify members and/or providers of the impending expiration, nonrenewal, or termination of the subcontract.

- (7) In order to assure availability of services and qualifications of providers, ODJFS may require submission of documentation in accordance with paragraph (B) of this rule regardless of whether the MCP subcontracts directly for services or does so through another entity.

~~(8) MCPs must submit to ODJFS within thirty calendar days of execution, any amendment to a subcontract with a hospital, FQHC or RHC.~~

- ~~(9)~~(8) In the event that an MCP's medicaid managed care program participation in a service area is terminated, the MCP must provide written notification to its affected subcontractors at least forty-five calendar days prior to the termination date, unless otherwise specified by ODJFS.

(C) Provider qualifications.

- (1) MCPs must ensure that subcontractors that have medicaid provider agreements are in good standing and must ensure that all subcontractors are not sanctioned/excluded from providing medicaid or medicare services. At a minimum, monthly, MCPs shall utilize available resources for identifying sanctioned providers, including, but not limited to, the federal office of inspector general provider exclusion list; ~~the national practitioner data bank~~; the ODJFS excluded provider web page; and the discipline pages of the applicable state boards that license providers. ODJFS will provide notification to MCPs of sanctions ODJFS imposes during the term of the provider agreement.
- (2) An MCP may not discriminate in regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable

state law, solely on the basis of that license or certification. If an MCP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision. This paragraph may not be construed to:

- (a) Require the MCP to contract with providers beyond the number necessary to meet the needs of its members;
  - (b) Preclude the MCP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
  - (c) Preclude the MCP from establishing measures that are designated to maintain quality of services and control costs and are consistent with its responsibilities to members.
- (3) MCPs must have written policies and procedures for the selection and retention of providers that cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
  - (4) When initially credentialing and recredentialing providers in connection with policies, contracts, and agreements providing basic health care services, MCPs must utilize the standardized credentialing form and process as prescribed by the Ohio department of insurance under sections 3963.05 and 3963.06 of the Revised Code. Upon ODJFS's request, MCPs must demonstrate the record keeping associated with maintaining this documentation.
  - (5) If any MCP delegates the credentialing/recredentialing of subcontractors to another entity, the MCP must retain the authority to approve, suspend, or terminate any subcontractors.

(D) Subcontracts.

MCP subcontracts must include a medicaid addendum that has been prior-approved by ODJFS. All addendums must contain the following elements:

- (1) An agreement by the subcontractor to comply with the applicable provisions for record keeping and auditing in accordance with Chapter 5101:3-26 of the Administrative Code.
- (2) Specification of the population and service area to be served.
- (3) Specification of the services to be provided.
- (4) Specification that the subcontract is governed by, and construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP and:
  - (a) ODJFS shall notify the MCP and the MCP shall notify the subcontractor of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP;
  - (b) The subcontract shall be automatically amended to conform to such changes without the necessity for written execution; and
  - (c) The MCP shall notify the subcontractor of all applicable contractual obligations.
- (5) Specification of the terms of the subcontract including the beginning date and expiration date, or automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination.
- (6) Specification of the procedures to be employed upon the ending, nonrenewal, or termination of the subcontract, including the agreement to promptly supply all records necessary for the settlement of outstanding medical claims.
- (7) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the MCP.
- (8) An agreement not to discriminate in the delivery of services based on the member's race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services.

- (9) An agreement by the subcontractor to not hold liable ODJFS and members in the event that the MCP cannot or will not pay for covered services performed by the subcontractor pursuant to the subcontract with the exception that:
  - (a) FQHCS and RHCs may be reimbursed by ODJFS in the event of MCP insolvency pursuant to Section 1902(bb) of the Social Security Act.
  - (b) The subcontractor may bill the member when the MCP has denied prior authorization or referral for the services and the following conditions are met:
    - (i) The member was notified by the subcontractor of the financial liability in advance of service delivery.
    - (ii) The notification by the subcontractor was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.
    - (iii) The notification is dated and signed by the member.
- (10) An agreement by the subcontractor that with the exception of any member co-payments the MCP has elected to implement in accordance with rule 5101:3-26-12 of the Administrative Code, the MCP's payment constitutes payment in full for any covered service and that the subcontractor will not charge the member or ODJFS any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit nursing facilities (NFs) from collecting patient liability payments from members as specified in rule 5101:1-39-24 of the Administrative Code or FQHCS and RHCs from submitting claims for supplemental payments to ODJFS as specified in rules 5101:3-28-07 and 5101:3-16-05 of the Administrative Code.
  - (a) MCP shall notify the subcontractor whether the MCP has elected to implement any member co-payments and if applicable under what circumstances member co-payment amounts will be imposed in accordance with rule 5101:3-26-12 of the Administrative Code; and
  - (b) Subcontractor agrees that member notifications regarding any applicable co-payment amounts must be carried out in accordance with rule 5101:3-26-12 of the Administrative Code.
- (11) A specification that the subcontractor and all employees of the subcontractor are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the subcontract, and that subcontractor and all employees of the subcontractor have not been excluded from participating in federally funded health care programs.
- (12) An agreement that subcontractors who are currently medicaid providers meet the qualifications specified in paragraph (C) of this rule.
- (13) A stipulation that the MCP give the subcontractor at least sixty-days prior notice for the nonrenewal or termination of the subcontract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the subcontract be terminated sooner.
- (14) A stipulation that the subcontractor may nonrenew or terminate the subcontract if one of the following occurs:
  - (a) The subcontractor gives the MCP at least sixty-days prior notice for the nonrenewal or termination of the subcontract. The effective date for any subcontractor's nonrenewal or termination must be the last day of the month.
  - (b) ODJFS has proposed action in accordance with paragraph (G) of rule 5101:3-26-10 of the Administrative Code, regardless of whether this action is appealed. The subcontractor's termination or nonrenewal notice must be received by the MCP within fifteen working days prior to the end of the month in which the subcontractor is proposing

termination or nonrenewal. If the notice is not received by this date, the subcontractor must agree to extend the termination or nonrenewal date to the last day of the subsequent month.

- (15) The subcontractor's agreement to serve members through the last day the subcontract is in effect.
- (16) The subcontractor's agreement to make the medical records for medicaid eligible individuals available for transfer to new providers at no cost to the individual.
- (17) A specification that all laboratory testing sites providing services to members must have either a current clinical laboratory improvement amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or certificate of registration along with a CLIA identification number.
- (18) A requirement securing cooperation with the MCP's quality assessment and performance improvement (QAPI) program in all its provider subcontracts and employment agreements for physician and nonphysician providers.
- (19) An agreement by the subcontractor and MCP that:
  - (a) The MCP shall disseminate written policies in accordance with the requirements of 42 U.S.C. 1396a(a)(68) and section 5111.101 of the Revised Code, regarding the reporting of false claims and whistleblower protections for employees who make such a report, and including the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse; and
  - (b) The subcontractor agrees to abide by the MCP's written policies related to the requirements of 42 U.S.C. 1396a(a)(68) and section 5111.101 of the Revised Code, including the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (20) A specification that hospitals and other subcontractors must allow the MCP access to all member medical records for a period of not less than six-years from the date of service or until any audit initiated within the six year period is completed and allow access to all record-keeping, audits, financial records, and medical records to ODJFS or its designee or other entities as specified in paragraph (F) of rule 5101:3-26-06 of the Administrative Code.
- (21) A specification, appearing above the signature(s), on the signature page in all PCP subcontracts stating the maximum number of MCP members that each PCP can serve at each practice site for that MCP.
- (22) A specification that the subcontractor must cooperate with the ODJFS external quality review identified in rule 5101:3-26-07 of the Administrative Code.
- (23) A specification that the subcontractor must be bound by the same standards of confidentiality that apply to ODJFS and the state of Ohio as described in rule 5101:1-1-03 of the Administrative Code, including standards for unauthorized uses of or disclosures of PHI.
- (24) A specification that any third party administrator (TPA) must include the elements of paragraph (D) of this rule in its subcontracts and ensure that its subcontractors will forward information to ODJFS as requested.
- (25) A specification that home health subcontractors must meet the eligible provider requirements specified in Chapter 5101:3-12 of the Administrative Code and comply with the requirements for home care dependent adults as specified in section 121.36 of the Revised Code.
- (26) A specification that PCPs must participate in the care coordination requirements outlined in rule 5101:3-26-03.1 of the Administrative Code.
- (27) A specification that the subcontractor in providing health care services to members must identify and where indicated arrange, pursuant to the mutually agreed upon policies and procedures between the MCP and subcontractor, for the following at no cost to the member;

- (a) Sign language services; and
  - (b) Oral interpretation and oral translation services.
- (28) A specification that the MCP agrees to fulfill the subcontractor's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the subcontractor bills a member due to the MCP's denial of payment of a service, as specified in rule 5101:3-26-08.4 of the Administrative Code, utilizing the procedures and forms as specified in rule 5101:6-2-35 of the Administrative Code.
- (29) The subcontractor's agreement to contact the twenty-four-hour post-stabilization services phone line designated by the MCP to request authorization to provide post-stabilization services in accordance with paragraph (G) of rule 5101:3-26-03 of the Administrative Code.
- (30) A specification that the MCP may not prohibit, or otherwise restrict a subcontractor acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
- (a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
  - (b) Any information the member needs in order to decide among all relevant treatment options;
  - (c) The risks, benefits, and consequences of treatment versus non-treatment; and
  - (d) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- (31) A stipulation that the subcontractor must not identify the addressee as a medicaid consumer on the outside of the envelope when contacting members by mail.
- (32) An agreement by the subcontractor that members will not be billed for missed appointments.
- (33) An agreement by the subcontractor that in the performance of the subcontract or in the hiring of any employees for the performance of services under the subcontract, shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.
- (34) An agreement by the subcontractor that it shall not in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance ~~of~~ of services under the subcontract on account of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.
- (35) Notwithstanding paragraphs (D)(13) and (D)(14) of this rule, in the event of a subcontractor's proposed nonrenewal or termination of a hospital subcontract, an agreement by the hospital subcontractor to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the subcontract and the last date the hospital will provide services to members under the MCP contract. This notice must be sent at least forty-five calendar days prior to the effective date of the deletion. If the subcontractor issues less than forty-five days prior notice to the MCP, the provider notice must be sent within one working day of the subcontractor issuing notice of nonrenewal or termination of the subcontract.
- (36) An agreement by the subcontractor to supply, upon request, the business transaction information required under 42 C.F.R. 455.105.

Effective: 08/01/2011

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 07/22/2011

Promulgated Under: 119.03

Statutory Authority: 5111.0112, 5111.02, 5111.16, 5111.162, 5111.17

Rule Amplifies: 5111.01, 5111.0112, 5111.02, 5111.16, 5111.162, 5111.17

Prior Effective Dates: 4/1/85, 10/1/87, 2/15/89 (Emer), 5/8/89, 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 12/10/99, 7/1/00, 10/27/00, 7/20/01, 7/1/02, 7/1/03, 1/1/06, 6/1/06, 1/1/07, 7/1/07, 1/1/08, 7/1/09

**MCTL 38**

**Effective Date: July 1, 2013**

**Most Current Prior Effective Date: September 15, 2008**

- (A) MCPs must provide the following written information to their contracting providers:
- (1) The MCP's grievance, appeal and state fair hearing procedures and time frames, including:
    - (a) The member's right to file grievances and appeals and the requirements and time frames for filing;
    - (b) The MCP's toll-free telephone number to file oral grievances and appeals;
    - (c) The member's right to a state fair hearing, the requirements and time frames for requesting a hearing, and representation rules at a hearing;
    - (d) The availability of assistance from the MCP in filing any of these actions;
    - (e) The member's right to request continuation of benefits during an appeal or a state hearing and specification that at the discretion of ~~ODJFS~~SODM the member may be liable for the cost of any such continued benefits; and
    - (f) The provider's rights to participate in these processes on behalf of the provider's patients and to challenge the failure of the MCP to cover a specific service.
  - (2) The MCP's requirements regarding the submission and processing of prior authorization requests including:
    - (a) A list of the benefits, if any, that require prior authorization approval from the MCP;
    - (b) The process and format to be used in submitting such requests;
    - (c) The time frames in which the MCP must respond to such requests;
    - (d) Pursuant to the provisions of paragraph (A)(1) of this rule, how the provider will be notified of the MCP's decision regarding such requests; and
    - (e) Pursuant to the provisions of paragraph (A)(1) of this rule, the procedures to be followed in appealing the MCP's denial of a prior authorization request.
  - (3) The MCP's requirements regarding the submission and processing of requests for specialist referrals including:
    - (a) A list of the provider types, if any, that require prior authorization approval from the MCP;
    - (b) The process and format to be used in submitting such requests;
    - (c) How the provider will be notified of the MCP's decision regarding such requests; and
    - (d) The procedures to be followed in appealing the MCP's denial of such requests.
  - (4) The MCP's documentation, legibility, confidentiality, maintenance and access standards for member medical records; including a member's right to amend or correct his or her medical record as specified in 45 C.F.R. ~~part 164.~~164.526 (May 1, 2013).
  - (5) The MCP's process and requirements for the submission of claims and the appeal of denied claims.
  - (6) The MCP's process and standards for the recredentialing of providers.
  - (7) The MCP's policies and procedures regarding what action the MCP may take in response to occurrences of undelivered, inappropriate or substandard health care services, including the reporting of serious deficiencies to the appropriate authorities.

- (8) A description of the MCP's care coordination and care management programs, and the role of the provider in those programs, including:
    - (a) The MCP's criteria for determining which members might benefit from care management;
    - (b) The provider's responsibility in identifying members who may meet the MCP's care management criteria; and
    - (c) The process for the provider to follow in notifying the MCP when such members are identified.
  - (9) The MCP's requirements and expectations for PCPs, including triage requirements.
  - (10) The mutually agreed upon policies and procedures between the MCP and provider that explain the provider's obligation to provide oral translation, oral interpretation, and sign language services to the MCP's members including:
    - (a) The provider's responsibility to identify those members who may require such assistance;
    - (b) The process the provider is to follow in arranging for such services to be provided;
    - (c) Information that members will not be liable for the costs of such services; and
    - (d) Specification of whether the MCP or the provider will be financially responsible for the costs of providing these services.
  - (11) The procedures that providers are to follow in notifying the MCP of changes in their practice, including at a minimum:
    - (a) Address and phone numbers;
    - (b) Providers included in the practice;
    - (c) Acceptance of new patients; and
    - (d) Standard office hours.
  - (12) Specification of what service utilization and provider performance data the MCP will make available to providers.
  - (13) Specification of the healthchek components to be provided to eligible members as specified in Chapter 5101:3-14 of the Administrative Code.
- (B) MCPs must adopt practice guidelines and provide written copies to all affected providers. These guidelines must:
- (1) Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
  - (2) Consider the needs of the MCP's members;
  - (3) Be adopted in consultation with contracting health care professionals; and
  - (4) Be reviewed and updated periodically, as appropriate.
- (C) MCPs must have staff specifically responsible for resolving individual provider issues, including, but not limited to, problems with claims payment, prior authorizations and referrals. MCPs must provide written information to their contracting providers detailing how to contact these designated staff.

Effective: 07/01/2013

R.C. 119.032 review dates: 04/16/2013 and 07/01/2018

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Date: 06/21/2013

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**MCTL 43**

**Effective Date: February 1, 2015**

**Most Current Prior Effective Date: July 1, 2013**

- (A) Each MCP~~MCPs~~ must have administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud and abuse.
- (1) These arrangements or procedures must include the implementation of sound business practices which support appropriate access to and appropriate payment for quality services and must include the following:
    - (a) Written policies, procedures, and standards of conduct that articulate the MCP's commitment to comply with all applicable federal and state standards, including the prevention, identification, investigation, correction, and reporting of fraud and abuse;
    - (b) Designation of a compliance officer and a compliance committee that are accountable to senior management;
    - (c) Effective training and education for the compliance officer and the MCP's employees;
    - (d) Effective lines of communication between the compliance officer and the MCP's employees. To ensure effective communication, the MCP must organize resources to respond to complaints of fraud and abuse and have established procedures to process these complaints;
    - (e) Education of providers and delegated entities about fraud and abuse;
    - (f) Enforcement of MCP standards through well-publicized disciplinary guidelines;
    - (g) Provision for internal monitoring and auditing, including procedures to monitor service patterns of providers and subcontractors;
    - (h) Establishment and/or modification of internal MCP controls to ensure the proper submission and payment of claims;
    - (i) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCP's contract; and
    - (j) Prompt reporting of all instances of fraud and abuse to ODM and member fraud to the CDJFS.
  - (2) These arrangements or procedures must be made available to ODM upon request.
  - (3) The MCP~~MCPs~~ must annually submit to ODM a report ~~which~~that summarizes the MCP's fraud and abuse activities for the previous year and ~~which~~ identifies any proposed changes to the MCP's fraud and abuse program for the coming year.
- (B) ODM or its designee, the state auditor's office, the state attorney general's office, the MFCU and the U.S. department of health and human services may evaluate or audit a contracting MCP's performance for the purpose of determining compliance with the requirements of Chapter ~~5101:35~~160-26 of the Administrative Code, fraud and abuse statutes, applicable state and federal regulations or requirements under federal waiver authority.
- (C) ODM or its designee may conduct on-site audits and reviews as deemed necessary based on periodic analysis of financial, utilization, provider panel, and other information.
- (D) The MCP must submit required reports and additional information, as requested by ODM, as related to ~~their~~its duties and obligations and where needed to assure operation in accordance with all state and federal regulations or requirements.

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

(F) Record retention.

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

Effective: 02/01/2015

Five Year Review (FYR) Dates: 10/30/2014 and 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

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**MCTL 43**

**Effective Date: February 1, 2015**

**Most Current Prior Effective Date: January 1, 2008**

- (A) Marketing means any communication from an MCP to an eligible individual who is not a member of that MCP that can reasonably be interpreted as intended to influence the individual to select membership in that MCP, or to not select membership in or to terminate membership from another MCP.
- (B) MCPs:
- (1) Must ~~assure~~ensure that representatives, as well as materials and plans, represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing or otherwise misrepresentative, or which defraud the eligible individuals or ~~ODJFS~~ODM.
  - (2) Must ~~assure~~ensure that no marketing activity directed specifically toward the medicaid population begins prior to approval by ~~ODJFS~~ODM.
  - (3) Are prohibited from engaging directly or indirectly in cold-call marketing activities including, but not limited to, door-to-door or telephone contact. Cold-call marketing means any unsolicited personal contact by the MCP with an eligible individual for the purpose of marketing as defined in paragraph (A) of this rule.
  - (4) Must receive prior approval from any event or location where the MCP plans to provide information to eligible individuals.
  - (5) Are prohibited from offering material or financial gain, including but not limited to, the offering of any other insurance, to an eligible individual as an inducement to select MCP membership.
  - (6) Are prohibited from offering inducements to CDJFS or ~~MCEC~~medicaid consumer hotline staff or to others who may influence an individual's decision to select MCP membership.
  - (7) Are allowed to offer nominal gifts prior-approved by ~~ODJFS~~ODM to an eligible individual as long as these gifts are offered whether or not the individual selects membership in the MCP.
  - (8) May reference member incentive/appreciation items, as specified in ~~paragraph (B) of rule 5101:3~~5160-26-08.2 of the Administrative Code, in marketing presentations and materials; however, such member items must not be made available to non-members.
  - (9) Must ensure that marketing representatives represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud the eligible individuals or ODM.
  - (10) Are prohibited from making one-on-one marketing presentations in any setting unless requested by the eligible individual.
- (C) MCPs must comply with the following ~~requirement~~requirements:
- (1) Only ~~ODJFS~~ODM-approved MCP marketing representatives may make a marketing presentation as outlined in paragraph (F) ~~(5)~~(6)(e) of this rule to an eligible individual or in any way advise or recommend to an eligible individual that ~~he/she~~ he or she select MCP membership in a particular MCP. As provided in Chapter 1751. and section 3905.01 of the Revised Code, and rule 3901-1-10 of the Administrative Code, all non-licensed agents, including providers, are prohibited from advising or recommending to an eligible individual that ~~he/she~~ he or she select MCP membership in a particular MCP as this would constitute the unlicensed practice of marketing.
  - ~~(2) Must assure that marketing representatives represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud the eligible individuals or ODJFS.~~

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

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

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

- (1) All MCP marketing materials must be available in a manner and format that may be easily understood.
- (2) Written materials developed to promote membership selection in an MCP must be available in:
  - (a) The prevalent non-English languages of eligible individuals in the service area.
  - (b) Alternative formats in an appropriate manner that takes into consideration the special needs of eligible individuals including but not limited to visually-limited and LRP eligible individuals.
- (3) Oral interpretation and oral translation services must be available for the review of marketing materials at no cost to eligible individuals.
- (4) The mailing/ and distribution of all MCP marketing materials must be prior-approved by ODJFSODM and may contain no information or text on the outside of the mailing that identifies the addressee as a medicaid consumer. Marketing materials must be distributed to the MCP's entire service area.
- (5) ODJFSODM or its designee may, at an MCP's request, mail MCP marketing materials to eligible individuals. Postage and handling for each mailing will be charged to the requesting MCP. The MCP address must not be used as the return address in mailings to eligible individuals processed by ODJFSODM.
- (6) An MCP~~MCPs~~ must have a solicitation brochure available to eligible individuals which contains, at a minimum:
  - (a) Identification of the medicaid consumers eligible for the MCP's coverage.
  - (b) Information that the MCP's identification card replaces the member's monthly medicaid health card.
  - (c) A statement that all medically-necessary medicaid-covered services, including healthchek (EPSDT) services, will be available to all members.
  - (d) A description of any additional services available to all members.
  - (e) Information that membership selection in a particular MCP is voluntary, that a decision to select MCP membership or to not select MCP membership in the MCP will not affect eligibility for medicaid or other public assistance benefits, and that individuals may change MCPs under certain circumstances.
  - (f) Information on how the individual can request or access additional MCP information or services, including clarification on how this information can be requested or accessed through:
    - (i) Sign language, oral interpretation and oral translation services at no cost to the eligible individual;
    - (ii) Written information in the prevalent non-English languages of eligible individuals or members in the MCP's service area;
    - (iii) Written information in alternative formats.

