FROM: **Maureen M. Corcoran, Director**

TO: **Ohio Department of Medicaid Clearance Reviewers**

SUBJECT: **Next Generation MyCare Ohio Five Year Rule Review**

Summary

Attached for your review and comment are the Ohio Administrative Code (OAC) rules in Chapter 5160-58 that will be proposed for five-year rule review.

OAC Rule 5160-58-01, entitled "MyCare Ohio plans: definitions." This rule will be rescinded and made new. The rule provides definitions used in the MyCare Ohio program for recipients, providers, and MyCare Ohio plans. Some definitions will be removed, amended, and several new definitions will be added to provide improved transparency and clarity in the next generation program.

OAC Rule 5160-58-01.1, entitled "MyCare Ohio plans: application of general managed care rules." This rule explains authorities provided to the MyCare Ohio program through Chapter 5160-26 of the Administrative Code and authorities granted through Chapter 5160-58 of the Administrative Code. The rule will be amended and filed for five-year rule review.

OAC Rule 5160-58-02, entitled "MyCare Ohio plans: eligibility and enrollment," is retitled as "MyCare Ohio plans: eligibility, ineligibility, and optional enrollment." This rule describes the criteria for recipient enrollment into the MyCare Ohio program, explains criteria which exclude recipients from the MyCare Ohio program, and individuals who are granted optional enrollment under the Code of Federal Regulations. The rule will be rescinded and filed as new due to reorganization which will strike and move sections to make the rule easier to understand and will add additional sections which will explain the transitions and changes in the enrollment process for MyCare, which differs in the next generation program from the demonstration program.

OAC Rule 5160-58-02.1, entitled "MyCare Ohio plans: termination of enrollment" is retitled as "MyCare Ohio plans: disenrollments." This rule will be amended and filed for a five-year rule review. The rule describes circumstances which could result in removal from the MyCare Ohio program or changes in an individual's MyCare Ohio plan enrollment, including options to change plans outside the annual open enrollment period. Changes to this rule will include a new title with softer, clearer language (changed from terminate to disenroll), more clearly explaining different kinds of disenrollment- individual program disenrollment, individual-initiated disenrollment from a plan, plan-initiated disenrollment, ODM-initiated disenrollment, removal of a duplicated section, and removal of language limiting the ODM to communications by mail.

OAC Rule 5160-58-02.2, entitled "MyCare Ohio waiver: eligibility and enrollment." This rule includes criteria for participation in the MyCare Ohio waiver to receive home and community-based services which includes services from the Ohio Home Care Waiver, the PASSPORT waiver, and the Assisted Living Services Waiver. This rule will be amended and filed for five-year rule review. Changes

to this rule will include removal of a rescinded rule citation and updates to terminology referring to staff who coordinate care for the MyCare Ohio waiver from care manager to waiver services coordinator.

OAC Rule 5160-58-03, entitled "MyCare Ohio plans: covered services." This rule describes services available in the MyCare Ohio program. This rule will be amended and filed for five-year rule review. Changes to this rule will include clarification that prescription drugs are covered through the Medicare Part D program and that the Ohio Medicaid drug coverage will be specifically the over the counter drugs specified by OAC 5160-9-03 and will remove language referring to the early and periodic screening, diagnostic, and treatment (EPSDT) benefit and Medicaid Schools Program (MSP) due to the age increase from eighteen years to twenty-one years for MyCare Ohio participation.

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

OAC Rule 5160-58-03.2, entitled "MyCare Ohio waiver: member choice, control, responsibilities and participant direction" will be retitled as "MyCare Ohio waiver: member choice, control, responsibilities and self-direction." This rule will be amended and filed for five-year rule review. Changes to this rule will include changes in terminology to match new and updated definitions from OAC 5160-58-01 and changes in formatting so the structure has consistent flow.

OAC Rule 5160-58-04, entitled "MyCare Ohio waiver: covered services and providers." This rule will be amended and filed for five-year rule review. This rule outlines the scope of services for waiver services providers and provides cross citation for the services from the three fee-for-service waivers which are available the MyCare Ohio waiver. Changes to this rule will include addition of services available in Ohio Home Care Waiver, PASSPORT, and Assisted Living Services Waiver, but were not yet included in the MyCare Ohio rule, updated service names, and updated rule citations. Additional changes include a requirement of providers to be enrolled with ODM and the MyCare Ohio plan, or enroll with the financial management services (FMS), if the member participates in self-direction.