- (g) Information clearly identifying corporate or parent company identity when a trade name or DBA is used for the medicaid product.
- (h) A statement that this brochure contains only a summary of the relevant information and that more details, including at a minimum a list of providers, and any physician incentive plans the MCP operates, will be provided upon request.
- (i) Information that an individual must choose a PCP from the MCP's provider panel and that the PCP will coordinate the member's health care.
- (j) Information that a member may change PCPs at least monthly.
- (k) A statement that all medically-necessary health care services must be obtained in or through the ~~MCP facilities and/or providers~~ MCP's providers except emergency care, behavioral health services provided through facilities and medicaid providers certified by the Ohio department of mental health and addiction services ~~the ODMH or at ODADAS-certified facilities which are medicaid providers,~~ and any other services or provider types designated by ODJFSODM.
- (l) A description of how to access emergency services including information that access to emergency services is available within and outside the service area.
- (m) A description of the MCP's policies regarding access to providers outside the service area.
- (n) Information on member-initiated termination options in accordance with ~~paragraph (D) of rule 5101:3~~ 5160-26-02.1 of the Administrative Code.
- (o) Information on the procedures an eligible individual must follow to select MCP membership in an MCP including any applicable ODJFSODM selection requirements.
- (p) If applicable, information on any member co-payments the MCP has elected to implement in accordance with rule ~~5101:3~~ 5160-26-12 of the Administrative Code.

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

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

- (1) All marketing representatives must be employees of the MCP. A copy of the representative's job description(s) must be submitted to ODJFSODM.
- (2) Marketing representatives must be trained and duly licensed by ODI to perform such activities.
- (3) The MCP must develop and submit to ODJFSODM for prior-approval a marketing representative training program. This training program must include, at a minimum:
  - (a) A training curriculum that includes at a minimum:
    - (i) A full review of the MCP's solicitation brochure, provider directory and all other marketing materials including all video, audio, electronic and print materials.
    - (ii) An overview of applicable public assistance benefits, designed to familiarize and impart a working knowledge of these programs.
    - (iii) The MCP's process for providing sign language, oral interpretation and oral translation services to an eligible individual to whom a marketing presentation is being made, including a review of the MCP's written marketing materials.
    - (iv) Instruction on acceptable and appropriate marketing tactics, including a requirement that the marketing representatives may not discriminate on the basis of age, gender, sexual orientation, disability, race, color, religion, national origin,

~~veteran's~~ military status, genetic information, ancestry, health status, or the need for health services.

- (v) An overview of the ramifications to the MCP and/or the marketing representatives if ~~ODJFS~~ ODM rules are violated.
- (vi) Review of the MCP's code of conduct ~~/~~ or ethics.
- (b) Methods that the MCP will utilize to determine initial and ongoing competency with the training curriculum.
- ~~(c) Any revisions to the ODJFS-approved training program must be submitted to ODJFS for review and prior approval.~~
- (4) Any revisions to the ODM-approved training program must be submitted to ODM for review and prior approval.
- ~~(4)~~ (5) No more than fifty per cent of each marketing representative's total annual compensation, including salary, benefits, and bonuses may be paid on a commission basis. For the purpose of this rule, any performance-based compensation would be considered a form of commission. The MCP must make available for inspection, upon request by ~~ODJFS~~ ODM, the compensation package(s) for marketing representatives as its assurance of compliance with this requirement.
- ~~(5)~~ (6) Any MCP staff person providing information on the MCP or making marketing presentations to an eligible individual(s) must comply with the following:
  - (a) The MCP staff person must not discriminate on the basis of age, gender, sexual orientation, race, color, religion, national origin, ~~veteran's~~ military status, ancestry, disability, genetic information, health status, or the need for health services.
  - (b) No MCP staff person may ask eligible individual(s) questions related to health status or the need for health services.
  - (c) The MCP staff person must visibly wear or display an identification tag and offer a business card when speaking to an eligible individual(s) and provide information which ensures that the staff person is not mistaken for ~~an MCEC~~ a medicaid consumer hotline, ~~or~~ federal, state or county employee.
  - (d) The MCP staff person must inform ~~Inform~~ eligible individuals that the following MCP information or services are available and how the eligible individual can access the information or services:
    - (i) Sign language, oral interpretation, and oral translation services at no cost to the member;
    - (ii) Written information in the prevalent non-English languages of eligible individuals or members residing in the MCP's service area; and
    - (iii) Written information in alternative formats.
  - (e) For the purposes of this rule, a marketing presentation is defined as a one-on-one interaction between an MCP's marketing representative and an eligible individual(s). MCP marketing representatives must offer the ~~ODJFS~~ ODM-approved solicitation brochure to the eligible individual(s) at the time of the marketing presentation and must provide, at a minimum:
    - (i) An explanation of the importance of reviewing the information in the ~~ODJFS~~ ODM-approved solicitation brochure, how ~~they~~ the individual can receive additional information about the MCP prior to making an MCP membership selection, and the process for contacting ~~ODJFS~~ ODM to select an MCP.
    - (ii) Information that membership in the particular MCP is voluntary and that a decision to select or not select the MCP will not affect eligibility for medicaid or other public assistance benefits.

- (iii) Information that each member must choose a PCP and must access providers and services as directed in the MCP's member handbook and provider directory.
- (iv) Information that all medically-necessary medicaid-covered services, as well as any additional services provided by the MCP, will be available to all members.

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

(H) Alleged marketing violations.

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

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

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**MCTL 43**

**Effective Date: February 1, 2015**

**Most Current Prior Effective Date: January 1, 2012**

- (A) MCP member services program.
- (1) Each MCP must establish and operate a member services toll-free telephone number. This telephone line must have services available to assist:
    - (a) Hearing-impaired members; and
    - (b) LEP members in the primary language of the member.
  - (2) The member services program must, at a minimum, assist MCP members, and, as applicable, eligible individuals seeking information about MCP membership, with the following:
    - (a) Accessing medicaid-covered services;
    - (b) Obtaining or understanding information on the MCP's policies and procedures;
    - (c) Understanding the requirements and benefits of the plan;
    - (d) Resolution of concerns, questions, and problems;
    - (e) Filing of grievances and appeals as specified in rule ~~5101:3~~5160-26-08.4 of the Administrative Code;
    - (f) Obtaining information on state hearing rights;
    - (g) Appealing to or filing directly with the United States department of health and human services office of civil rights any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services;
    - (h) Appealing to or filing directly with the ~~ODJFS~~ODM office of civil rights any complaints of discrimination on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, ~~veteran's~~military status, genetic information, ancestry, health status, or need for health services in the receipt of health services; and
    - (i) Accessing sign language, oral interpretation, and oral translation services. The MCP~~MCPs~~ must ensure that these services are provided at no cost to the eligible individual or member. The MCP~~MCPs~~ must designate a staff person, to coordinate and document the provision of these services.
  - (3) In the event the consumer contact record (CCR) does not identify a member-selected primary care provider (PCP) for each assistance group member, or if the member-selected PCP is not available, the MCP must:
    - (a) Select a PCP for each member prior to the effective date of coverage based on the PCP assignment methodology prior-approved by ~~ODJFS~~ODM;
    - (b) Notify each member ~~members~~ of the name of their~~his or her~~ PCP prior to the effective date of coverage and pursuant to the provisions of ~~paragraphs (D)(1) and (D)(2) of~~ rule ~~5101:3~~5160-26-02 of the Administrative Code;
    - (c) Simultaneously notify each ~~members~~ member with an MCP-selected PCP of the ability within the first month of initial MCP membership to change the MCP-selected PCP effective on the date of contact with the MCP; and
    - (d) Explain that PCP change requests after the initial month of MCP membership shall be processed according to the procedures outlined in the MCP member handbook.
- (B) MCP member materials.

- (1) The MCP must develop and disseminate member materials, including at a minimum member materials specified in paragraph (B)(3) of this rule. All MCP member materials, including but not limited to those used for member education, member appreciation and member incentive programs, and changes thereto must be prior-approved in writing by ODJFS ODM.
- (2) Member materials must be:
  - (a) Provided in a manner and format that may be easily understood.
  - (b) Printed in the prevalent non-English languages of members in the MCP's service area.
  - (c) Available in alternative formats in an appropriate manner that takes into consideration the special needs of members including but not limited to visually-limited and LRP members.
  - (d) Consistent with the practice guidelines specified in paragraph (B) of rule 5401:35160-26-05.1 of the Administrative Code.
- (3) At a minimum, ~~MCPs~~ the MCP must provide the following materials to each member or assistance group, as applicable. ~~;~~ The MCP must provide the materials specified in paragraphs (B)(3)(a) and (B)(3)(c) of this rule by no later than the effective date of coverage and the materials specified in paragraphs (B)(3)(b) and (B)(3)(d) of this rule prior to the effective date of coverage.
  - (a) The MCP's member handbook as specified in paragraph (B)(4) of this rule.
  - (b) An MCP identification card bearing unique features, clearly listing:
    - (i) The MCP's name as stated in its article of incorporation and any other trade or DBA name used;
    - (ii) The name(s) of the member(s) enrolled in the MCP and ~~their~~ each member's medicaid management information system billing number(s);
    - (iii) The MCP's emergency procedures, which must be consistent with those approved in the member handbook, including the toll-free call-in system phone numbers as specified in paragraph (A)(6) of rule 5401:35160-26-03.1 of the Administrative Code;
    - (iv) The MCP's toll-free member services number(s) as specified in paragraph (A)(1) of this rule;
    - (v) The name(s) and telephone number(s) of the PCP(s) assigned to the member(s);
    - (vi) Information on how to obtain the current eligibility status for the member(s); and
    - (vii) Coordinated services program (CSP) information as specified by ODJFS ODM.
  - (c) Information concerning a member's right to formulate, at the member's option, advance directives including a description of applicable state law.
  - (d) A letter informing each member ~~members~~ at a minimum of:
    - (i) The new member materials issued by the MCP, what action the member should ~~members are to~~ take if they have ~~he or she has~~ not yet received those materials, and how to access the MCP's provider directory;
    - (ii) How to access MCP-provided transportation services;
    - (iii) How to change primary care providers;
    - (iv) The population groups that are not required to select MCP membership and what action to take if a member believes he or she meets ~~members believe they meet~~ this criteria and ~~do~~ does not want to be an MCP member;
    - (v) The need and time frame for a member ~~members~~ to contact the MCP if the member has ~~members have~~ a health care condition that the MCP should be aware

of in order to most appropriately manage/or transition the ~~members'~~member's care; and

- (vi) The need and how to access information on medications that require prior authorization.
- (4) The MCP's member handbook must be clearly labeled as such and include, at a minimum:
- (a) The rights of members that include at a minimum, all rights found in rule ~~5101:35160-26-08.3~~ of the Administrative Code and any member responsibilities specified by the MCP. With the exception of any prior-authorization requirements the MCP ~~stipulates~~describes in the member handbook, the MCP cannot establish any member responsibility that would preclude the MCP's coverage of a medicaid-covered service.
  - (b) Information regarding services that are excluded from MCP coverage and the services and benefits that are available at or through the MCP, and how to obtain them, including at a minimum:
    - (i) All services and benefits requiring prior-authorization or referral by the MCP or the member's PCP;
    - (ii) Self-referral services, including at a minimum Title X services, and women's routine and preventative health care services provided by a woman's health specialist as specified in ~~paragraphs (H)(5) and (H)(6) of~~ rule ~~5101:35160-26-03~~ of the Administrative Code;
    - (iii) FQHC/RHC and certified nurse practitioner services as specified in ~~paragraphs (H)(7) and (H)(8) of~~ rule ~~5101:35160-26-03~~ of the Administrative Code; and
    - (iv) If applicable, any pharmacy utilization management strategies prior-approved by ~~ODJFS~~ODM.
  - (c) Information that emergency services are available to the member, the procedures for accessing emergency services, and directives as to the appropriate utilization, including at a minimum:
    - (i) An explanation ~~Explanation~~ of the terms "emergency medical condition," "emergency services," and "post-stabilization services," as defined in rule ~~5101:35160-26-01~~ of the Administrative Code;
    - (ii) A statement that prior~~Prior~~ authorization is not required for emergency services;
    - (iii) An explanation regarding the~~The~~ availability of the 911-telephone system or its local equivalent;
    - (iv) A statement that members~~Members~~ have a right to use any hospital or other appropriate setting for emergency services; and
    - (v) An explanation of the~~The~~ post-stabilization care services requirements specified in ~~paragraph (G) of~~ rule ~~5101:35160-26-03~~ of the Administrative Code.
  - (d) The procedure for members to express their recommendations for change to the MCP's staff.
  - (e) Identification of the categories of medicaid consumers eligible for MCP membership.
  - (f) Information stating that the MCP's identification card replaces the member's monthly medicaid health card, how often the card is issued, and how to use it.
  - (g) A statement that medically necessary health care services must be obtained ~~in or~~ through the providers in the MCP's provider network except for emergency care, behavioral health services provided through facilities and medicaid providers certified by the Ohio department of mental health and addiction services, ~~MCP facilities and/or providers except emergency care, behavioral health services provided through the ODMH or at~~

~~ODADAS-certified facilities that are medicaid providers~~, and any other services or provider types designated by ODJFSODM.

- (h) Information on the member's responsibility to select a PCP from the MCP provider directory, how to change PCPs including the ability to change PCPs no less often than monthly, the MCP's procedures for processing PCP change requests after the initial month of MCP membership, and how the MCP will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change.
- (i) A description of the healthchek (EPSDT, early and periodic screening, diagnosis and treatment) program, including who is eligible and how to obtain healthchek (EPSDT) services through the MCP.
- (j) Information on the additional services available to all members including, at a minimum, care management services as specified in ~~paragraph (A)(8) of rule 5101:35160-26-03.1~~ of the Administrative Code and the member services toll-free call-in system.
- (k) A description of the MCP's policies regarding access to providers outside the service area for non-emergency services and if, applicable, access to providers within ~~and/or~~ outside the service area for non-emergency after-hours services.
- (l) Information on member-initiated termination options in accordance with ~~paragraph (D) of rule 5101:35160-26-02.1~~ of the Administrative Code.
- (m) An explanation of automatic renewal of MCP membership in accordance with ~~paragraph (C)(3)(h) of rule 5101:35160-26-02~~ of the Administrative Code.
- (n) The procedure for members to file an appeal, a grievance, or a state hearing request as specified in ~~rules rule 5101:35160-26-08.4 and 5101:3-26-08.5~~ of the Administrative Code.
- (o) Information about MCP-initiated terminations.
- (p) The issuance date of the member handbook.
- (q) A statement that the MCP may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, ~~veteran's~~military status, ancestry, genetic information, health status, or need for health services in the receipt of health services.
- (r) An explanation of subrogation and coordination of benefits.
- (s) A clear identification of corporate or parent identity when a trade name or DBA is used for the medicaid product.
- (t) Information on the procedures for members to access behavioral health services.
- (u) Information on the MCP's policies respecting the implementation of the member's rights regarding advance directives, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- (v) Information stating that the MCP provides covered services to members through a provider agreement with ODJFSODM, and how members can contact ODJFSODM, by mail or by telephone, if they so desire.
- (w) The toll-free call-in system phone numbers specified in paragraph (A)(1) of this rule and ~~paragraph (A)(6) of rule 5101:35160-26-03.1~~ of the Administrative Code.
- (x) A statement that additional information is available from the MCP upon request including, at a minimum, the structure and operation of the MCP and any physician incentive plans that the MCP operates.
- (y) Information on how the member can request or access additional MCP information or services including, at a minimum:
  - (i) Oral interpretation and oral translation services;

- (ii) Written information in the prevalent non-English languages of members in the MCP's service area; and
- (iii) Written information in alternative formats.
- (z) If applicable, detailed information on any member co-payments the MCP has elected to implement in accordance with rule ~~5104:3~~5160-26-12 of the Administrative Code.
- (aa) Information on how members can access the MCP's provider directory.
- (bb) The standard and expedited state hearing resolution time frames as outlined in 42 C.F.R. 431.244 (f). (October 1, 2013).
- (5) If a member's MCP membership is automatically renewed as specified in ~~paragraph (C)(3)(h) of~~ rule ~~5104:3~~5160-26-02 of the Administrative Code, the MCP must issue an identification card as specified in paragraph (B)(3) of this rule prior to the new effective date of coverage. Additionally, in the event the member handbook has been revised since the initial MCP membership date of the member's assistance group, the MCP must issue a new member handbook to the member.
- (6) At least annually, ~~MCPs~~the MCP must determine the predominant health care needs of ~~their~~its medicaid members and provide health education materials as indicated by these assessments. ~~MCPs~~The MCP must provide ~~ODJFS~~ODM a summary of the results of the health care needs assessment and a list of the materials distributed to members as a result of the assessment.
- (7) No information or text that identifies the addressee as a medicaid recipient may appear on the outside of any MCP or MCP subcontractor mailing.

Effective: 02/01/2015

Five Year Review (FYR) Dates: 10/30/2014 and 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/05/2015

Promulgated Under: 119.03

Statutory Authority: 5167.02

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**MCTL 43**

**Effective Date: February 1, 2015**

**Most Current Prior Effective Date: July 1, 2013**

- (A) MCPs must develop and implement written policies ~~which~~that ensure that members have and are informed of the following rights:
- (1) To receive all services that the MCP is required to provide pursuant to the terms of their provider agreement with ODM.
  - (2) To be treated with respect and with due consideration for their dignity and privacy.
  - (3) To be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history.
  - (4) To be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.
  - (5) To be given the opportunity to participate in decisions involving their health care ~~unless contraindicated~~.
  - (6) To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
  - (7) To ~~be assured of~~maintain auditory and visual privacy during all health care examinations or treatment visits.
  - (8) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
  - (9) To request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
  - (10) To be afforded the opportunity to approve or refuse the release of information except when release is required by law.
  - (11) To be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation will be entered into the medical record accordingly.
  - (12) To be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of ~~rules~~rule 5101:3-5160-26-08.4 and 5101:3-26-08.5 of the Administrative Code.
  - (13) To be ~~assured that all~~provided written member information from ~~provided by~~ the MCP ~~is available~~:
    - (a) At no cost to the member,
    - (b) In the prevalent non-English languages of members in the MCP's service area, and
    - (c) In alternative formats and in an appropriate manner that takes into consideration the special needs of members including but not limited to visually-limited and LRP members.
  - (14) To ~~be assured that~~receive necessary oral interpretation and oral translation services ~~are available~~ at no cost ~~to members~~.
  - (15) To ~~be assured that the~~receive necessary services of sign language assistance at no cost ~~are available to hearing impaired members~~.
  - (16) To be informed of specific student practitioner roles and the right to refuse student care.
  - (17) To refuse to participate in experimental research.

- (18) To formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio department of health.
- (19) To change PCPs no less often than monthly. The MCP~~MCP's~~ must mail written confirmation to the member of ~~their~~his or her new PCP selection prior to or on the effective date of the change.
- (20) To appeal to or file directly with the United States department of health and human services office of civil rights any complaints of discrimination on the basis of race, color, national origin, age or disability in the receipt of health services.
- (21) To appeal to or file directly with the ODM office of civil rights any complaints of discrimination on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, ~~veteran's~~military status, genetic information, ancestry, health status or need for health services in the receipt of health services.
- (22) To be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way the MCP, the MCP's providers, or ODM treats the member.
- (23) To be assured that the MCP must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- (24) To choose his or her health professional to the extent possible and appropriate.
- (25) ~~To be assured that~~For female members, have to obtain direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to ~~the~~a member's designated PCP if the PCP is not a woman's health specialist.
- (26) To be provided a second opinion from a qualified health care professional within the MCP's panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for a second opinion outside the network, at no cost to the member.
- (27) To receive information on their MCP.

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

Effective: 02/01/2015

Five Year Review (FYR) Dates: 07/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 01/05/2015

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MCTL 44

**Effective Date: March 6, 2015**

**Most current Prior Effective Date: January 1, 2012**

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

(A) ~~General requirements~~ Definitions.

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

- (1) An "action" is the MCP's
  - (a) Denial or limited authorization of a requested service, including the type or level of service;
  - (b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP;
  - (c) Denial, in whole or part, of payment for a service;
  - (d) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code; or
  - (e) Failure to act within the resolution timeframes specified in this rule.
- (2) An "appeal" is the request for an MCP's review of an action.
- (3) A "grievance" is an expression of dissatisfaction with any aspect of the MCP's or provider's operation, provision of health care services, activities, or behaviors, other than an MCP's action as defined in paragraph (A)(1) of this rule.
- (4) "Resolution" means a final decision is made by the MCP and the decision is communicated to the member.
- (5) "Notice of action (NOA)" is the written notice an MCP must provide to members when an MCP action has occurred or will occur.

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

- ~~(a) An "action" is the MCP's:~~
  - ~~(i) Denial or limited authorization of a requested service, including the type or level of service;~~
  - ~~(ii) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP;~~
  - ~~(iii) Denial, in whole or part, of payment for a service;~~
  - ~~(iv) Failure to provide services in a timely manner as specified in paragraph (A)(7)(c) of rule 5101:3-26-03.1 of the Administrative Code; or~~
  - ~~(v) Failure to act within the resolution timeframes specified in this rule.~~
- ~~(b) An "appeal" is the request for a review of an action.~~
- ~~(c) A "grievance" is an expression of dissatisfaction with any aspect of the MCP's or provider's operation, provision of health care services, activities, or behaviors, other than an MCP's action as defined in paragraph (A)(1)(a) of this rule.~~
- ~~(d) "Resolution" means a final decision is made by the MCP and the decision is communicated to the member.~~

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

- ~~(2) For the purposes of filing grievances or appeals on behalf of a member under the age of eighteen, written consent to file is not required when the individual filing the grievance or appeal belongs to the member's assistance group.~~
- ~~(3) Each MCP must develop and implement a grievance system for members that includes an appeals process, a grievance process, and a process to access the state's hearing system as specified in this rule. MCPs must have written grievance system policies and procedures and, upon request, the MCP's policies and procedures must be made available for review by ODJFS.~~
- ~~(4) MCPs must give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including but not limited to:
  - ~~(a) Explaining the MCP's process to be followed in resolving the member's appeal or grievance.~~
  - ~~(b) Completing forms and taking other procedural steps as outlined in this rule.~~
  - ~~(c) Providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.~~~~
- ~~(5) Members are not required to exhaust the MCP's appeal or grievance process in order to access the state's hearings system.~~
- ~~(6) MCPs must ensure that the individuals who make decisions on appeals and grievances are individuals who:
  - ~~(a) Were not involved in previous levels of review or decision-making.~~
  - ~~(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:
    - ~~(i) An appeal of a denial that is based on lack of medical necessity.~~
    - ~~(ii) A grievance regarding the denial of an expedited resolution of an appeal.~~
    - ~~(iii) An appeal or grievance that involves clinical issues.~~~~~~
- ~~(7) The procedure to be followed to file an appeal, grievance, or state hearing request must be described in the MCP's member handbook and must include the telephone number(s) for the MCP's toll-free member services hotline, the MCP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file an appeal or grievance must also be made available through the MCP's member services program.~~
- ~~(8) Grievance system procedures must include the participation of individuals authorized by the MCP to require corrective action.~~
- ~~(9) MCPs are prohibited from delegating the appeal or grievance process to another entity.~~

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

- (1) A process by which members may file grievances with the MCP, in compliance with paragraph (H) of this rule;
- (2) A process by which members may file appeals with the MCP, in compliance with paragraphs (C) through (G) of this rule; and
- (3) A process by which members may access the state's hearing system through the Ohio Department of Job and Family Services (ODJFS) in compliance with paragraph (I) of this rule.

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

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

~~(1)(2)~~ ~~When an MCP action has or will occur, the MCP must provide the affected member(s) with a written NOA.~~ The NOA must meet the language and format requirements for member materials specified in paragraph (B)(2) of rule 5101:35160-26-08.2 of the Administrative Code and explain:

- (a) The action the MCP has taken or intends to take;
- (b) The reasons for the action;
- (c) The member's or authorized representative's right to file an appeal to the MCP;
- (d) If applicable, the member's right to request a state hearing through the state's hearing system;
- (e) Procedures for exercising the member's rights to appeal or grieve the action;
- (f) Circumstances under which expedited resolution is available and how to request it;
- (g) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services;
- (h) The date that the notice is being issued;
- (i) Oral interpretation is available for any language;
- (j) Written translation is available in prevalent languages as applicable;
- (k) Written alternative formats may be available as needed; and
- (l) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP.

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

- (a) For a decision to deny or limit authorization of a requested service, including the type or level of service, the MCPs MCP must issue an NOA simultaneously with the MCP's decision. ~~MCP service authorization decisions must be made in accordance with the timeframes specified in paragraphs (A)(7)(c)(v), (A)(7)(c)(vi), and (A)(7)(c)(viii) of rule 5101:3-26-03.1 of the Administrative Code.~~
- (b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCP, the MCP MCPs must give notice fifteen calendar days before the date of action except:
  - (i) If probable recipient fraud has been verified, the MCP must give notice five calendar days before the date of action.
  - (ii) ~~The MCP must give notice on or before the date of action in accordance with~~ Under the circumstances set forth in 42 C.F.R. 431.213 (January 29, 1993) October 1, 2013), the MCP must give notice on or before the date of action.
- (c) For denial of payment for a noncovered service, MCPs must give notice simultaneously with the MCP's action to deny; the claim, in whole or part, for a service that is not covered by medicaid, including a service that was determined through the MCP's prior authorization process as not medically necessary.
- (d) For untimely prior authorization, service, appeal or grievance resolution, the MCP MCPs must give notice simultaneously with the MCP becoming aware of the action. A service Service authorization decisions decision not reached within the timeframes specified in paragraphs (A)(7)(c)(v), (A)(7)(c)(vi), and (A)(7)(c)(viii) of rule 5101:35160-26-03.1 of the Administrative Code, constitutes a denial and are is thus considered to be

an adverse ~~actions~~action. Notice must be given on the date that the authorization decision timeframe expires.

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

- (1) A member, provider, or a member's authorized representative may file an appeal orally or in writing within ninety days from the date on the NOA. The ninety day period begins on the day after the mailing date of the NOA. An oral filing must be followed with a written appeal. The MCP must: ~~MCPs must ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal. An oral filing must be followed with a written appeal. The MCP must assist the member to ensure that a written appeal is filed by immediately converting an oral filing to a written record. If the member follows the oral filing with a written appeal, this appeal will supersede the written record, however, the date of the oral filing must be considered the filing date of the appeal.~~
  - (a) Assist members that file an oral appeal by immediately converting an oral filing to a written record;
  - (b) Ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal; and
  - (c) Consider the date of the oral filing as the filing date if the member follows the oral filing with a written appeal.
- (2) ~~The member's authorized representative and a~~ Any provider acting on the member's behalf must have the member's written consent to file an appeal. ~~The MCPs~~ MCP must begin processing the appeal pending receipt of the written consent.
- (3) ~~The MCP~~ MCPs must acknowledge receipt of each appeal to the individual filing the appeal. At a minimum, acknowledgment must be made in the same manner that the appeal was filed. If an appeal is filed in writing, written acknowledgment must be made by the MCP within three working days of the receipt of the appeal.
- (4) The MCP must provide members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member and/or member's authorized representative must be allowed to examine the case file, including medical records and any other documents and records, before and during the appeals process.
- (5) ~~MCPs~~ The MCP must consider the member, member's authorized representative, or estate representative of a deceased member as parties to the appeal.
- (6) ~~MCPs~~ The MCP must review and resolve each appeal as expeditiously as the member's health condition requires, but the resolution timeframe must not exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph ~~(E)~~(F) of this rule.
- (7) The MCP must provide written notice to the member, and to the member's authorized representative if applicable, of the resolution including, at a minimum, the decision and date of the resolution.
- (8) For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding:
  - (a) Oral interpretation that is available for any language;
  - (b) Written translation that is available in prevalent languages as applicable;
  - (c) Written alternative formats that may be available as needed;
  - (d) How to access the MCP's interpretation and translation services as well as alternative formats that can be provided by the MCP;
  - (e) The right to request a state hearing through the state's hearing system; and ;
  - (f) How to request a state hearing; and if applicable:

- (i) The right to continue to receive benefits pending a state hearing,
  - (ii) How to request the continuation of benefits; and
  - (iii) If the MCP action is upheld at the state hearing that the member may be liable for the cost of any continued benefits.
- (9) For appeals decided in favor of the member, the MCP must:
- (a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending.
  - (b) Pay for the disputed services if the member received the services while the appeal was pending.

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

- (1) Each MCPsMCP must establish and maintain an expedited review process to resolve appeals when the MCP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- (2) MCPs In utilizing an expedited appeal process, the MCP must comply with the standard appeal process specified in paragraph ~~(C)~~ (D) of this rule, except the MCPsMCP must:
  - (a) Not require that an oral filing be followed with a written, signed appeal.;
  - (b) Make a determination within one working day of the appeal request whether to expedite the appeal resolution.;
  - (c) Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution.;
  - (d) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing.;
  - (e) Resolve the appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed three working days from the date the MCP received the appeal unless the resolution timeframe is extended as outlined in paragraph ~~(E)~~ (F) of this rule.;
  - (f) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification.;
  - (g) Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.;
  - (h) Notify ODJFSODM within one working day of any appeal that meets the criteria for expedited resolution as specified by ODJFSODM.
- (3) If the MCP denies the request for expedited resolution of an appeal the MCP must:
  - (a) Transfer the appeal to the standard resolution timeframe of fifteen calendar days from the date the appeal was received unless the resolution timeframe is extended as outlined in paragraph ~~(E)~~(F) of this rule;
  - (b) Provide the member written notice of the denial to expedite the resolution within two calendar days of the receipt of the appeal, including information that the member can grieve the decision.

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

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

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

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

- (1) The MCP must continue a member's benefits when an appeal has been filed if the following conditions are met:
  - (a) The member or authorized representative files the appeal on or before the later of the following:
    - (i) Within fifteen working days of the MCP mailing the NOA; or
    - (ii) The intended effective date of the MCP's proposed action;
  - (b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized course of treatment;
  - (c) The services were ordered by an authorized provider;
  - (d) The authorization period has not expired; and
  - (e) The member requests the continuation of benefits.
- (2) If the MCP continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
  - (a) The member withdraws the appeal;
  - (b) Fifteen calendar days pass following the mailing date of the MCP's notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing with continuation of benefits and in which case therefore the benefits must be continued as specified in rule 5101:6-4-01 of the Administrative Code;
  - (c) A state hearing regarding the ~~continuation of the benefits~~reduction, suspension or termination of services is decided adverse to the member; or
  - (d) The initial time period for the authorization expires or the authorization service limits are met.
- (3) At the discretion of ODJFS~~ODM~~, the MCP may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the MCP's original action.

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

- (1) A member or authorized representative can file a grievance. An authorized representative must have the member's written consent to file a grievance on the member's behalf.
- (2) Grievances may be filed only with the MCP, orally or in writing, ~~only with the MCP~~, within ninety calendar days of the date that the member became aware of the issue.
- (3) The MCPs~~MCP~~ must acknowledge the receipt of each grievance to the individual filing the grievance. Oral acknowledgment is acceptable, ~~However~~ ~~however~~, if the grievance is filed in writing, written acknowledgment must be made within three working days of receipt of the grievance.
- (4) MCPs~~The MCP~~ must review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions including member notification must meet the following timeframes:

- (a) Within two working days of receipt if the grievance is regarding access to services.
  - (b) Within thirty calendar days of receipt for non claims-related grievances except as specified in paragraph ~~(G)~~(H)(4)(a) of this rule.
  - (c) Within sixty calendar days of receipt for claims-related grievances.
- (5) At a minimum, the MCP must provide oral notification to the member of a grievance resolution. However, if the MCP is unable to speak directly with the member ~~and~~ or the resolution includes information that must be confirmed in writing, the resolution must be provided in writing simultaneously with the MCP's decision.
- (6) If the MCP's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service or billing of a member due to the MCP's denial of payment for that service, the MCP must notify the member of his or her right to request a state hearing as specified in paragraph ~~(H)~~(I) of this rule, if the member has not previously been notified.

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

- (1) The MCP must develop and implement written policies and procedures that ensure the plan's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code.
- (2) Members are not required to exhaust the appeal or grievance process through the MCP in order to access the state's hearing system.

~~(4)~~(3) When required by paragraph (C) of this rule and division 5101:6 of the Administrative Code, the MCPs must notify members, and any authorized representatives on file with the MCP, of the right to a state hearing. The following requirements apply as follows:

- (a) If the MCP denies a request for the authorization of a service, in whole or in part, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Medical Services By Your Managed Care Plan" (~~JFS ODM 04043, 7/2014~~ formerly JFS 04043 rev. 7/2009).
- (b) If the MCP decides to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the MCP, the MCP must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension, or termination, the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (~~JFS ODM 04066, 7/2014~~ formerly JFS 04066 7/2009).
- (c) If the MCP learns that a member has been billed for services received by the member due to the MCP's denial of payment, and the MCP upholds the denial of payment, the MCP must immediately complete and mail or personally deliver the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (~~JFS ODM 04046, 7/2014~~ formerly JFS 04046 rev. 7/2009).
- (d) If the MCP proposes enrollment in the coordinated services program (CSP), the MCP must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed enrollment, the "Notice of Proposed Enrollment in the Coordinated Services Program (CSP) ~~By ODJFS Or By Your Managed Care Plan~~" (~~JFS ODM 01717 01704, 7/2014~~ formerly JFS 01717 rev. 7/2011).
- (e) If the MCP decides to continue enrollment in CSP, the MCP must simultaneously complete and mail or personally deliver the "Notice of Continued Enrollment in the Coordinated Services Program (CSP) ~~By ODJFS Or By Your Managed Care Plan~~" (~~JFS ODM 01705, 7/2014~~ formerly JFS 01705 rev. 7/2011).
- (f) If the MCP denies a CSP member's request to change designated provider(s) within the MCP's provider panel, the MCP must simultaneously complete and mail or personally deliver the "Notice of Denial of Designated Provider or Pharmacy Change in the

Coordinated Services Program (CSP) ~~By ODJFS Or By Your Managed Care Plan~~" (JFS 01706, (ODM 01718, 7/2014 formerly JFS 01718~~rev. 7/2014~~)).

- (4) The member or member's authorized representative may request a state hearing within ninety calendar days by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS). The ninety-day period begins on the day after the mailing date on the state hearing form.
- (5) There are no state hearing rights for a member(s) terminated from the MCP pursuant to an MCP-initiated membership termination as permitted in rule 5160-26-02.1 of the Administrative Code.
- (6) Following the bureau of state hearings' notification to the MCP that a member has requested a state hearing the MCP must:
  - (a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014 formerly JFS 01959) with appropriate attachments, and file it with the bureau of state hearings at least three business days prior to the scheduled hearing date. The appeal summary must provide all facts and documents relevant to the issue, and be sufficient to demonstrate the basis for the MCP's action or decision.
  - (b) Send a copy of the completed appeal summary to the appellant, the bureau of state hearings, the local agency, and the designated ODM contact.
  - (c) Continue or reinstate the benefit(s) specified in rule 5101:6-4-01 of the Administrative Code, if the MCP is notified that the member's state hearing request was received within the prior notification period.
  - (d) Not enroll the individual in the coordinated services program (CSP) if the MCP is notified that the member's state hearing request was received within the prior notification period.
- (7) The MCP must participate in the hearing in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, rev. 09/2002) sent to the MCP by the bureau of state hearings.
- (8) In addition to the MCP and member, other parties to a state hearing may include an authorized representative of a member, or the representative of the member's estate, if the member is deceased.
- (9) The MCP must comply with the state hearing officer's decision provided to the MCP via the "State Hearing Decision" (JFS 04005, rev. 03/2003). If the hearing officer's decision is to sustain the member's appeal, the MCP must complete the "State Hearing Compliance" form (JFS 04068, rev. 05/2001). A copy of the completed form, including applicable documentation, is due by no later than the compliance date specified in the hearing decision to the bureau of state hearings and the designated ODM contact. If applicable, the MCP must:
  - (a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.
  - (b) Pay for the disputed services if the member received the disputed services while the appeal was pending.
- ~~(2)~~(10) MCPs ~~The MCP must provide a copy of the state hearing forms referenced in this paragraph to (H)(1) of this rule to ODJFS ODM, as directed by ODJFS ODM.~~
- ~~(3)~~(11) Upon request, the MCP's state hearing policies and procedures must be made available for review by ODM. ~~The MCP, member, and member's authorized representative are parties to the state hearing.~~
- ~~(4)~~(J) Logging and reporting of appeals and grievances.
  - (1) MCPs ~~The MCP must maintain records of all appeals and grievances including resolutions for a period of six eight years and the records must be made available upon request to ODJFS ODM and the MFCU~~ medicaid fraud control unit.

- (2) The MCP~~MCPs~~ must identify a key staff person responsible for the logging and reporting of appeals and grievances and assuring that the grievance system is in accordance with this rule.
- (3) ~~MCPs~~The MCP is ~~are~~ required to submit information regarding appeal and grievance activity as directed by ~~ODJFS~~ODM.

(K) Other duties of an MCP regarding appeals and grievances.

- (1) The MCP must give members all reasonable assistance in filing an appeal, a grievance, or a state hearing request including but not limited to:
  - (a) Explaining the MCP's process to be followed in resolving the member's appeal or grievance;
  - (b) Completing forms and taking other procedural steps as outlined in this rule; and
  - (c) Providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.
- (2) The MCP must ensure that the individuals who make decisions on appeals and grievances are individuals who:
  - (a) Were not involved in previous levels of review or decision-making; and
  - (b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following:
    - (i) An appeal of a denial that is based on lack of medical necessity;
    - (ii) A grievance regarding the denial of an expedited resolution of an appeal; or
    - (iii) An appeal or grievance that involves clinical issues.
- (3) The procedure to be followed to file an appeal, grievance, or state hearing request must be described in the MCP's member handbook and must include the telephone number(s) for the MCP's toll-free member services hotline, the MCP's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the MCP. Copies of the form(s) to file an appeal or grievance must also be made available through the MCP's member services program.
- (4) Appeals and grievance procedures must include the participation of individuals authorized by the MCP to require corrective action.
- (5) The MCP is prohibited from delegating the appeal or grievance process to another entity.