OAC Rule 5160-58-05, entitled "MyCare Ohio: care coordination." This rule will be a new rule which outlines and sets expectations for care coordination in the MyCare Ohio program for members, their interdisciplinary care team, and MyCare Ohio plans for the public for clarity and transparency.

OAC Rule 5160-58-08.4, entitled "Appeals and grievances for "MyCare Ohio"" will be retitled as "MyCare Ohio plans: grievances, appeals, and state fair hearings." This rule will be rescinded and

made new. This rule will describe the grievances and appeals activities for MyCare Ohio. Changes to this rule will include added sections to clarify grievance and appeal pathways which differ when a member is enrolled as dual-benefits versus enrolled for Medicaid benefits only, reorganization to clearly identify grievances processes, first-level appeals, and state fair hearings for all Medicaid-covered MyCare services, and explain how grievances and appeals are directed for Medicaid-covered services when members are enrolled with MyCare Ohio for their Medicaid benefits only.

Questions pertaining to this clearance should be sent to Rules@Medicaid.Ohio.gov.

To receive notification when ODM posts draft rules for public comment please register via the Common Sense Initiative eNotifications Sign-up: eNotifications Sign Up | Governor Mike DeWine (ohio.gov). The Ohio Department of Medicaid will use this list to notify subscribers when draft rules are posted for public comment.

To receive notification when ODM original, revise, refile, or final files a rule package please register for Joint Committee on Agency Rules Review's (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by the rule number or department.

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is http://www.medicaid.ohio.gov.

5160-58-01 MyCare Ohio plans: definitions.

(A) The general definitions set forth in rule 5160-26-01 of the Administrative Code regarding managed care entities (MCEs) apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code.

(B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code, the following definitions apply to Chapter 5160-58 of the Administrative Code:

(1) "Assessment" means a comprehensive evaluation of an individual's medical, behavioral health, long-term services and supports, and social needs. Results of the assessment process are used to develop the integrated, individualized care plan, inclusive of the waiver services plan.

(2) "Auto-assign" means the process for determining in which MyCare Ohio Plan (MCOP) a member is assigned. Auto-assignment uses preset rules to best match needs and preserve existing provider-patient relationships. The process does not include manual intervention for assignment.

(3) "Care management" means a collaborative, team based, and personalized approach that encompasses the full spectrum of care coordination activities, ranging from short term assistance to meet care gaps to long term, intensive and holistic care coordination for members with the most intensive needs, designed to assist members and their support systems in managing medical conditions and social determinants of health (SHOD) more effectively. Care management includes care coordination activities to deliberately organize and support an individual to address needs for the purpose of achieving better health outcomes.

(4) "Care coordinator" means a healthcare professional who works with individuals to create and manage their care plans. Care coordinators help individuals navigate the healthcare system, access resources, and advocate for the individuals’needs. They assess individuals' physical, psychological, and social needs, develop personalized care plans, coordinate care, monitor individuals' progress, provide education, connect individuals with community resources and other support services, and address individuals' social determinants of health.

(5) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (January 1, 2026).

(6) "Critical incident" is defined in rule 5160-44-05 of the Administrative Code.

(7) "Dual benefits member" means an individual for whom a MyCare Ohio plan is responsible for the coordination and payment of both medicare and medicaid benefits.

(8) "Dual-eligible member" means an individual who is eligible for and enrolled in

both medicare parts a, b, and d, and full benefits under the medicaid program as defined in paragraph (B)(11) of this rule.

(9) "Dual special needs plan (D-SNP)" is defined in 42 CFR 422.2 (October 1, 2025).

(10) "Financial management service (FMS)" means a support that is provided to waiver individuals who direct some or all of their waiver services. When used in conjunction with the employer authority, this support includes, but is not limited to, operating a payroll service for staff who provide care and services for the individual and making required payroll withholdings. When used in conjunction with the budget authority, this support includes, but is not limited to, paying invoices for waiver goods and services and tracking expenditures against the self-directed budget.