Effective: 03/06/2015

Five Year Review (FYR) Dates: 10/30/2014 and 03/06/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 02/24/2015

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Prior Effective Dates: 7/1/03, 6/1/06, 9/15/08, 7/1/09, 8/1/10

**MCTL 43****Effective Date: February 1, 2015****Most Current Prior Effective Date: June 1, 2006 (No Change)****(A) ~~Reimbursement~~Payment.**

- (1) The Ohio department of medicaid (ODM) will compute managed care plan (MCP) premium rates on an actuarially sound basis. The premium rates do not include any amount for risks assumed under any other existing or any previous agreement or contract. ODM will review the premium rates at least annually and the rate(s) may be modified based on existing actuarial factors and experience.
- ~~(1)(2) The MCP~~~~MCPs~~ ~~will receive a monthly premium payment for each member from ODM. For the covered families and children category as described in paragraph (B)(1)(a) of rule 5101:3-26-02 of the Administrative Code, when MCPs provide or arrange maternity coverage, a separate payment will be made for each reimbursable delivery. These payments will be in effect for the duration of the agreement unless restricted in accordance with rule 5101:3-26-10 of the Administrative Code.~~
- (3) When an MCP provides or arranges for maternity coverage, ODM will make a separate payment to the MCP for each reimbursable delivery for applicable covered populations described in rule 5160-26-02 of the Administrative Code.
- ~~(2) The premium rates are computed on an actuarially sound basis. This rate does not include any amount for risks assumed under any other existing or any previous agreement or contract. The premium rate will be reviewed at least once every two years and may be modified based on existing actuarial factors and experience.~~
- ~~(3)~~(4) Under full-risk arrangements the~~The~~ amounts paid by ODM in accordance with this paragraph (A)(1) of this rule represent a full-risk arrangement and the total obligation of ~~ODJFS~~ODM to the MCP for the costs of medical care and services provided. Any savings or losses remaining after costs have been deducted from the premium will be wholly retained by the MCP, ~~except as provided in paragraph (A)(5) of this rule.~~
- ~~(4) Under partial-risk arrangements, the MCP and ODJFS will partially share the risk for the cost of medical care and services provided. Any savings which accrue will also be shared.~~
- (5) Payments made by ODM in accordance with this paragraph will be in effect for the duration of the provider agreement entered into between ODM and the MCP unless restricted in accordance with rule 5160-26-10 of the Administrative Code or the terms of the provider agreement.
- ~~(5)~~(6) ~~ODJFS~~ODM may establish financial incentive programs based on performance for MCPs.

**(B) Fiscal responsibility requirements.**

- (1) ~~Each~~ An MCP must maintain a fiscally-sound operation and meet ~~ODFJS~~ODM performance standards.
- (2) ~~Each~~ An MCP must make provisions against the risk of insolvency.
- (3) Neither members nor ~~ODJFS~~ODM shall be liable for any MCP debts, including those that remain in the event of MCP insolvency or the insolvency of any subcontractors.
- (4) ~~Each~~ An MCP must pay providers in accordance with 42 C.F.R. 447.46 (October 1, 2013).
- (5) The following requirements apply to an MCP ~~MCPs~~ licensed as a health insuring corporation (HIC) by the Ohio department of insurance (ODI):
  - (a) A copy of the MCP's current license or certificate of authority must be submitted to ~~ODJFS~~ODM annually, no later than thirty days after issuance;

- (b) Copies of all annual and quarterly financial statements and any revision to such copies must be submitted to ODJFSODM. For purposes of this rule, "~~Annual~~annual financial statement" is the annual statement of financial condition prescribed by the "National Association of Insurance Commissioners" (NAIC) ~~statutory filing of financial condition as adopted~~ and required by ~~the Ohio department of insurance (ODI)~~ in accordance with sections 1751.32 and 1751.47 of the Revised Code.
- (c) ~~Each~~The MCP must submit to ODJFSODM a copy of its audited financial statement as compiled by an independent auditor and including the statement of reconciliation with statutory accounting principles as required by ODI in accordance with section 1751.321 of the Revised Code. The statement must be submitted annually to ODJFSODM.

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

- (a) ~~Each MCP must submit cost~~Cost reports on ODJFSODM forms quarterly and annually, no later than ninety days after the close of the calendar year or as otherwise specified as directed by ODJFSODM. ~~The annual cost report must be audited by an independent licensed auditor and include a statement of reconciliation with statutory accounting principles. The annual cost report must also include a description of the methodology used to calculate incurred but not reported (IBNR) claims and an annual certification signed by an independent accredited actuary or licensed auditor that the methodology is valid. Such certification must be signed within the preceding twelve months and must be accompanied by a signed statement from the MCP that the methodology has not materially changed since the date the certification was signed by the independent actuary or auditor.~~The MCP must adhere to ODM provider agreement and cost report instructions;
- (b) Financial disclosure statements to be submitted in conjunction with cost report submissions as specified in paragraph (B)(5)(b) of this rule for MCPs. The MCP must also submit copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the ~~MCP~~,MCP, or an indirect interest of five percent or more or a combination of direct and indirect interest equal to five percent or more in the MCP; and
- (c) MCP physician incentive plan disclosure statements ~~and other information as required by~~in accordance with 42 C.F.R. 417438.6 (October 1, 2013).

(C) Reinsurance requirements.

- (1) All MCPs must carry reinsurance coverage from a licensed commercial carrier to protect against catastrophic inpatient-related medical expenses incurred by medicaid members.
- (2) To the extent that the risk for such expenses is transferred to a subcontractor, the MCP must provide proof of reinsurance coverage for that subcontractor in accordance with the provisions of this paragraph.
- (3) A copy of the fully-executed reinsurance agreement to provide the specified coverage must be submitted to ODJFSODM prior to the effective date of the provider agreement. No provider agreement will be signed in the absence of such documentation.
- (4) The annual deductible must be specified in the reinsurance agreement and must not exceed the amount specified by ODJFSODM.
- (5) The reinsurance coverage must remain in force during the term of the provider agreement with ODJFSODM and must contain adequate provisions for contract extensions.
- (6) ~~Each~~ The MCP shall provide written notification to ODJFSODM when directed by ODM, specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all medicaid members for which reinsurance claims have been submitted. ~~The MCP must provide such notification to ODJFS as part of the ODJFS "Medicaid Managed Care Plan Cost Report."~~
- (7) The MCP must give ODJFSODM prior written notice of any proposed changes or modifications in the reinsurance agreements for ODJFSODM review and approval. Such notice shall be

submitted to ODJFS ODM thirty days prior to the intended effective date of any proposed change and must include the complete and exact text of the proposed change. The MCP MCPs must provide copies of new or modified reinsurance agreements to ODJFS ODM within thirty days of execution.

- (8) In the event of termination of the reinsurance agreement due to insolvency of the MCP or the reinsurance carrier, the MCP will be fully responsible for all pending or unpaid claims.
- (9) Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency must include medicaid members as a covered class.
- (10) Reinsurance requirements for partial-risk arrangements may differ from those specified in this paragraph.

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MCTL 40

**Effective Date: January 1, 2014**

**Most Current Prior Effective Date: August 1, 2011**

(A) Tort

- (1) Pursuant to sections ~~5101.58~~ 5160.37. and ~~5101.59~~ 5160.38 of the Revised Code, ODJFSODM maintains all rights of recovery (tort) against the liability of any third party payer (TPP) for the cost of medical services arising out of any accident/incident related to an injury of a member.
- (2) Managed care plans (MCPs) are prohibited from accepting any settlement, compromise, judgment, award, or recovery of any action or claim by the member.
- (3) MCPs must notify ODJFSODM and/or its designated entity within fourteen calendar days of all requests for the release of financial and medical records to a member or the member's representative pursuant to the filing of a tort action. Notification must be made via the "Notification of Third Party (tort) Request For Release" form (JFS 03245, rev. 1/2011) or a method determined by the ODJFSODM designated entity, provided ODJFSODM has approved the designated entity's method and notified MCPs.
- (4) MCPs must submit a summary of financial information to ODJFSODM and/or its designated entity within thirty calendar days of receiving an original authorization to release a financial claim statement letter from ODJFSODM pursuant to a tort action. MCPs must use the "Tort Summary Statement for ODJFS" form (JFS 03246, rev. 1/2011) or a method determined by the ODJFSODM designated entity, provided ODJFSODM has approved the designated entity's method and notified MCPs. Upon request, the MCPs must provide ODJFSODM and/or its designated entity with true copies of medical claims.

(B) Fraud and abuse recovery

- (1) Except as set forth in paragraph (B)(2) of this rule, ODM assigns to MCPs its rights of recovery against any TPP for the costs arising out of provider fraud or abuse as defined by rule 5160-26-01 of the Administrative Code related to each member during periods of membership in the MCP.
- (2) MCPs must promptly report to ODM all cases of suspected fraud or abuse, in the manner specified by ODM. If an MCP fails to properly report a case of suspected fraud or abuse before the suspected fraud or abuse is identified by the state of Ohio, its designees, the United States or private parties acting on behalf of the United States, any portion of the fraud or abuse recovered by the state of Ohio or designees shall be retained by the state of Ohio or its designees.

~~(B)~~(C) Coordination of benefits (COB)

- (1) ODJFSODM assigns its right to third party ~~(TP)~~ resources (coordination of benefits) to contracted MCPs for services rendered to each member during periods of membership, ~~except as stated in paragraph (A) of this rule.~~
- (2) MCPs must act to provide coordination of benefits if a member has third party resources available for the payment of medical expenses for medically necessary medicaid-covered services. Such expenses will be paid in accordance with this rule and sections ~~5101.58~~ 5160.37 and ~~5101.59~~ 5160.38 of the Revised Code.
- (3) The MCP is the payer of last resort when a member has third party resources available for payment of medical expenses for medicaid-covered services, except for ~~those~~ the following resources ~~listed in paragraphs (B)(3)(a) to (B)(3)(c) of this rule. In these instances,~~ in which the MCP is the primary payer:.

- (a) Resources provided through the children with medical handicaps program under ~~Title V of the Social Security Act~~ sections 3701.021 to 3701.0210 of the Revised Code, as specified in rule ~~5101:35160-1-03~~ of the Administrative Code.
  - (b) Resources that are exempt from primary payer status under ~~Title XIX of the Social Security Act~~ federal medicaid law, 42 U.S.C. 1396 (August 19, 2013).
  - (c) Resources provided through the state sponsored program awarding reparations to victims of crime, as set forth in sections 2743.51 to 2743.72 of the Revised Code.
  - (d) Resources available for prenatal care for pregnant women, or preventive pediatric services pursuant to 42 CFR 433.139 (August 14, 2013).
- (4) MCPs will take reasonable measures to ascertain and verify any third party resources that are available to the member. When an MCP denies a claim due to third party liability (TPL), the MCP must timely share appropriate and available information regarding the third party resources to the provider for the purposes of coordination of benefits, including, but not limited to, the following information:
- (a) Insurance company name;
  - (b) Insurance company billing address for claims;
  - (c) Member's group number;
  - (d) Member's policy number; and
  - (e) Policy holder name.
- (5) MCPs must require providers who are submitting TPL claims to the MCPs to request information regarding third party benefit(s) from the member or his/her authorized representative. If the member or the member's authorized representative specifies that the member has no ~~TP~~third party benefit(s), or the provider is unable to determine that the member has third party benefit(s), the MCP must permit the provider to submit a claim to the MCP. If, as a result of requesting the information, the provider determines that ~~TP~~third party liability exists, the MCP must allow the provider to submit a claim for reimbursement if he/she first takes reasonable measures to obtain ~~TP~~third party payment(s) as set forth in paragraph ~~(B)(C)~~(6) of this rule.
- (6) The MCP must be the last payer to receive and adjudicate the claim, except for those exemptions listed in paragraph ~~(B)(C)~~(3) of this rule. The MCP must require providers to take reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing the MCP. MCPs must permit providers who have taken reasonable measures to obtain all third party payments, but who have not received payment from a TPP, or have taken reasonable measures and received partial payment, to submit a claim to the MCP requesting reimbursement for the rendered service(s).
- (a) MCPs must process claims when the provider has complied with one or more of the following reasonable measures:
    - (i) The provider first submits a claim to the TPP for the rendered service(s) and does not receive a remittance advice or other communication from the TPP within ninety days after the submission date. MCPs may require providers to document the claim and date of the claim submission to the TPP.
    - (ii) The provider has retained and/or submitted at least one of the following types of documentation that indicates a valid reason for non-payment for the service(s) that is not related to provider error:
      - (a) Documentation from the TPP;
      - (b) Documentation from the TPP's automated eligibility and claim verification system;
      - (c) Documentation from the TPP's member benefits reference guide/manual; or

- (d) Any other information and/or documentation from the TPP that there is no third party benefit coverage for the rendered service(s).
- (iii) The provider submitted a claim to the TPP and received a partial payment along with a remittance advice documenting the allocation of the charges.
- (b) Valid reasons for non-payment from a third party payer to the provider for a third party benefit claim include, but are not limited to, the following:
  - (i) The service(s) is not covered under the member's third party benefits.
  - (ii) The member does not have third party benefits through the TPP for the date of service.
  - (iii) All of the provider's billed charges or the TPP's approved rate was applied, in whole or in part, to the member's third party benefit deductible amount, coinsurance and/or co-payment for the TPP. The provider may then submit a secondary claim to the MCP showing the appropriate amount received from the TPP.
  - (iv) The member has not met any required waiting periods, or residency requirements for his/her third party benefits, or was non-compliant with the TPP's requirements in order to maintain coverage.
  - (v) The member is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.
  - (vi) The member has reached the lifetime benefit maximum for the medical service or third party benefits being billed to the third party payer.
  - (vii) The TPP is disputing or contesting its liability to pay the claim or cover the service.
- (7) If the provider receives payment from the TPP after the MCP has made payment, the MCP must require the provider to repay the MCP any amount overpaid by the MCP. The MCP must not allow the provider to reimburse any overpaid amounts to the member.
- (8) MCPs must make available to providers information on how to submit a claim that will have a zero paid amount in the third party field on the claim.
- (9) MCP reimbursement for third party claims will not exceed the MCP allowed amount for the service, less all third party payments for the service.
- (10) An MCP's timely filing limits for provider claims shall be at least ninety days from the date of the remittance advice that indicates adjudication or adjustment of the third party claim by the TPP.
- (11) MCPs must ensure that providers do not hold liable or bill members in the event that the MCP cannot or will not pay for covered services unless all of the specifications set forth in ~~paragraph (D)(9)~~ of rule ~~5101:35160-26-05~~ and ~~paragraph (E)~~ of rule ~~5101:35160-26-11~~ of the Administrative Code are met. The provider may not collect and/or bill the member for any difference between the MCP payment and the provider's charge or request the member to share in the cost through a deductible, coinsurance, co-payment, or other similar charge, other than MCP co-payments as permitted in rule ~~5101:35160-26-12~~ of the Administrative Code.

Effective: 01/01/2014

R.C. 119.032 review dates: 10/15/2013 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 12/20/2013

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**Effective Date: October 9, 2008 (No Change)**

- (A) If the MCP fails to fulfill its duties and obligations under Chapter 5101:3-26 of the Administrative Code and/or the MCP provider agreement, ODJFS will provide timely written notification to the MCP identifying the violations/deficiencies, and may impose any of the following sanctions in addition to or instead of any sanctions specified in the provider agreement:
- (1) Corrective action in accordance with the following:
    - (a) If requested by ODJFS, the MCP must submit, within the specified time frame, a proposed CAP for each cited violation/deficiency.
    - (b) The CAP must contain the proposed correction date, describe the manner in which each violation/deficiency will be resolved, and address all items specified in the ODJFS notification.
    - (c) The CAP must be reviewed and approved by ODJFS.
    - (d) Following the approval of the CAP, ODJFS will monitor the correction process until all violations/deficiencies are corrected to the satisfaction of ODJFS.
    - (e) Failure to submit an approvable CAP within the ODJFS-specified time frames may result in the imposition of an ODJFS-developed CAP and/or additional sanctions.
    - (f) If ODJFS has already determined the specific action which must be implemented by the MCP, ODJFS may require the MCP to comply with an ODJFS-developed or directed CAP.
    - (g) Failure to successfully complete the correction process and correct the violations/deficiencies to the satisfaction of ODJFS may lead to the imposition of any or all of the sanctions listed in paragraphs (A)(2) to (A)(5) of this rule.
  - (2) Suspension of further membership except MCP automatic renewals, and MCP newborns and case additions.
  - (3) ODJFS notification to the MCP's members that they may terminate from the MCP without cause.
  - (4) Reduction of the premium rate.
  - (5) Retention of premium payments or a portion thereof by ODJFS until violations/deficiencies are corrected.
- (B) Sanction selection will be determined based on a pattern of repeated violations/deficiencies, the severity of cited violations/deficiencies, and/or the failure of the MCP to meet the requirements of an approved CAP.
- (C) Sanctions in paragraphs (A)(2) to (A)(5) of this rule are subject to reconsideration as specified in paragraph (B) of rule 5101:3-1-57 of the Administrative Code, with the exception of the sanction in paragraph (A)(3) of this rule when such notification occurs in conjunction with action taken under paragraph (D) of this rule.
- (D) Regardless of any other sanction that may be imposed, ODJFS shall appoint a temporary manager for any MCP that has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 C.F.R. Part 438 subpart I. Such temporary management shall be imposed in accordance with the following:
- (1) The MCP must pay the costs of a temporary manager for performing the duties of a temporary manager, as determined by ODJFS.
  - (2) Any costs or liabilities incurred on behalf of an MCP by a temporary manager shall be paid by the MCP and the MCP shall be solely responsible for such costs or liabilities.

- (3) The imposition of temporary management is not subject to the appeals process provided under Chapter 119. of the Revised Code but the MCP may request that the deputy director for the medicaid program reconsider this action. ODJFS will not delay imposition of temporary management to provide reconsideration prior to imposing this sanction.
  - (4) Unless the deputy director for the medicaid program determines through the reconsideration process that temporary management should not have been imposed, the temporary management will remain in place until such time as ODJFS determines that the MCP can ensure that the sanctioned behavior will not recur.
  - (5) Regardless of the imposition of temporary management, the MCP retains the right to appeal any proposed termination or nonrenewal of their provider agreement under Chapter 119. of the Revised Code. The MCP also retains the right to initiate the sale of the MCP or its assets.
  - (6) If temporary management is imposed, ODJFS will notify the MCP's members that such action has occurred and inform them that they therefore have the right to terminate their membership in the MCP without cause.
- (E) ODJFS will provide an MCP with written notice before imposing any sanction. The notice will include specification of any reconsideration or appeal rights that are available to the MCP.
- (F) Regardless of whether ODJFS imposes a sanction, MCPs are to initiate corrective action for any MCP program violations/deficiencies as soon as they are identified by either the MCP or ODJFS.
- (G) ODJFS may terminate, nonrenew, deny or amend a provider agreement if at any time ODJFS determines that continuation or assumption of a provider agreement is not in the best interest of recipients or the state of Ohio. For the purposes of this rule, an amendment to an MCP's provider agreement is defined as and limited to the elimination of one or more service areas included in that MCP's current agreement. For MCPs, the phrase "not in the best interest" includes, but is not limited to, the following:
- (1) The MCP's delivery system does not assure adequate access to services for their members.
  - (2) The MCP's delivery system does not assure the availability of all services covered under the provider agreement.
  - (3) The MCP fails to provide all medically-necessary covered services.
  - (4) The MCP fails to provide proper assurances of financial solvency.
  - (5) The MCP fails to comply with the provisions of:
    - (a) Chapter 5101:3-26 of the Administrative Code;
    - (b) The provider agreement;
    - (c) The applicable requirements in sections 1932 and 1903(m) of the Social Security Act; and/or
    - (d) 42 C.F.R. Part 438.
- (H) If ODJFS has proposed termination, nonrenewal, denial, or amendment of a provider agreement pursuant to paragraph (I)(2) of this rule, ODJFS may notify the MCP's members of this proposed action and inform the members of their right to immediately disenroll from the MCP without cause. If ODJFS has proposed termination, nonrenewal, denial, or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODJFS may propose membership termination of all the MCP's members. This proposed action would be subject to appeal by the MCP and reconsideration by the deputy director for the medicaid program. If the proposed action is not appealed or if upheld by the deputy director upon appeal, the membership termination would occur at the earliest possible effective date.
- (I) If ODJFS determines that the termination, nonrenewal, denial or amendment of a provider agreement is warranted:

- (1) Notification will be given, at a minimum, forty-five days prior to the effective date of the proposed action, in accordance with Chapter 5101:6-50 of the Administrative Code;
  - (2) The action will be in accordance with and subject to Chapter 5101:6-50 and rule 5101:3-1-57 of the Administrative Code; and
  - (3) All such actions will be effective at the end of the last day of a calendar month.
- (J) Notwithstanding the preceding paragraphs of this rule, provider agreements may be terminated effective on the last day of the calendar month in which any of the following occur:
- (1) The determination by ODJFS that the loss or reduction of federal or state funding has reduced funding to a level which is insufficient to maintain the activities or services agreed to in the provider agreement; or
  - (2) The exclusion from participation of the MCP in a program administered under Title XVIII, XIX, or XX of the Social Security Act due to criminal conviction or the imposition of civil monetary penalties in accordance with 42 C.F.R. Part 455 subpart B, 42 C.F.R. Part 1002 subpart A, and rule 5101:3-1-17.3 of the Administrative Code; or
  - (3) The suspension, revocation or nonrenewal of ODJFS' authority to operate the program under waivers of certain federal regulations granted by CMS or congress; or
  - (4) The suspension, revocation or nonrenewal of the MCP's certificate of authority or license.
  - (5) The entity is excluded from participation in accordance with 42 C.F.R. 438.808.
- (K) MCPs whose provider agreements are amended, terminated or nonrenewed are required to fulfill all duties and obligations under Chapter 5101:3-26 of the Administrative Code and/or the provider agreement.

R.C. 119.032 review dates: 04/14/2009 and 04/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 04/14/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.16, 5111.17

Rule Amplifies: 5111.01, 5111.02, 5111.16, 5111.17

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**MCTL 43**

**Effective Date: February 1, 2015**

**Most Current Prior Effective Date: July 1, 2013**

- (A) For the purposes of this rule, the following terms are defined as follows:
- (1) "Managed care plan (MCP) non-contracting provider" means any provider with a medicaid provider agreement with ODM who does not contract with the MCP but delivers health care services to that MCP's member(s), as described in paragraphs (C) and (D) of this rule.
  - (2) "Managed care plan (MCP) non-contracting provider of emergency services" means any person, institution, or entity ~~who~~that does not contract with the MCP but provides emergency services to an MCP member, regardless of whether or not that provider has a medicaid provider agreement with the Ohio department of medicaid (ODM).
- (B) MCP non-contracting providers of emergency services, ~~as defined in paragraph (A)(2) of this rule,~~ must accept as payment in full from the MCP the lesser of billed charges or one hundred per cent of the Ohio medicaid program ~~fee-for-service~~ reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program ~~fee-for-service~~ reimbursement rate) in effect for the date of service. Pursuant to section 5167.10 of the Revised Code, the MCP shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.
- (C) When ~~the Ohio department of medicaid (ODM)~~ODM has approved an MCP's members to be referred to an MCP non-contracting hospital pursuant to ~~paragraph (H)(9) of rule 5101.3~~5160-26-03 of the Administrative Code, the MCP non-contracting hospital must provide the service for which the referral was authorized and must accept as payment in full from the MCP one hundred per cent of the current Ohio medicaid program ~~fee-for-service~~ reimbursement rate in effect for the date of service. Pursuant to section 5167.10 of the Revised Code, the MCP shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM. MCP non-contracting hospitals are exempted from this provision when:
- (1) The hospital is located in a county in which eligible individuals were required to enroll in an MCP prior to January 1, 2006;
  - (2) The hospital is contracted with at least one MCP serving the eligible individuals specified in paragraph (C)(1) of this rule prior to January 1, 2006; and
  - (3) The hospital remains contracted with at least one MCP serving eligible individuals who are required to enroll in MCPs in the service area where the hospital is located.
- (D) MCP non-contracting qualified family planning providers (QFPPs) must accept as payment in full from the MCP the lesser of one hundred per cent of the Ohio medicaid program ~~fee-for-service~~ reimbursement rate or billed charges, in effect for the date of service.
- (E) An MCP non-contracting provider may not bill an MCP member unless all of the following conditions are met:
- (1) The member was notified by the provider of the financial liability in advance of service delivery.
  - (2) The notification by the provider was in writing, specific to the service being rendered, and clearly states that the recipient is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.
  - (3) The notification is dated and signed by the member.
  - (4) The reason the service is not covered by the MCP is specified and is one of the following:
    - (a) The service is a benefit exclusion;

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

- (F) An MCP non-contracting provider may not bill an MCP member for a missed appointment.
- (G) MCP non-contracting providers, including MCP non-contracting providers of emergency services, must contact the twenty-four hour post-stabilization services phone line designated by the MCP to request authorization to provide post-stabilization services in accordance with ~~paragraph (G) of rule 5101:35160-26-03~~ of the Administrative Code.
- (H) MCP non-contracting providers, including MCP non-contracting providers of emergency services, must allow the MCP, ~~and/or ODM, and ODM's or its~~ designee access to all enrollee medical records for a period not less than sixeight years from the date of service or until any audit initiated within the sixeight year period is completed. Access must include ~~at least one copy~~copies of the medical record(s) at no cost for the purpose of activities related to the annual external quality review specified by 42.C.F.R. 438.358 (October 1, 2013) ~~in rule 5101:3-26-07 of the Administrative Code.~~
- (I) When an MCP elects~~MCPs elect~~ to impose member co-payments in accordance with rule ~~5101:35160-26-12~~ of the Administrative Code, applicable co-payments shall also apply to services rendered by MCP non-contracting providers. When an MCP has~~MCPs have~~ not elected to impose co-payments in accordance with rule ~~5101:35160-26-12~~ of the Administrative Code, MCP non-contracting providers are not permitted to impose co-payments on MCP members.

Effective: 02/01/2015

Five Year Review (FYR) Dates: 07/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 01/05/2015

Promulgated Under: 119.03

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Rule Amplifies: 5162.03, 5164.02, 5167.03, 5167.10, 5167.20, 5167.201

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**MCTL 43****Effective Date: February 1, 2015****Most Current Prior Effective Date: October 1, 2011**

- (A) Managed care plans (MCPs) may elect to implement a member co-payment program pursuant to section ~~5111.0112~~ 5162.20 of the Revised Code. ~~MCPs may establish a member co-payment program~~ for dental services, vision services, non-emergency emergency department services, or prescription drugs as provided for in this rule. MCPs must receive prior approval from the Ohio department of ~~medicaid~~ job and family services (ODJFS/ODM) before notifying members that a co-payment program will be implemented. This rule does not apply to MyCare Ohio plans pursuant to Chapter 5160-58 of the Administrative Code.
- (B) MCPs that elect to implement member co-payment amounts must:
- (1) Exclude the populations and services set forth in paragraph (C) of this rule;
  - (2) Not deny services to members as specified in paragraph (D) of this rule;
  - (3) Not impose co-payment amounts in excess of the maximum amounts specified in 42 C.F.R. 447.54 (October 1, 2013);
  - (4) Specify in provider subcontracts ~~per paragraph (D) of~~ governed by rule ~~5101:3~~ 5160-26-05 of the Administrative Code ~~under what~~ the circumstances under which member co-payment amounts can be requested. For MCPs that elect to implement a co-payment program, no provider can waive a member's obligation to pay the provider a co-payment except as described in paragraph (G) of this rule;
  - (5) ~~Assure~~ Ensure that the member is not billed for any difference between the MCP's payment and the provider's charge or request that the member share in the cost through co-payment or other similar charge, other than medicaid co-payments as defined in this rule;
  - (6) ~~Assure~~ Ensure that member co-payment amounts are requested by providers in accordance with this rule; and
  - (7) ~~Assure~~ Ensure that no provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent shall pay any co-payment on behalf of the member.
- (C) Exclusions to the member co-payment program for dental, vision, non-emergency emergency department services, and prescription medications include the following:
- (1) Children. Members who are under the age of twenty-one are excluded from medicaid co-payment obligations.
  - (2) Pregnant women. With the exception of routine eye examinations and the dispensation of eyeglasses during a member's pregnancy or post-partum period, all services provided to pregnant women during their pregnancy and the post-partum period are excluded from a medicaid co-payment obligation. The post-partum period is the period that begins on the last day of pregnancy and extends through the end of the month in which the sixty-day period following termination of pregnancy ends.
  - (3) Institutionalized members. Services or medications provided to members who reside in a nursing facility (NF) or intermediate care facility for ~~the mentally retarded (ICF-MR)~~ individuals with intellectual disabilities (ICF/IID) are excluded from medicaid co-payment obligations.
  - (4) Emergency. ~~Members receiving~~ An MCP shall not impose a co-payment obligation for emergency services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in

serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily part or organ. ~~are excluded from medicaid co-payments obligations.~~

- (5) Family planning (pregnancy prevention/~~or~~ contraceptive management). An MCP shall not impose a medicaid co-payment obligation on any Any service identified by ODJFS ODM as a pregnancy prevention/contraceptive management service in accordance with rule ~~5101:35160-~~ 21-02 and the appendix to rule ~~5101:35160-~~ 9-12 of the Administrative Code and provided to an individual of child-bearing age. ~~is not subject to a medicaid co-payment obligation.~~
  - (6) Hospice. Members receiving services for hospice care are excluded from medicaid co-payment obligation.
  - (7) Medicare cross-over claims. Medicare cross-over claims defined in accordance with rule ~~5101:35160-~~ 1-05 of the Administrative Code will not be subject to medicaid co-payment obligations.
  - (8) Medications administered to a member during a medical encounter provided in a hospital, clinic, office or other facility, when the medication is part of the evaluation and treatment of the condition, are not subject to a member co-payment.
- (D) No provider may deny services to a member who is eligible for ~~the~~ services due to the member's inability to pay the member co-payment. Members who are unable to pay their member co-payment may declare their inability to pay for services or medication and receive their services or medications without paying their member co-payment amount. This provision does not relieve the member from the obligation to pay a member co-payment or prohibit the provider from attempting to collect an unpaid member co-payment. If it is the routine business practice of the provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid medicaid co-payment as an outstanding debt and may refuse service to a member who owes the provider an outstanding debt. If the provider intends to refuse service to a member who owes the provider an outstanding debt, the provider shall notify the individual of the provider's intent to refuse services. In such situations, MCPs must still ~~assure~~ ensure that the member has access to needed services.
- (E) MCPs may elect to impose member co-payments as follows:
- (1) For dental services, the member co-payment amount may not exceed ~~three dollars per date of service per provider, as~~ the amount set forth in Chapter 5160-5 ~~rule 5101:3-5-01~~ of the Administrative Code. Services provided to a member on the same date of service by the same provider are subject to only one co-payment.
  - (2) For non-emergency emergency department services, the member co-payment amount must not exceed ~~three dollars for non-emergency emergency department services, as~~ the amount set forth in Chapter 5160-2 ~~rule 5101:3-2-21.1~~ of the Administrative Code. For purposes of this rule, the hospital provider shall determine if services rendered are non-emergency emergency department services and will report, through claim submission, the applicable co-payment to the MCP in accordance with medicaid hospital billing instructions.
  - (3) For vision services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-6 of the Administrative Code.:
    - (a) ~~A two-dollar member co-payment per date of service per claim for the vision exam codes set forth in rule 5101:3-6-01 of the Administrative Code, and~~
    - (b) ~~A one-dollar member co-payment per date of service per claim for the dispensing codes set forth in rule 5101:3-6-01 of the Administrative Code.~~
  - (4) For pharmacy services, the member co-payment amounts must not exceed the amounts set forth in Chapter 5160-9 of the Administrative Code. ~~MCPs must not impose a member co-payment greater than:~~
    - (a) ~~Two dollars for selected trade name drugs as indicated in the appendix to rule 5101:3-9-12 of the Administrative Code, and~~

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

- (F) Prescriptions for medications are subject to the applicable member co-payment for medications if they are given to a member during a medical encounter provided in the emergency department or other hospital setting, clinic, office, or other facility as a result of the evaluation and treatment of the condition, and if regardless of whether they are ~~to be~~ filled at a pharmacy located at the facility or at an outside location.
- (G) If an MCP has implemented a member co-payment program for non-emergency emergency department services, as described in paragraph ~~(A)~~ (E)(2) of this rule, a hospital may take action to collect a co-payment by providing, at the time services are rendered to a managed care member, notice that a co-payment may be owed. If the hospital provides the notice and chooses not to take further action to pursue collection of the co-payment, the prohibition against waiving co-payments, as described in paragraph (B)(4) of this rule, does not apply.
- (H) If an MCP elects not to impose a co-payment amount for dental services, vision services, non-emergency emergency department services or prescription drugs and the MCP reimburses contracting or non-contracting providers for these services using the medicaid provider reimbursement rate, the MCP must not reduce its provider payments by the applicable co-payment amount set forth in this rule.

Effective: 02/01/2015

Five Year Review (FYR) Dates: 10/01/2016

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Prior Effective Dates: 1/1/06, 6/1/06, 1/1/07, 7/1/09, 2/1/10

MCTL 41

**Effective Date: March 1, 2014**

- (A) The definitions set forth in rule 5160-26-01 of the Administrative Code apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code, except that the following definitions apply to MyCare Ohio:
- (1) "Authorized representative" has the same meaning as in rule 5160:1-1-55.1 of the Administrative Code.
  - (2) "Covered services" means the set of required services offered by the MyCare Ohio plan pursuant to rule 5160-58-03 of the Administrative Code.
  - (3) "Eligible individual" also known as "potential enrollee" means a medicaid recipient who is a legal resident of the MyCare Ohio program service area and who is subject to mandatory enrollment or may voluntarily elect to enroll in a MyCare Ohio plan, but is not yet an enrollee of a specific MyCare Ohio plan.
  - (4) "Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" has the same meaning as in rule 5123:2-7-01 of the Administrative Code.
  - (5) "Medicaid" means medical assistance as defined in section 5162.01 of the Revised Code.
  - (6) "Medically necessary services" means services provided in accordance with medicaid law and regulations, in accordance with clinical coverage guidelines specified in agency 5160 of the Administrative Code.
  - (7) "Member," also known as "enrollee," means a medicaid eligible beneficiary that has selected MyCare Ohio plan membership or has been assigned to a MyCare Ohio plan for the purpose of receiving health care services.
  - (8) "Nursing facility (NF)" has the same meaning as in section 5165.01 of the Revised Code.
  - (9) "Oral interpretation services" means services provided to a limited-reading proficient eligible individual or member to ensure that he or she receives MyCare Ohio plan information in a format and manner that is easily understood by the eligible individual or member.
  - (10) "Oral translation services" means services provided to a limited-English proficient eligible individual or member to ensure that he or she receives MyCare Ohio plan information translated into the primary language of the eligible individual or member.
  - (11) "PACE" has the same meaning as in rule 5160-36-01 of the Administrative Code.
  - (12) "PCP (primary care provider)" means an individual physician (medical doctor or doctor of osteopathy), certain physician group practice, a physician assistant in accordance with 5160-4-03 of the Administrative Code under the supervision of the qualifying treating physician, or advanced practice nurse as defined in section 4723.43 of the Revised Code, or advanced practice nurse group practice within an acceptable specialty, contracting with a MyCare Ohio plan to provide primary care services. Acceptable specialty types include family/general practice, internal medicine, pediatrics, geriatrics and obstetrics/gynecology (OB/GYN).
  - (13) "Premium" means the monthly payment amount per member to which the MyCare Ohio plan is entitled as compensation for performing its obligations in accordance with Chapter 5160-58 of the Administrative Code and/or the provider agreement with ODM.
  - (14) "Provider" means a hospital, health care facility, physician, dentist, pharmacy, HCBS provider or otherwise licensed, certified, or other appropriate individual or entity, that is authorized to or may be entitled to reimbursement for health care services rendered to a MyCare Ohio plan's member.

(15) "Provider agreement" means a formal agreement between ODM and a MyCare Ohio plan for the provision of medically necessary services to medicaid members who are enrolled in the MyCare Ohio plan.

(B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code and paragraph (A) of this rule, the following definitions apply to Chapter 5160-58 of the Administrative Code:

(1) "Assessment" means a comprehensive evaluation of an individual's medical, behavioral health, long term services and supports, and social needs. Results of the assessment process are used to develop the integrated, individualized care plan, inclusive of the waiver services plan.

(2) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (October 17, 2013).

(3) "Dual benefits (also referred to as "opt-in") member" means a member for whom a MyCare Ohio plan is responsible for the coordination and payment of both medicare and medicaid benefits.

(4) "Financial management service" or "FMS" means a support that is provided to waiver participants who direct some or all of their waiver services. When used in conjunction with the employer authority, this support includes, but is not necessarily limited to, operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes, but is not necessarily limited to, paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.

(5) "HCBS" means home and community-based services.

(6) "Health and welfare" means a requirement that necessary safeguards are taken to protect the health and welfare of individuals enrolled on HCBS waivers. It includes the following:

(a) Risk and safety planning and evaluations;

(b) Critical incident management;

(c) Housing and environmental safety evaluations;

(d) Behavioral interventions;

(e) Medication management; and

(f) Natural disaster and public emergency response planning.

(7) "Individual care plan" means an integrated, individualized, person-centered care plan developed by the member and his or her MyCare Ohio plan's trans-disciplinary care management team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.

(8) "Medicaid consumer hotline" means an organization or individual under contract with or designated by ODM to provide MyCare Ohio plan information and enrollment services to eligible members.

(9) "Medicaid only (also referred to as "opt-out") member" means a member for whom a MyCareOhio plan is responsible for coordination and payment of medicaid benefits.

(10) "MHAS" means the Ohio department of mental health and addiction services.

(11) "MyCare Ohio plan" means a health insuring corporation contracted to comprehensively manage medicaid benefits for medicare and medicaid eligible members, including home and community-based services. MyCare Ohio plans are also managed care plans in accordance with rule 5160-26-01 of the Administrative Code. For the purpose of this chapter, a MyCare Ohio plan does not include entities approved to operate as a PACE site.

(12) "NF-based level of care" means the intermediate and skilled levels of care, as described in rule 5160-3-08 of the Administrative Code.

- (13) "Participant direction" means the opportunity for a MyCare Ohio waiver member to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.
- (14) "Significant change event" is a change experienced by a member that warrants further evaluation. Significant changes include, but are not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective service agency; institutionalization; and when the waiver-enrolled individual has not received MyCare Ohio waiver services for ninety calendar days.
- (15) "Trans-disciplinary care management team" means a team of appropriately qualified individuals comprised of the member, the member's family/caregiver, the MyCare Ohio plan manager, the waiver service coordinator, if appropriate, the primary care provider, specialists, and other providers, as applicable, that is designed to effectively meet the enrollee's needs.
- (16) "Waiver services plan" is a component of the care plan that identifies specific goals, objectives and measurable outcomes for a waiver-enrolled member's health and functioning expected as a result of HCBS provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the individual. At a minimum, the waiver services plan shall include:
- (a) Essential information needed to provide care to the member that assures the member's health and welfare;
  - (b) Signatures indicating the member's acceptance or rejection of the waiver services plan; and
  - (c) Information that the waiver services plan is not the same as the physician's plan of care.

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**MCTL 41**

**Effective Date: March 1, 2014**

- (A) MyCare Ohio plans must comply with all of the requirements applicable to managed care plans in the following rules:
- (1) Rule 5160-26-05 of the Administrative Code;
  - (2) Rule 5160-26-05.1 of the Administrative Code;
  - (3) Rule 5160-26-06 of the Administrative Code;
  - (4) Rule 5160-26-07 of the Administrative Code;
  - (5) Rule 5160-26-07.1 of the Administrative Code;
  - (6) Rule 5160-26-08 of the Administrative Code;
  - (7) Rule 5160-26-08.3 of the Administrative Code;
  - (8) Rule 5160-26-09 of the Administrative Code;
  - (9) Rule 5160-26-09.1 of the Administrative Code;
  - (10) Rule 5160-26-10 of the Administrative Code; and
  - (11) Rule 5160-26-11 of the Administrative Code.
- (B) MyCare Ohio plans must comply with all of the requirements applicable to managed care plans in rule 5160-26-03.1 of the Administrative Code, with the following revisions:
- (1) In paragraph (A)(7)(c)(iv), the references to rules 5101:3-26-08.4 and 5101:3-26-08.5 of the Administrative Code should be replaced by a reference to rule 5160-58-08.4 of the Administrative Code for MyCare Ohio plans.
  - (2) ) The phrase "seventy-two hours" replaces the phrase "three working days" in paragraph (A)(7)(c)(vi) for MyCare Ohio plans.
  - (3) In paragraph (A)(7)(c)(vii), the reference to paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code should be replaced by a reference to paragraph (C) of rule 5160-58-08.4 of the Administrative Code for MyCare Ohio plans.
  - (4) The following language replaces all of paragraph (A)(7)(c)(viii) for MyCare Ohio plans: "Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (October 17, 2013) must be made within the timeframes specified in 42 C.F.R. 423.568(b) (October 18, 2013) for standard decisions and 42 C.F.R. 423.572(a) (October 18, 2013) for expedited decisions. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the plan is unable to obtain the information needed to make the prior authorization decision within seventy-two hours, the decision timeframe has expired and the MCP must give notice to the member as specified in paragraph (C) of rule 5160-58-08.4 of the Administrative Code."
  - (5) Only the first sentence in paragraph (A)(7)(e) applies to MyCare Ohio plans.
- (C) MyCare Ohio plans must comply with all of the requirements applicable to managed care plans in rule 5160-26-08.2 of the Administrative Code, except for the following:
- (1) The phrases "by no later than the effective date of coverage" and "prior to the effective date of coverage" in paragraph (B)(3) do not apply to My Care Ohio plans, and
  - (2) The phrase "prior to the new effective date of coverage" in paragraph (B)(5) does not apply to MyCare Ohio plans.
- (D) For all rules listed in paragraphs (A), (B) and (C) of this rule, the following provisions apply to the MyCare Ohio program described in Chapter 5160-58 of the Administrative Code:

- (1) All cross-references to rule 5101:3-26-01 of the Administrative Code are replaced by cross-references to rule 5160-58-01 of the Administrative Code for MyCare Ohio plans.
  - (2) All cross-references to rule 5101:3-26-02 of the Administrative Code are replaced by cross-references to rule 5160-58-02 of the Administrative Code for MyCare Ohio plans.
  - (3) All cross-references to rule 5101:3-26-02.1 of the Administrative Code are replaced by cross-references to rule 5160-58-02.1 of the Administrative Code for MyCare Ohio plans.
  - (4) All cross-references to rule 5101:3-26-03 of the Administrative Code are replaced by cross-references to rule 5160-58-03 of the Administrative Code for MyCare Ohio plans.
  - (5) All cross-references to rules 5101:3-26-08.4 and 5101:3-26-08.5 of the Administrative Code are replaced by cross-references to rule 5160-58-08.4 of the Administrative Code for MyCare Ohio plans.
- (E) The following rules in Chapter 5160-26 of the Administrative Code do not apply to MyCare Ohio, as they are replaced by corresponding rules in Chapter 5160-58 of the Administrative Code:
- (1) Rule 5160-26-02 of the Administrative Code
  - (2) Rule 5160-26-02.1 of the Administrative Code
  - (3) Rule 5160-26-03 of the Administrative Code, and
  - (4) Rule 5160-26-08.4 of the Administrative Code.
- (F) When an MCP holds provider agreements with ODM for the MyCare Ohio and Medicaid managed care programs, ODM may apply all of the applicable provisions in Chapter 5160-26 of the Administrative Code separately to each of the contracts.

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**MCTL 41**

**Effective Date: March 1, 2014**

**(A) Eligibility.**

- (1) In mandatory service areas as permitted by 42 CFR 438.52 (October 1, 2013), an individual must be enrolled in a MyCare Ohio plan (also known as "plan") if he or she meets all of the following criteria:

  - (a) Age 18 or older at the time of enrollment in the plan;
  - (b) Eligible for medicare Parts A and B and D, and full benefits under the medicaid program; and
  - (c) Reside in a plan demonstration county in Ohio. A list of demonstration counties, and the plans available in those counties, is available at <http://medicaid.ohio.gov>.
- (2) The following individuals are not eligible for enrollment in a plan:

  - (a) Individuals with intellectual disabilities who have a level of care that meets the criteria specified in rule 5160-3-07 of the Administrative Code and receive services through a 1915(c) home and community based services (HCBS) waiver or an intermediate care facility for individuals with intellectual disabilities (ICF-IID).
  - (b) Individuals enrolled in the program of all inclusive care for the elderly (PACE).
  - (c) Individuals who have other third party creditable health care coverage, except Medicare coverage as authorized by 42 U.S.C. 1395 (October 1, 2013).
  - (d) Individuals for whom a delayed medicaid spenddown is required.
- (3) Indians who are members of federally recognized tribes are not required to enroll in a plan, except as permitted under 42 C.F.R. 438.50(d)(2) (October 1, 2013).
- (4) Individuals are eligible for plan membership in the manner prescribed in this rule if ODM has a provider agreement with the plan applicable to the eligible individual's county of residence.
- (5) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for medicare or other non-medicaid benefits to which he or she may be entitled.

**(B) MyCare Ohio plan enrollment.**

- (1) The following applies to plan enrollment:

  - (a) The plan must accept eligible individuals without regard to race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. The plan will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.6(d)(4) (September 27, 2013).
  - (b) The plan must accept eligible individuals who request plan membership without restriction.
  - (c) The plan must accept PCP(s) selected by the members when available, except as otherwise provided in this rule.
  - (d) In the event that a plan member loses medicaid eligibility and is terminated from the plan, but regains medicaid eligibility within a period of sixty days or less, his or her membership in the same plan shall be re-instated.

- (e) The plan must cover all members that are designated by ODM in an ODM-produced roster of new members, continuing members, and terminating members.
- (f) The plan shall not be required to provide medicaid coverage to an individual until the individual's membership in the plan is confirmed via an ODM-produced roster or upon mutual agreement between ODM and the plan.

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

(a) When a service area is initially designated by ODM as mandatory for eligible individuals specified in paragraph (A)(1) of this rule, ODM shall confirm the eligibility of each individual as prescribed in paragraph (A)(1) of this rule. Upon the confirmation of eligibility:

(i) Eligible individuals residing in the service area who are currently plan members are deemed participants in the mandatory program; and

(ii) All other eligible individuals residing in the mandatory service area may request plan membership at any time but must select a plan following receipt of a notification of mandatory selection (NMS) issued by ODM.

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

(i) A newly eligible individual that does not make a choice following issuance of an NMS by ODM and one additional notice will be assigned to a plan by ODM, the medicaid consumer hotline, or other ODM-approved entity.

(ii) ODM or the medicaid consumer hotline shall assign the individual to a plan based on prior medicaid fee-for-service or plan membership history.

(C) Commencement of coverage.

(1) Coverage of plan members will be effective on the first day of the calendar month specified on the ODM-produced 834 electronic data interchange (EDI) roster to the plan.

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**MCTL 41**

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- (A) A member will be terminated from membership in a MyCare Ohio plan ("plan") for any of the following reasons:
- (1) The member becomes ineligible for full medicaid or medicare parts A or B or D. When this occurs, termination of plan membership takes effect at 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. When this occurs, termination of plan membership takes effect at 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 the period of plan membership ends on the date of death.
  - (4) The member is incarcerated for either more than fifteen working days or is incarcerated and has accessed non-emergent medical care. When this occurs and after the Ohio Department of Medicaid (ODM) receives notification from the member's plan, a county department of job and family services (CDJFS), or other public agency, termination of plan membership takes effect the last day of the month prior to incarceration.
  - (5) The member is found by ODM to meet the criteria for an intermediate care facility for individuals with intellectual disabilities (ICF-IID) level of care and is then placed in an ICF-IID facility or enrolled in an ICF-IID qualified waiver. After the plan notifies ODM that this has occurred, termination of plan membership takes effect on the last day of the month preceding placement in the ICF-IID facility or enrollment on the ICF-IID waiver.
  - (6) The member has third party coverage, excepting medicare coverage, and ODM determines that it is not in the best interest of the member to continue in the plan. When this occurs the effective date of termination shall be determined by ODM but in no event shall the termination date be later than the last day of the month in which ODM approves the termination.
  - (7) The provider agreement between ODM and the plan is terminated or not renewed. When this occurs, the effective date of termination shall be the end of the last day of the month of the provider agreement termination or nonrenewal.
  - (8) The member is not eligible for enrollment in a plan for one of the reasons set forth in rule 5160-58-02 of the Administrative Code.
- (B) All of the following apply when membership in a MyCare Ohio plan is terminated for any of the reasons set forth in paragraph (A) 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 plan of a member's termination from the plan, ODM shall continue to pay the plan the applicable monthly premium rate for the member. The plan shall remain liable for the provision of covered services as set forth in rule 5101:3-58-03 of the Administrative Code, until such time as ODM provides the plan with documentation of the member's termination.
  - (5) ODM shall recover from the plan any premium paid for retroactive membership termination occurring as a result of paragraph (A) of this rule.
  - (6) A member may lose medicaid eligibility during an annual open enrollment period, and thus become temporarily unable to change to a different plan. If the member then regains medicaid eligibility, he or she may request to change plans within thirty days following reenrollment in the plan.

(C) Member-initiated terminations

- (1) A dual-benefits member may request disenrollment from the plan and transfer between plans on a month-to-month basis any time during the year. Plan coverage continues until the end of the month of disenrollment.
- (2) A medicaid-only member may request a different plan in a mandatory service as follows:
  - (a) From the date of initial enrollment through the first three months of plan membership, whether the first three months of enrollment are dual-benefits or medicaid-only membership periods;
  - (b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or
  - (c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.
- (3) A medicaid-only member may request a different plan if available or be returned to medicaid fee-for-service in a voluntary service area as follows:
  - (a) From the date of enrollment through the initial three months of plan membership;
  - (b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or
  - (c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.
- (4) The following provisions apply when a member either requests a different plan in a mandatory service area or requests disenrollment in a voluntary service area:
  - (a) The request may be made by the member, or by the member's authorized representative, as defined in rule 5160-58-01 of the Administrative Code.
  - (b) All member-initiated changes or terminations must be voluntary. Plans are not permitted to encourage members to change or terminate enrollment due to a member's race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. Plans may not use a policy or practice that has the effect of discrimination on the basis of the above criteria.
  - (c) If a member requests disenrollment because he or she is a member of a federally-recognized tribe, as described in 42 CFR 438.50(d)(2) (October 18, 2013), the member will be disenrolled after the member notifies the consumer hotline.
  - (d) Disenrollment will take effect on the last day of the calendar month as specified by an ODM-produced 834 electronic data interchange (EDI) transaction to the plan.
  - (e) In accordance with 42 C.F.R. 438.56(d)(2) (October 18, 2013), a change or termination of plan membership may be permitted for any of the following just cause reasons:
    - (i) The member moves out of the plan's service area and a non-emergency service must be provided out of the service area before the effective date of a termination that occurs for one of the reasons set forth in paragraph (A) of this rule;
    - (ii) The plan does not, for moral or religious objections, cover the service the member seeks;
    - (iii) The member needs related services to be performed at the same time in a coordinated manner; however, not all related services are available within the plan 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 plan'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 plan's network and is the only available and accessible PCP in the plan who speaks the primary language of the member, and another PCP speaking the member's language is available and accessible in another plan in the member's service area; or
  - (vii) ODM determines that continued membership in the plan would be harmful to the interests of the member.
- (f) The following provisions apply when a member seeks a change or termination in plan membership for just cause:
- (i) The member or an authorized representatives must contact the plan to identify providers of services before seeking a determination of just cause from ODM.
  - (ii) The member may make the request for just cause directly to ODM or an ODM-approved entity, either orally or in writing.
  - (iii) ODM shall review all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the member and the plan. ODM shall make a decision within ten working days of receipt of all necessary documentation, or forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.
  - (iv) ODM may establish retroactive termination dates and/or recover premium payments as determined necessary and appropriate.
  - (v) Regardless of the procedures followed, the effective date of an approved just cause request must be no later than the first day of the second month following the month in which the member requests change or termination.
  - (vi) If the just cause request is not approved, ODM shall notify the member or the authorized representative of the member's right to a state hearing.
  - (vii) Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate.
  - (viii) If a member submits a request to change or terminate membership for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall assure that the member's plan membership is not automatically renewed if eligibility for medicaid is reauthorized.

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

- (1) A plan may submit a request to ODM for the termination of a member for the following reasons:
  - (a) Fraudulent behavior by the member; or
  - (b) Uncooperative or disruptive behavior by the member or someone acting on the member's behalf to the extent that such behavior seriously impairs the plan's ability to provide services to either the member or other plan members.
- (2) The plan may not request termination due to a member's race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims

experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services.

- (3) The plan must provide covered services to a terminated member through the last day of the month in which the plan membership is terminated.
- (4) If ODM approves the plan's request for termination, ODM shall notify in writing the member, the authorized representative, the medicaid consumer hotline and the plan.

(E) Open Enrollment

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

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**MCTL 41**

**Effective Date: March 1, 2014**

- (A) To be eligible for enrollment in the MyCare Ohio waiver, a member must meet all of the following requirements:
- (1) Be enrolled in the MyCare Ohio demonstration at the time of application for the MyCare Ohio waiver;
  - (2) Be determined to have a nursing facility (NF) -based level of care (i.e., intermediate or skilled) in accordance with rule 5160-3-08 of the Administrative Code;
  - (3) In the absence of the MyCare Ohio waiver, require hospitalization or institutionalization in a nursing facility (NF) to meet his or her needs;
  - (4) Be determined to require at least one waiver service monthly that is otherwise unavailable through another source (including the medicaid state plan) and in an amount sufficient to meet the member's assessed needs;
  - (5) Not reside in a hospital, nursing facility (NF), intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382(e) (March 2, 2004)), residential care facility (except an assisted living facility that is approved to furnish assisted living services pursuant to rule 5160-58-04 of the Administrative Code), adult foster home or another group living arrangement subject to state licensure or certification.
  - (6) Sign an agreement prior to waiver enrollment confirming that the member has been informed of service alternatives, choice of qualified providers available in the MyCare Ohio plan's provider panel and the options of institutional and community-based care, and he or she elects to receive MyCare Ohio waiver services; and
  - (7) Be able to have waiver services that can be identified in a waiver service plan that will safely meet his or her assessed needs.
- (B) To be enrolled, and maintain enrollment in the MyCare Ohio waiver, a member must be determined by the MyCare Ohio plan to meet all of the following requirements:
- (1) Be determined eligible for the MyCare Ohio waiver in accordance with paragraph (A) of this rule;
  - (2) Be able to have his or her health and welfare assured on the waiver;
  - (3) Participate in the development and implementation of an integrated, individualized care plan that includes a person-centered waiver service plan, and sign and date the plan as a condition of its acceptance;
  - (4) Agree to receive waiver service coordination from the MyCare Ohio plan or its designee; and
  - (5) Agree to participate in quality management and evaluation activities during his or her enrollment on the MyCare Ohio waiver.
- (C) If a member fails to meet any of the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, the member shall be denied enrollment on the MyCare Ohio waiver.
- (D) Once enrolled on the MyCare Ohio waiver, a member's NF level of care shall be reassessed at least annually, and more frequently if there is a significant change in the member's situation that may impact his or her health and welfare. If the reassessment determines the member no longer meets the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the MyCare Ohio waiver.
- (E) If a member enrolled on the MyCare Ohio waiver does not receive at least one waiver service for ninety consecutive days, the MyCare Ohio plan shall, within ten days of the ninetieth day, reassess the member's need for waiver services. If it is determined the member no longer meets the requirements

set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the MyCare Ohio waiver.

- (F) If, at any other time, it is determined that a member enrolled on the MyCare Ohio waiver no longer meets the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the MyCare Ohio waiver.
- (G) If a member is denied enrollment in the MyCare Ohio waiver pursuant to paragraph (C) of this rule, or is disenrolled from the waiver pursuant to paragraph (D), (E) or (F) of this rule, ODM shall afford the member notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

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**MCTL 41**

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- (A) A MyCare Ohio plan (plan) must ensure that members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based services (HCBS) covered by medicaid. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the plan must ensure that:
- (1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;
  - (2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;
  - (3) Medicaid coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code; and practice guidelines specified in paragraph (B) of rule 5160-26-05.1 of the Administrative Code; and
  - (4) ) If a member is unable to obtain medically-necessary medicaid services from a plan panel provider, the plan must adequately and timely cover the services out of panel until the plan is able to provide the services from a panel provider.
- (B) The plan may place limits on services;
- (1) On the basis of medical necessity;
  - (2) Except as otherwise specified in this rule, to available panel providers;
  - (3) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.
- (C) The plan must cover annual physical examinations for adults.
- (D) At the request of a member, a plan must provide for a second opinion from a qualified health care professional within the panel. If such a qualified health care professional is not available within the plan's panel, the plan must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.
- (E) The plan must assure that emergency services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:
- (1) The plan may not deny payment for treatment obtained when a member had an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.
  - (2) The plan cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
  - (3) The plan must cover all emergency services without requiring prior authorization.
  - (4) The plan must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the plan including but not limited to the member's PCP or the plan's twenty-four-hour toll-free call-in-system.
  - (5) The plan cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.
  - (6) For the purposes of this rule, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the plan but provides emergency services to an plan member, regardless of whether or not that provider has a medicaid provider agreement with ODM. The plan must cover emergency services as defined in rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of

emergency services. Claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code. Such services must be reimbursed by the plan at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the plan is required to reimburse at this rate only until the member can be transferred to a provider designated by the plan.

- (7) The plan must adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The plan may establish arrangements with hospitals whereby the plan may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.
- (8) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

(F) The plan must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (E)(6) of this rule. These written policies and procedures must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. The plan may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

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

- (1) The plan must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day, seven days a week. The plan must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The plan must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time that the plan communicated the decision in writing to the provider.
- (2) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:
  - (a) The plan must cover services obtained within or outside the plan's panel that have not been pre-approved in writing by a plan provider or other plan representative.
  - (b) If the plan does not respond within one hour of a provider's request for preapproval of further services that were administered to maintain the member's stabilized condition, the plan must cover the services, whether or not they were provided within the plan's panel .
  - (c) The plan must cover services obtained within or outside the plan's panel that are not pre-approved by a plan provider or other plan representative but are administered to maintain, improve or resolve the member's stabilized condition if:
    - (i) The plan fails to respond within one hour to a provider request for authorization to provide such services.
    - (ii) The plan cannot be contacted.
    - (iii) The plan's representative and treating provider cannot reach an agreement concerning the member's care and a plan provider is not available for consultation. In this situation, the plan must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care until a plan

provider is reached or one of the criteria specified in paragraph (G)(3) of this rule is met.

- (3) The plan's financial responsibility for post stabilization care services it has not pre-approved ends when:
- (a) A plan provider with privileges at the treating hospital assumes responsibility for the member's care;
  - (b) A plan provider assumes responsibility for the member's care after the member is transferred to another facility;
  - (c) A plan representative and the treating provider reach an agreement concerning the member's care; or
  - (d) The member is discharged.

(H) Exclusions, limitations and clarifications.

- (1) The plan must permit members to self-refer to Title X services provided by any qualified family planning provider (QFPP). The plan is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the plan at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges, in effect for the date of service.
- (2) The plan must permit members to self-refer to any women's health specialist within the plan's panel for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.
- (3) The plan must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- (4) Where available, the plan must ensure access to covered services provided by a certified nurse practitioner.
- (5) The plan is not responsible for payment of services provided through the medicaid schools program (MSP) providers pursuant to Chapter 5160-35 of the Administrative Code.
- (6) The plan must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with the periodicity schedule identified in Chapter 5160-14 of the Administrative Code, to healthchek eligible members and assure that services are delivered and monitored as follows:
  - (a) Healthchek exams must include those components specified in Chapter 5160-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual external quality review.
  - (b) The plan or its contracting provider must notify members of the appropriate healthchek exam intervals as specified in Chapter 5160-14 of the Administrative Code.
  - (c) Healthchek exams are to be completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.

(I) A plan is not required to cover services provided to members outside the United States.

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**MCTL 41**

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A member and/or their authorized representative who is acting on the member's behalf, who is enrolled on the MyCare Ohio HCBS waiver program in accordance with rule 5160-58-02.2 of the Administrative Code has choice and control over the arrangement and provision of HCBS. Members also have choice over the selection and control over the direction of approved waiver service providers.

For the purpose of this rule, the term "member" includes, as appropriate, an authorized representative who is selected by the member and acts on behalf of the member.

- (A) A member may choose to receive MyCare Ohio waiver services from any combination of providers on the provider panel of the MyCare Ohio plan selected by the member and serving in the MyCare Ohio HCBS waiver program pursuant to paragraph (B) of rule 5160-58-04 of the Administrative Code.
- (B) A member receiving waiver services from any MyCare Ohio HCBS waiver program provider shall comply with the requirements set forth in paragraphs (B)(1) to (B)(13) of this rule.
  - (1) Participate with the waiver service coordinator in the development of the waiver service plan and all plans of care including the development of a back-up plan.
  - (2) Decide who from their trans-disciplinary care management team will participate in the face-to-face development of the integrated, individualized care plan.
  - (3) Communicate to the service provider and, as appropriate, the provider's management staff, personal preferences about the manner in which duties, tasks and procedures are to be performed.
  - (4) Work with the waiver service coordinator and the provider to identify and secure additional service provider orientation, training and/or continuing education within the provider's scope of practice in order to meet the member's specific needs.
  - (5) Shall not direct the provider to act in a manner that is contrary to all relevant MyCare Ohio HCBS waiver program requirements, medicaid rules and regulations, and the provider's policies and procedures.
  - (6) Understand the responsibilities of the member as set forth in rule 5160-58-05.3 of the Administrative Code relative to incident management and reporting.
  - (7) Communicate to the waiver service coordinator and/or MyCare Ohio plan care manager any significant changes, as defined in rule 5160-58-01 of the Administrative Code, that may affect the provision of services or result in a need for more or fewer hours of service.
  - (8) Sign a complete and accurate timesheet or other documentation, as appropriate, to verify services have been furnished. The member shall never approve blank timesheets, or timesheets that have been completed before services have been furnished. Verification may be written or electronic at the discretion of the MyCare Ohio plan.
  - (9) Participate in the recruitment, selection and dismissal of providers in collaboration with the trans-disciplinary care management team.
  - (10) In the manner specified by the waiver service coordinator, notify the provider if the member is going to miss a scheduled visit.
  - (11) Notify the waiver service coordinator if the assigned provider misses a scheduled visit.
  - (12) Notify the waiver service coordinator when any change in provider is necessary. Notification shall include the desired end date of the current provider.
  - (13) Participate in the monitoring of the performance of the provider.
- (C) If a member chooses to receive waiver services from any non-agency provider, or is exercising participant-direction over the services in paragraph (F) of rule 5160-58-04 of the Administrative Code

using one or more consumer-directed individual providers or consumer-directed personal care providers, the following additional requirements shall apply as appropriate to the service being furnished:

- (1) In accordance with paragraph (B)(9) of this rule, members shall take a proactive role in the delivery of their MyCare Ohio HCBS waiver program services. This includes, but is not limited to, identifying prospective providers, recruiting and training MyCare Ohio providers to furnish tasks in accordance with the member's needs and preferences, and working with the MyCare Ohio care manager or waiver service coordinator to schedule and manage the delivery of authorized MyCare Ohio HCBS waiver program services.
  - (2) The member shall designate a location in their home in which the member and, as appropriate, the the provider can safely store a copy of the member's records in a manner that protects the confidentiality of the records, and for the purpose of contributing to the continuity of the member's care.
  - (3) The member or, as appropriate, the provider shall make the member's records available upon request by the MyCare Ohio plan, ODM and/or ODM's designee.
  - (4) The member shall not aid the provider in furnishing a service in a manner that does not comply with any rule or law that regulates the provider.
  - (5) Members who exercise participant-direction of providers under the MyCare Ohio HCBS waiver program shall work with ODM's designated financial management service.
- (D) The MyCare Ohio plan shall comply with all of the requirements set forth in this paragraph:
- (1) Ensure the health and welfare of the member enrolled in the MyCare Ohio HCBS waiver program while acknowledging the member's right to make informed decisions and accept the resulting consequences that may impact the member's life.
  - (2) Upon the member's enrollment in the MyCare Ohio HCBS waiver program, provide the member with waiver-related information, including information about the member's rights and responsibilities and opportunities for participant-direction, using communication mechanisms that are most effective for the member. The waiver service coordinator shall review these materials with the member and assist him or her to understand his or her specific responsibilities.
  - (3) Work with the member to do the following:
    - (a) Select and direct approved waiver service providers;
    - (b) Develop the waiver service plan including service back-up plans that meet the needs of the member;
    - (c) Exchange information with all of the member's service providers for development of the waiver service plan;
    - (d) Identify provider orientation and training that is within the provider's scope of practice and meets the member's needs; and
    - (e) Assist the member with resolving conflicts between the member and provider(s) and, upon request, identify and work with the member to secure new providers when the member notifies the waiver service coordinator that a change is necessary.
  - (4) Adhere to the incident management requirements set forth in rule 5160-58-05.3 of the Administrative Code.
  - (5) Address significant changes, as defined in rule 5160-58-01 of the Administrative Code, experienced by the member that may affect the provision of services or result in a need for more or fewer hours of service.
  - (6) Document, in writing, that the member:
    - (a) Understands their specific needs;

- (b) Possesses the skills necessary to meet the requirements set forth in paragraph (B), (C) or (D) of this rule, as appropriate;
- (c) Demonstrates an understanding of his or her responsibilities pursuant to paragraphs (B) and (C) of this rule; and
- (d) Identifies the method by which the member will verify that services have been furnished as identified on the waiver service plan.

(7) Communicate with the member in a manner that protects the member's right to confidentiality.

(E) If the member elects to receive services from a participant-directed provider, the waiver service coordinator shall assess the member's strengths and weaknesses (and/or, if the member has an authorized representative, the authorized representative's strengths or weaknesses) and ability to direct a provider. The waiver service coordinator shall allow the member to direct a provider if the waiver service coordinator determines that the member demonstrates the following:

- (1) An understanding of the elements of the service the provider shall furnish;
- (2) An understanding of how to direct the provider; and
- (3) An understanding of, and ability to, perform the responsibilities of an employer, including:
  - (a) Completion of any training that ODM or the MyCare Ohio plan requires;
  - (b) Understanding which service activities are covered according to rule 5160-58-04 of the Administrative Code;
  - (c) Understanding the methods for selecting and dismissing participant-directed service providers including the requirements for providers to furnish services in the MyCare Ohio waiver;
  - (d) Understanding the methods for entering into written agreements with participant-directed service providers for specific activities;
  - (e) Understanding the methods for training participant-directed service providers to meet the member's specific needs;
  - (f) Understanding the methods for supervising and monitoring the participant-directed service provider's performance of specific activities, including written approval of the provider's time sheets;
  - (g) Development of a back-up plan for furnishing services if a provider is unable to furnish the agreed-upon service;
  - (h) Understanding the methods for filing grievances, including use of the regional and state long term care ombudsman, and familiarity with how to contact the state long-term care ombudsman;
  - (i) Familiarity with the MyCare Ohio grievance process and the state appeal and fair hearing request procedures;
  - (j) Understanding and compliance with the State's record-retention requirements; and,
  - (k) An ability to manage the participant-directed service provider when he or she furnishes a service.

(F) If the waiver service coordinator determines that the member cannot meet the requirements set forth in paragraphs (C) or (E) of this rule, as appropriate, the waiver service coordinator may require the member to appoint an authorized representative to assist the member with directing services.

(G) If the waiver service coordinator, in consultation with the trans-disciplinary care management team, determines that the member and/or the member's authorized representative cannot meet the requirements set forth in paragraphs (C) or (E) of this rule, and/or the health and welfare of the member receiving services from a non-agency or participant-directed provider cannot be ensured, the waiver service coordinator may require the member to receive services from only agency providers.

The member will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

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[MCTL 41](#)

**Effective Date: March 1, 2014**

- (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 HCBS waiver program shall meet the requirements in Chapters 173-39 or 5160-45 of the Administrative Code, as appropriate, prior to furnishing services in the MyCare Ohio HCBS waiver.
- (C) The MyCare Ohio HCBS waiver program's 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 rules 5160-46-04 and 5160-50-04 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;
  - (5) Chore services as set forth in rule 173-39-02.5 of the Administrative Code;
  - (6) Community transition services as set forth in rule 173-39-02.17 of the Administrative Code;
  - (7) Emergency response services as set forth in rule 173-39-02.6 or rules 5160-46-04 and 5160-50-04 of the Administrative Code;
  - (8) Enhanced community living services as set forth in rule 173-39-02.20 of the Administrative Code.
  - (9) Homemaker services as set forth in rule 173-39-02.8 of the Administrative Code;
  - (10) Home care attendant services as set forth in rules 5160-46-04.1 and 5160-50-04.1 of the Administrative Code;
  - (11) Home delivered meal services as set forth in rule 173-39-02.14 or rules 5160-46-04 and 5160-50-04 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 rules 5160-46-04 and 5160-50-04 of the Administrative Code;
  - (13) Home modification, maintenance and repair services as set forth in rule 173-39-02.9 or rules 5160-46-04 and 5160-50-04 of the Administrative Code;
  - (14) Independent living assistance services as set forth in rule 173-39-02.15 of the Administrative Code;
  - (15) Nutrition consultation services as set forth in rule 173-39-02.10 of the Administrative Code;
  - (16) Out-of- home respite services as set forth in rules 5160-46-04 and 5160-50-04 of the Administrative Code;
  - (17) Personal care services as set forth in rule 173-39-02.11 or rules 5160-46-04 and 5160-50-04 of the Administrative Code;
  - (18) Pest control services as set forth in rule 173-39-02.3 of the Administrative Code;
  - (19) Social work counseling services as set forth in rule 173-39-02.12 of the Administrative Code;
  - (20) Waiver nursing services as set forth in rules 5160-46-04 and 5160-50-04 of the Administrative Code; and

- (21) Waiver transportation services as set forth in rules 173-39-02.13 and 173-39-02.18 or rules 5160-46-04 and 5160-50-04 of the Administrative Code.
- (D) If a member enrolled in the MyCare Ohio HCBS waiver program is also a participant in the helping ohioans move, expanding (HOME) choice demonstration program pursuant to Chapter 5160-51 of the Administrative Code, the members may, at their discretion, use the HOME choice community transitions service in lieu of, but not in addition to, the community transition service available through the MyCare Ohio HCBS waiver program.
- (E) If a member receives enhanced community living services, the member shall not also receive personal care or homemaker services available through the MyCare Ohio HCBS waiver program.
- (F) The following services may be participant directed using budget and/or employer authority. To exercise these authorities, members must demonstrate the ability to direct providers in accordance with paragraph (E) 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 consumer-directed individual provider; and
    - (b) Personal care services provided by a consumer-directed personal care provider.
  - (2) Budget authority which includes, but is not limited to, 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 modification, maintenance and repair;
    - (d) Pest control; and
    - (e) Home medical equipment and supplemental adaptive and assistive devices.

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**MCTL 41**

**Effective Date: March 1, 2014**

- (A) For the purposes of this rule,
- (1) "Alert" means an incident that must be reported to the Ohio department of medicaid (ODM) due to the severity and/or impact on a member enrolled on the MyCare Ohio waiver or the need for ODM involvement in the incident investigation. Alerts include, but are not limited to the events described in paragraph (J) of this rule.
  - (2) "Incident" means an alleged, suspected or actual event that is not consistent with the routine care of, and/or service delivery to, a member. Incidents include, but are not limited to the events described in paragraph (F) of this rule.
  - (3) "Provider" means a MyCare Ohio waiver service provider, any other service provider that is directed to adhere to this rule, and all of their respective staff who have direct contact with members.
- (B) ODM shall operate an incident management system that includes responsibilities for reporting, responding to, investigating and remediating incidents. This rule sets forth the standards and procedures for operating that system. It applies to ODM, its designees (which, unless otherwise stated, for the purposes of this rule includes, but is not limited to MyCare Ohio plans and their designees), members and providers. ODM may designate other agencies or entities to perform one or more of the incident management functions set forth in this rule.
- (C) ODM and its designees shall assure the health and welfare of members enrolled on the MyCare Ohio waiver. ODM, its designees and providers are responsible for ensuring members are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being.
- (D) Upon entering into a medicaid provider agreement, and annually thereafter, all providers, including all employees who have direct contact with members enrolled on the MyCare Ohio waiver, must acknowledge in writing they have reviewed this rule and related procedures.
- (E) Upon a member's enrollment in the MyCare Ohio waiver, and at the time of each annual reassessment, ODM or the MyCare Ohio plan shall provide the member and/or the member's authorized representative or legal guardian with a waiver handbook that includes information about how to report abuse, neglect, exploitation and other incidents. The MyCare Ohio plan shall secure from the member, authorized representative and/or legal guardian written confirmation of receipt of the handbook and it shall be maintained in the member's case record.
- (F) Incidents include, but are not limited to, all of the following:
- (1) Abuse: the injury, confinement, control, intimidation or punishment of a member by another person that has resulted, or could reasonably be expected to result, in physical harm, pain, fear or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal and/or sexual abuse, and use of restraint, seclusion or restrictive intervention that results in, or could reasonably be expected to result in, physical harm, pain, fear or mental anguish to the member.
  - (2) Neglect: when there is a duty to do so, the failure to provide goods, services and/or treatment necessary to assure the health and welfare of a member.
  - (3) Exploitation: the unlawful or improper act of using a member or a member's resources for monetary or personal benefit, profit or gain.
  - (4) Misappropriation: depriving, defrauding or otherwise obtaining the money, or real or personal property (including medication) of a member by any means prohibited by law.
  - (5) Death of a member.
  - (6) Hospitalization or emergency department visit (including observation) as a result of:
    - (a) Accident, injury or fall;

- (b) Injury or illness of an unknown cause or origin; and
  - (c) Reoccurrence of an illness or medical condition within seven calendar days of the member's discharge from a hospital.
- (7) Unauthorized use of restraint, seclusion and/or restrictive intervention that does not result in, or cannot reasonably be expected to result in, injury to the member.
- (8) An unexpected crisis in the member's family or environment that results in an inability to assure the member's health and welfare in his or her primary place of residence.
- (9) Inappropriate service delivery including, but not limited to:
- (a) A provider's violation of the requirements set forth in rule 5160-58-04 of the Administrative Code and/or any other Administrative Code rules referenced therein;
  - (b) Services provided to the member that are beyond the provider's scope of practice;
  - (c) Services delivered to the member without, or not in accordance with, physician's orders; and
  - (d) Medication administration errors involving the member.
- (10) Actions on the part of the member that place the health and welfare of the member or others at risk including, but not limited to:
- (a) The member cannot be located;
  - (b) Activities that involve law enforcement;
  - (c) Misuse of medications; and
  - (d) Use of illegal substances.
- (G) Incident reporter responsibilities.
- (1) ODM, its designees and all providers are required to report incidents in accordance with the procedures set forth in this rule.
- (2) Members and/or their authorized representative or legal guardian should report incidents to the member's MyCare Ohio care manager or waiver service coordinator and the appropriate authorities.
- (3) If a person or an entity identified in paragraph (G)(1) of this rule learns of an incident, the person or entity shall do all of the following:
- (a) Take immediate action to assure the health and welfare of the member which may include, but is not limited to, seeking or providing medical attention.
  - (b) Immediately report any incident(s) set forth in paragraphs (F)(1) to (F)(5) of this rule to the MyCare Ohio care manager or waiver service coordinator and the appropriate authorities set forth in paragraph (G)(5)(a) of this rule.
  - (c) Report any incidents set forth in paragraphs (F)(6) to (F)(10) of this rule to the MyCare Ohio care manager or waiver service coordinator within twenty-four hours unless bound by federal, state or local law or professional licensure or certification requirements to report sooner.
- (4) At a minimum, all incident reports shall include:
- (a) The facts that are relevant to the incident;
  - (b) The incident type; and
  - (c) The names of, and when available, the contact information for, all persons involved.
- (5) The appropriate authority is dependent upon the nature of the incident. Examples of appropriate authorities include, but are not limited to:
- (a) The following agencies that hold investigative and/or protective authority:

- (i) Local law enforcement if the incident involves conduct that constitutes a possible criminal act including but not limited to, abuse, neglect, exploitation, misappropriation or death of the member;
- (ii) The local coroner's office;
- (iii) The local county board of developmental disabilities (CBDD);
- (iv) The local public children services agency (PCSA); and
- (v) The local public adult protective services agency.

(b) The following regulatory, oversight and/or advocacy agencies:

- (i) The Ohio long term care ombudsman;
- (ii) The alcohol, drug addiction and mental health service board;
- (iii) The Ohio department of health (ODH), or other licensure or certification board or accreditation body when the allegation involves a provider regulated by that entity;
- (iv) The Ohio attorney general when the allegation is suspected to involve medicaid fraud; and
- (v) The local probate court when the allegation is suspected to involve the legal guardian.

(6) The incident reporter must also notify his or her supervisor if he or she has one.

(H) MyCare Ohio plan responsibilities.

(1) The MyCare Ohio plan shall do all of the following upon discovery of an incident:

- (a) Ensure that immediate action was taken to protect the health and welfare of the member and any other members who may be at-risk.
- (b) Notify the appropriate agencies that hold investigative and/or protective authority as set forth in paragraph (G)(5)(a) of this rule if the incident was one of those set forth in paragraphs (F)(1) to (F)(5) of this rule.
- (c) Notify the appropriate additional regulatory, oversight and/or advocacy agencies set forth in paragraph (G)(5)(b) of this rule.
- (d) Notify the member's primary care provider.

(2) The MyCare Ohio plan shall complete an incident report in ODM's or its provider oversight contractor's electronic incident management system within twenty-four hours of discovery if the incident was one of those set forth in paragraphs (F)(1) to (F)(5) of this rule.

(3) The MyCare Ohio plan shall complete an incident report in the MyCare Ohio plan's own incident management system within twenty-four hours of discovery if the incident was one of those set forth in paragraphs (F)(6) to (F)(10) of this rule.

(4) The MyCare Ohio plan shall notify ODM or its provider oversight contractor, as appropriate, within twenty-four hours of any incident that meets the criteria of an alert as set forth in paragraph (J) of this rule.

(5) The MyCare Ohio plan shall notify the member and/or the member's authorized representative or legal guardian of the incident as long as such notification will not jeopardize the incident investigation and/or place the health and welfare of the member or reporter at risk.

(6) The MyCare Ohio plan shall submit all incident data resulting from reports filed pursuant to paragraphs (H)(2) and (H)(3) of this rule to ODM or its designee by the close of business on the last business day of the first week following the end of the month.

(I) Incident investigation responsibilities.

- (1) As appropriate, ODM or its provider oversight contractor, or the MyCare Ohio plan must review all reported incidents within one business day of notification via ODM's or its designee's electronic incident management system, and shall do all of the following as part of its review:
  - (a) Verify that immediate action was taken to protect the health and welfare of the member and any other members who may be at-risk. If such action was not taken, the provider oversight contractor must do so immediately.
  - (b) Verify that the county coroner was notified in the event of the death of a member. If such action was not taken, the provider oversight contractor must do so immediately.
  - (c) Verify that the appropriate authorities have been notified as required by this rule. If such action was not taken, the provider oversight contractor must do so immediately.
  - (d) Verify that the incident was reported within the timeframe required by this rule.
  - (e) Notify ODM of any incident that meets the criteria of an alert as set forth in paragraph (J) of this rule.
- (2) As appropriate, the provider oversight contractor or the MyCare Ohio plan shall initiate an investigation no later than two business days after having been notified of an incident. At a minimum, the provider oversight contractor or MyCare Ohio plan shall:
  - (a) Contact and work cooperatively with protective agencies and any other entities to whom the incident was reported and that may be conducting a separate investigation.
  - (b) Conduct a review of all relevant documents including, but not limited to, integrated, individualized care plans, assessments, clinical notes, communication notes, coroner's reports, documentation available from other authorities, provider documentation, plans of care, provider billing records, medical reports, police and fire department reports and emergency response system reports.
  - (c) Conduct and document interviews with anyone who may have information relevant to the incident investigation including, but not limited to, the reporter, members, authorized representatives and/or legal guardians and providers.
  - (d) Include the member and the reporter in the incident investigation process, as long as such involvement is both safe and appropriate.
  - (e) When applicable, make referrals to appropriate licensure or certification boards, accreditation bodies, and/or other entities based on the information obtained during the investigation.
  - (f) Document all investigative activities.
  - (g) Document if and why any of the steps set forth in paragraph (I) of this rule were omitted from the incident investigation.
- (3) If, at any time during the investigation of a death, it is determined the incident meets the criteria for a suspicious death as described in paragraph (J)(2)(a) of this rule, or the death may have been preventable, the provider oversight contractor must notify ODM within twenty-four hours of the contractor's discovery. If ODM agrees the death is suspicious in nature or was preventable, it shall maintain lead responsibility for the investigation and follow all of the steps set forth in paragraph (I) of this rule and the ODM-approved death investigation protocol. All other deaths shall be investigated by the provider oversight contractor in accordance with the steps set forth in paragraph (I) of this rule and the ODM-approved death investigation protocol.
- (4) Concluding an incident investigation.
  - (a) As appropriate, the provider oversight contractor or the MyCare Ohio plan must conclude its incident investigation no later than forty-five days after the provider oversight contractor's initial receipt of the incident report. Extension of this deadline is only permissible upon prior approval by ODM.

- (b) At the conclusion of the investigation, the provider oversight contractor or the MyCare Ohio plan shall:
  - (i) Submit to ODM and the member, authorized representative and/or legal guardian a written report that:
    - (a) Summarizes the investigation;
    - (b) Identifies if the incident was substantiated and whether it was preventable; and
    - (c) Includes a prevention plan for the member that identifies the steps necessary to mitigate the effects of a substantiated incident, eliminate the causes and contributing factors that resulted in risk to the health and welfare of the member and any other persons impacted by the incident and prevent future incidents.
  - (ii) Notify MyCare Ohio waiver service providers who are subject to the incident investigation in writing upon substantiation of an incident. The notification shall specify:
    - (a) The findings of the investigation that substantiate the occurrence of the incident;
    - (b) The Administrative Code rule(s) that support(s) the finding(s) of the investigation;
    - (c) What steps the provider must take in order to mitigate against the causes of and factors contributing to the incident; and
    - (d) The timeframe within which the provider must submit a plan of correction in accordance with rule 5160-45-06 of the Administrative Code, not to exceed fifteen calendar days after the notification date.
  - (iii) Provide a written summary of the investigative findings to the reporter of the incident unless such action could jeopardize the health and welfare of the member.
  - (iv) Assure that all such reports issued pursuant to paragraph (I)(4) of this rule shall comply with all applicable state and federal confidentiality and information disclosure laws.

(J) Alerts.

- (1) As appropriate, the provider oversight contractor or the MyCare Ohio plan shall ensure that incidents that rise to the level of an alert are reported to ODM within twenty-four hours of the incident's identification and report submission.
- (2) The following incidents are cause for an alert:
  - (a) A suspicious death in which the circumstances and/or the cause of death are not related to any known medical condition of the member, and/or; in which someone's action or inaction may have caused or contributed to the member's death.
  - (b) Abuse or neglect that required the member's removal from his or her place of residence.
  - (c) Hospitalization or emergency department visit (including observation) as a result of:
    - (i) Abuse or neglect;
    - (ii) Accident, injury or fall;
    - (iii) Injury or illness of an unknown cause or origin; and
    - (iv) Reoccurrence within seven calendar days of the member's discharge from a hospital.

- (d) Harm to multiple members as a result of an incident.
- (e) Injury resulting from the authorized or unauthorized use of a restraint, seclusion or restrictive intervention.
- (f) Incidents involving an employee of the MyCare Ohio plan or provider oversight contractor.
- (g) Misappropriation that is valued at five hundred dollars or more.
- (h) Incidents generated from correspondence received from the Ohio attorney general, office of the governor, the centers for medicare and medicaid services (CMS) or the federal office of civil rights.
- (i) Incidents identified by a public media source.

- (K) At its discretion, ODM may request further review of any incident under investigation, and/or conduct a separate, independent review or investigation of any incident.
- (L) ODM or its designee shall determine when to close incident investigations, and shall be responsible for ensuring that all investigations are properly closed.
- (M) If, at any time during the discovery or investigation of an incident, it is determined that an employee of the provider oversight contractor or the MyCare Ohio plan is or may be responsible for, or contributed to, the abuse, neglect, exploitation or death of a member, the provider oversight contractor or MyCare Ohio plan shall immediately notify ODM. ODM shall assume responsibility for the investigation in accordance with the procedures set forth in this rule.
- (N) ODM may impose sanctions upon the provider in accordance with rules 5160-45-06 and 5160-45-09 of the Administrative Code or rules 173-39-05 to 173-39-08 of the Administrative Code, as appropriate, based upon the substantiation of an incident, failure to comply with any of the requirements set forth in this rule, failure to assure the health and welfare of the member and/or failure to comply with all applicable federal, state and local laws and regulations.

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**MCTL 42**

**Effective Date: December 1, 2014**

**Most Current Prior Effective Date: March 1, 2014**

(A) Definitions.

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

- (1) An "action" is the MyCare Ohio plan's
  - (a) Denial or limited authorization of a requested service, including the type or level of service;
  - (b) Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the plan;
  - (c) Denial, in whole or part, of payment for a service not covered by medicaid, including a service denied through the plan's prior authorization process as not medically necessary;
  - (d) Denial of a request for a specific plan-contracted non-agency or participant-directed waiver services provider pursuant to paragraph ~~(F)~~(G) of rule 5160-58-03.2 of the Administrative Code; or
  - (e) Failure to provide services in a timely manner as specified in rules 5160-26-03.1 and 5160-58-01.1 of the Administrative Code; or
  - (f) Failure to act within the resolution timeframes specified in this rule.
- (2) An "appeal" is the request for a plan's review of an action.
- (3) A "grievance" is an expression of dissatisfaction with any aspect of the plan's or provider's operation, provision of health care services, activities, or behaviors, other than the plan's action as defined in paragraph (A)(1) of this rule.
- (4) "Resolution" means a final decision is made by the plan and the decision is communicated to the member.
- (5) "Notice of action (NOA)" is the written notice the plan must provide to members when a plan action has occurred or will occur.
- (6) "Plan" is a MyCare Ohio plan.

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

- (1) A process by which members may file grievances with the plan, in compliance with paragraph (H) of this rule;
- (2) A process by which members may file appeals with the plan, in compliance with paragraphs (C) to (G) of this rule; and
- (3) A process by which members may access the state's hearing system through the Ohio department of job and family services (ODJFS), in compliance with paragraph (I) of this rule.

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

- (1) When a plan action has or will occur, the plan must provide the affected member(s) with a written NOA.
- (2) The NOA must explain:
  - (a) The action the plan has taken or intends to take;
  - (b) The reasons for the action;

- (c) The member's or authorized representative's right to file an appeal to the plan;
- (d) If applicable, the member's right to request a state hearing through the state's hearing system;
- (e) Procedures for exercising the member's rights to appeal or grieve the action;
- (f) Circumstances under which expedited resolution is available and how to request it;
- (g) If applicable, the member's right to have benefits continue pending the resolution of the appeal, and how to request that benefits be continued;
- (h) The date that the notice is being issued;
- (i) Oral interpretation is available for any language;
- (j) Written translation is available in prevalent languages as applicable;
- (k) Written alternative formats may be available as needed; and
- (l) How to access the plan's interpretation and translation services as well as alternative formats that can be provided by the plan.

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

- (a) It must be provided in a manner and format that may be easily understood;
- (b) When directed by ODM, it must be printed in the prevalent non-English languages of members in the plan's service area; and
- (c) It must be available in alternative formats in an appropriate manner that takes 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) A plan must give members a written NOA within the following timeframes:

- (a) For a decision to deny or limit authorization of a requested service, including the type or level of service, the plan must issue a NOA simultaneously with the plan's decision.
- (b) For reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the plan, the plan must give notice fifteen calendar days before the date of action except:
  - (i) If probable recipient fraud has been verified, the plan must give notice five calendar days before the date of action.
  - (ii) Under the circumstances set forth in 42 C.F.R. 431.213 (October 1, 2013), the plan must give notice on or before the date of action.
- (c) For denial of payment for a noncovered service, the plan must give notice simultaneously with the plan'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 plan's prior authorization process as not medically necessary.
- (d) For denial of a request for a provider pursuant to paragraph (A)(1)(d) of this rule, the plan must give notice simultaneously with the plan's decision.
- (e) For untimely prior authorization, appeal or grievance resolution, the plan must give notice simultaneously with the plan becoming aware of the action. Service authorization decisions not reached within the timeframes specified in rules 5160-26-03.1 and 5160-58-01.1 of the Administrative Code constitute a denial and are thus adverse actions. Notice must be given on the date that the authorization decision timeframe expires.

(D) Standard appeal to a MyCare Ohio plan.

- (1) A member, provider, or a member's authorized representative may file an appeal orally or in writing within ninety days from the date on the NOA. The ninety day period begins on the day

after the mailing date of the NOA. An oral filing must be followed with a written appeal. The plan must:

- (a) Assist members that file an oral appeal by immediately converting an oral filing to a written record;
- (b) Ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal; and
- (c) Consider the date of the oral filing as the filing date if the member follows the oral filing with a written appeal.

- (2) Any provider acting on the member's behalf must have the member's written consent to file an appeal. The plan must begin processing the appeal pending receipt of the written consent.
- (3) The plan must acknowledge receipt of each appeal to the individual filing the appeal. At a minimum, acknowledgment must be made in the same manner that the appeal was filed. If an appeal is filed in writing, written acknowledgment must be made by the plan within three working days of the receipt of the appeal.
- (4) The plan must provide members a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member and/or member's authorized representative must be allowed to examine the case file, including medical records and any other documents and records, before and during the appeals process.
- (5) The plan must consider the member, member's authorized representative, or estate representative of a deceased member as parties to the appeal.
- (6) The plan must review and resolve each appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed fifteen calendar days from the receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph (F) of this rule.
- (7) The plan must provide written notice to the parties of the resolution including, at a minimum, the decision and date of the resolution.
- (8) For appeal decisions not resolved wholly in the member's favor, the written notice to the member must also include information regarding:
  - (a) Oral interpretation that is available for any language;
  - (b) Written translation that is available in prevalent languages as applicable;
  - (c) Written alternative formats that may be available as needed;
  - (d) How to access the plan's interpretation and translation services as well as alternative formats that can be provided by the plan;
  - (e) The right to request a state hearing through the state's hearing system; and
  - (f) How to request a state hearing, and if applicable:
    - (i) The right to continue to receive benefits pending a state hearing; and
    - (ii) How to request the continuation of benefits.
- (9) For appeals decided in favor of the member, the plan must:
  - (a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires if the services were not furnished while the appeal was pending; and
  - (b) Pay for the disputed services if the member received the services while the appeal was pending.

(E) Expedited appeal to a MyCare Ohio plan.

- (1) Each plan must establish and maintain an expedited review process to resolve appeals when the plan determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- (2) In utilizing an expedited appeal process, the plan must comply with the standard appeal process specified in paragraph (E) of this rule, except the plan must:
  - (a) Not require that an oral filing be followed with a written, signed appeal;
  - (b) Make a determination within one working day of the appeal request whether to expedite the appeal resolution;
  - (c) Make reasonable efforts to provide prompt oral notification to the member of the decision to expedite or not expedite the appeal resolution;
  - (d) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;
  - (e) Resolve the appeal as expeditiously as the member's health condition requires but the resolution timeframe must not exceed seventy-two hours from receipt of the appeal unless the resolution timeframe is extended as outlined in paragraph (F) of this rule;
  - (f) Make reasonable efforts to provide oral notice of the appeal resolution in addition to the required written notification;
  - (g) Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal; and
  - (h) Notify ODM within one working day of any appeal that meets the criteria for expedited resolution as specified by ODM.
- (3) If the plan denies the request for expedited resolution of an appeal, the plan must:
  - (a) Transfer the appeal to the standard resolution timeframe of fifteen calendar days from the date the appeal was received unless the resolution timeframe is extended as outlined in paragraph (F) of this rule; and
  - (b) Provide the member written notice of the denial to expedite the resolution within two calendar days of the receipt of the appeal, including information that the member can grieve the decision.

(F) Appeal resolution extensions for an appeal to a MyCare Ohio plan.

- (1) A member may request that the plan extend the timeframe to resolve a standard or expedited appeal up to fourteen calendar days.
- (2) A plan may request that the timeframe to resolve a standard or expedited appeal be extended up to fourteen calendar days. The plan must seek such an extension from ODM prior to the expiration of the regular appeal resolution timeframe and its request must be supported by documentation that the extension is in the member's best interest. If ODM approves the extension, the plan must immediately give the member written notice of the reason for the extension and the date that a decision must be made.
- (3) The plan must maintain documentation of all requests for extension.

(G) Continuation of benefits for an appeal to a MyCare Ohio plan.

- (1) The plan must continue a member's benefits when an appeal has been filed if the following conditions are met:
  - (a) The member or authorized representative files the appeal on or before the later of the following:
    - (i) Within fifteen calendar days of the plan mailing the NOA; or
    - (ii) The intended effective date of the plan's proposed action.

- (b) The appeal involves the termination, suspension, or reduction of services prior to the member receiving the previously authorized course of treatment;
  - (c) The services were ordered by an authorized provider;
  - (d) The authorization period has not expired; and
  - (e) The member requests the continuation of benefits.
- (2) If the plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
- (a) The member withdraws the appeal;
  - (b) Fifteen calendar days pass following the mailing date of the MyCare Ohio plan's notice to the member of an adverse appeal decision unless the member, within the fifteen-day timeframe, requests a state hearing ~~with continuation of benefits~~ and therefore the benefits must be continued as specified in rule 5101:6-4-01 of the Administrative Code.
  - (c) A state hearing regarding the reduction, suspension or termination of the benefits is decided adverse to the member; or
  - (d) The initial time period for the authorization expires or the authorization service limits are met.
- (3) At the discretion of ODM, the plan may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the plan's original action.

(H) Grievances to a MyCare Ohio plan.

- (1) A member or authorized representative can file a grievance. An authorized representative must have the member's written consent to file a grievance on the member's behalf.
- (2) Grievances may be filed only with the plan, orally or in writing, within ninety calendar days of the date that the member became aware of the issue.
- (3) The plan must acknowledge the receipt of each grievance to the individual filing the grievance. Oral acknowledgment is acceptable. However, if the grievance is filed in writing, written acknowledgment must be made within three working days of receipt of the grievance.
- (4) The plan must review and resolve all grievances as expeditiously as the member's health condition requires. Grievance resolutions including member notification must meet the following timeframes:
  - (a) Within two working days of receipt if the grievance is regarding access to services.
  - (b) Within thirty calendar days of receipt for all other grievances that are not regarding access to services.
- (5) At a minimum, the plan must provide oral notification to the member of a grievance resolution. However, if the plan is unable to speak directly with the member and/or the resolution includes information that must be confirmed in writing, the resolution must be provided in writing simultaneously with the plan's decision.
- (6) If the plan's resolution to a grievance is to affirm the denial, reduction, suspension, or termination of a service, denial of a provider pursuant to paragraph (A)(1)(d) of this rule, or billing of a member due to the plan's denial of payment for that service, the plan must notify the member of his or her right to request a state hearing as specified in paragraph (I) of this rule, if the member has not previously been notified.
- (7) If the plan's resolution to a grievance is to affirm the denial, reduction, suspension or termination of a service or denial of a provider pursuant to paragraph (A)(1)(d) of this rule, the plan must notify the member of his or her right to request an appeal to the plan as specified in paragraph (C)(4) of this rule, if the member has not previously been notified.

- (I) Access to state's hearing system.
- (1) A plan must develop and implement written policies and procedures that ensure the plan's compliance with the state hearing provisions specified in division 5101:6 of the Administrative Code.
  - (2) Members are not required to exhaust the appeal or grievance process through the plan in order to access the state's hearing system.
  - (3) When required by paragraph (C) of this rule and division 5101:6 of the Administrative Code, a plan must notify members, and any authorized representatives on file with the plan, of the right to a state hearing. The following requirements apply:
    - (a) If the plan denies a request for the authorization of a service, in whole or in part, the plan must simultaneously complete and mail or personally deliver the "Notice of Denial of Medical Services By Your Managed Care Plan" (JFSODM 04043, rev. 7/2009 7/2014 formerly JFS 04043).
    - (b) If the plan decides to reduce, suspend, or terminate services prior to the member receiving the services as authorized by the plan, the plan must complete and mail or personally deliver no later than fifteen calendar days prior to the effective date of the proposed reduction, suspension, or termination, the "Notice of Reduction, Suspension or Termination of Medical Services By Your Managed Care Plan" (JFSODM 04066, 7/2009 7/2014 formerly JFS 04066).
    - (c) If the plan denies a request for the authorization to receive waiver services from a provider pursuant to paragraph (A)(1)(d) of this rule, the plan must simultaneously complete and mail or personally deliver the required notice of state hearing rights.
    - (d) If the plan learns that a member has been billed for services received by the member due to the plan's denial of payment, and the plan upholds the denial of payment, the plan must immediately complete and mail or personally deliver the "Notice of Denial of Payment for Medical Services By Your Managed Care Plan" (JFSODM 04046, rev. 7/2009 7/2014 formerly JFS 04046).
  - (4) The member or his or her authorized representative may request a state hearing within ninety calendar days by contacting the ODJFS bureau of state hearings or local county department of job and family services (CDJFS). The ninety-day period begins on the day after the mailing date on the state hearing form.
  - (5) There are no state hearing rights for a member(s) terminated from the plan pursuant to a plan-initiated membership termination as permitted in rule 5160-58-02.1 of the Administrative Code.
  - (6) Following notification by the bureau of state hearings to a plan that a member has requested a state hearing, the plan must:
    - (a) Complete the "Appeal Summary for Managed Care Plans" (ODM 01959, 7/2014 formerly JFS 01959, ~~rev. 06/03~~) with appropriate attachments, and file it with the bureau of state hearings, at least three business days prior to the scheduled hearing date. The appeal summary must provide all facts and documents relevant to the issue, and be sufficient to demonstrate the basis for the plan's action or decision;
    - (b) Send a copy of the completed appeal summary to the appellant, the bureau of state hearings, the local agency, and the designated ODM contact; and
    - (c) Continue or reinstate the benefit(s) as specified in rule 5101:6-4-01 of the Administrative Code, if the plan is notified that the member's state hearing request was received within the prior notification period, ~~and the member requested that the benefits be continued.~~
  - (7) The plan must participate in the hearing in person or by telephone, on the date indicated on the "State Hearing Scheduling Notice" (JFS 04002, rev. 09/~~02~~2002) sent to the plan by the bureau of state hearings.

- (8) In addition to the plan and member, other parties to a state hearing may include an authorized representative of a member, or the representative of the member's estate, if the member is deceased.
  - (9) The plan must comply with the state hearing officer's decision provided to the plan via the "State Hearing Decision" (JFS 04005, rev. 03/2003). If the hearing officer's decision is to sustain the member's appeal, the plan must complete the "State Hearing Compliance" form (JFS 04068, rev. 05/2001). A copy of the completed form, including applicable documentation, is due by no later than the compliance date specified in the hearing decision to the bureau of state hearings and the designated ODM contact. If applicable, the plan must:
    - (a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires; and
    - (b) Pay for the disputed services if the member received the disputed services while the appeal was pending.
  - (10) The plan must provide a copy of the state hearing forms referenced in this paragraph to ODM, as directed by ODM.
  - (11) Upon request, the plan's state hearing policies and procedures must be made available for review by ODM.
- (J) Logging and reporting of appeals and grievances.
- (1) A plan must maintain records of all appeals and grievances including resolutions for a period of eight years, and the records must be made available upon request to ODM and the medicaid fraud control unit.
  - (2) A plan must identify a key staff person responsible for the logging and reporting of appeals and grievances and assuring that the grievance system is in accordance with this rule.
- (K) Other duties of a MyCare Ohio plan regarding appeals and grievances.
- (1) A plan must give members all reasonable assistance in filing an appeal, a grievance, or accessing the state's hearing system, including but not limited to:
    - (a) Explaining the plan's process to be followed in resolving the member's appeal or grievance;
    - (b) Completing forms and taking other procedural steps as outlined in this rule; and
    - (c) Providing oral interpreter and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.
  - (2) The plan must ensure that the individuals who make decisions on appeals and grievances are individuals who:
    - (a) Were not involved in previous levels of review or decision-making; and
    - (b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease, if deciding any of the following:
      - (i) An appeal of a denial that is based on lack of medical necessity;
      - (ii) A grievance regarding the denial of an expedited resolution of an appeal; or
      - (iii) An appeal or grievance that involves clinical issues.
  - (3) The procedure to be followed to file an appeal or grievance must be described in the plan's member handbook and must include the telephone number(s) for the plan's toll-free member services hotline, the plan's mailing address, and a copy of the optional form(s) that members may use to file an appeal or grievance with the plan. Copies of the form(s) to file an appeal or grievance must also be made available through the plan's member services program.

- (4) The procedure to be followed to file a state hearing request must be described in the plan's member handbook.
- (5) Appeals and grievance procedures must include the participation of individuals authorized by the plan to require and implement corrective action.
- (6) A plan is prohibited from delegating the appeal or grievance process to another entity.
- (7) A plan must maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. Plan records must include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

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