(11) "Full benefits under the medicaid program" means the full scope of services covered by the medicaid state plan. Medicaid-enrolled individuals who have full benefits under the medicaid program exclude individuals whose medicaid enrollment is categorized as:

(a) Presumptive eligibility under rule 5160:1-2-13 of the Administrative Code;

(b) Non-citizen emergency medical assistance under rule 5160:1-5-06 of the Administrative Code;

(c) Refugee medical assistance under rule 5160:1-5-05 of the Administrative Code;

(d) Medicare premium assistance program under rule 5160:1-3-02.1 of the Administrative Code;

(e) Inmates subject to restrictions on medicaid payment under rule 5160:1-1-03 of the Administrative Code.

(12) "Fully integrated dual-eligible special needs plan (FIDE SNP)" is defined in 42 CFR 422.2 (October 1, 2025).

(13) "Health and welfare" as described in 42 CFR 441.302 (October 1, 2025) refers to a federal requirement that necessary safeguards are taken to protect the safety and independence of individuals enrolled in a home and community-based services (HCBS) waiver. Examples of such safeguards includes, without limitation:

(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.

(14) "Home and community-based services (HCBS)" means services available to individuals to help maintain their health and safety in a community setting in lieu of institutional care as described in 42 CFR 440 subpart A (October 1, 2025).

(15) "Hybrid services" are services which are covered by both medicare and medicaid.

(16) "Individual" is defined in rule 5160-1-04 of the Administrative Code.

(17) "Individual care plan" means an integrated, individualized, person-centered care plan developed by the individual and his or her MyCare Ohio plan's inter-disciplinary care management team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.

(18) "Interdisciplinary care management team" means a team made up of the member, the individual's authorized representative, the member's managed care team, other professionals, and information supports chosen by the member. The MCOP provides the member's care coordinator, and waiver service coordinator if the member is enrolled on the MyCare Ohio HCBS waiver, and internal support staff, such as social workers, mental health and substance use disorder licensed independent professionals, gerontologists, housing specialists, transportation specialists, and community health workers, to support the care coordinator.

(19) "Medicaid-only member" means an individual for whom a MyCare Ohio plan is responsible for coordination and payment of medicaid benefits, and, upon request, is responsible to assist with coordination of medicare benefits.

(20) "Member" is defined in rule 5160-26-01 of the Administrative Code.

(21) "MyCare Ohio plan (MCOP)" means a health insuring corporation (HIC), as defined in section 1751 of the Revised Code, which is also a FIDE SNP, contracted to comprehensively manage medicaid benefits, including HCBS, for medicare and medicaid eligible members. An MCOP is also a managed care organization as defined in rule 5160-26-01 of the Administrative Code. For the purpose of this chapter, an MCOP does not include entities approved

to operate as a program for the all-inclusive care of the elderly (PACE) site as defined in rule 5160-36-01 of the Administrative Code.

(22) "Nursing facility-based level of care" means the intermediate and skilled levels of care, as described in rule 5160-3-08 of the Administrative Code.

(23) "Person-centered services plan" is defined in rule 5160-44-02 of the Administrative Code.

(24) "Self-direction" means a service model that empowers individuals with choice and control over identifying, accessing, and managing the long-term services and supports needed to live at home while considering their personal preferences. Self-direction includes both self-directed services in accordance with rule 5160-45-03.2 of the Administrative Code and participant direction under rule 173-42-06 of the Administrative Code.

(25) "Significant change event" is a change experienced by a individual that warrants further evaluation. Significant changes include, but are not limited to, a change in health status, caregiver status, location, or 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.

(26) "Waiver services plan" is a component of the person-centered care plan that identifies specific goals, objectives, and measurable outcomes for a waiver-enrolled individual'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 includes:

(a) Essential information needed to provide care to the individual that assures the member's health and welfare;

(b) Signatures indicating the individual's acceptance or rejection of the waiver services plan. If the member is unable to provide the signature when the services plan is initially developed, the individual submits an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the care coordinator; and

(c) Information that the waiver services plan is not the same as the physician's plan of care.

TO BE RESCINDED

5160-58-01 **MyCare Ohio plans: definitions.**

(A) The definitions set forth in rule 5160-26-01 of the Administrative Code apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code.

(B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code, the following definitions apply to Chapter 5160-58 of the Administrative Code:

(1) "Assessment" means a comprehensive evaluation of an individual's medical, behavioral health, long-term services and supports, and social needs. Results of the assessment process are used to develop the integrated, individualized care plan, inclusive of the waiver services plan.

(2) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (October 1,2021).

(3) "Dual benefits member" or "opt-in member" means a member for whom a MyCare Ohio plan is responsible for the coordination and payment of both medicare and medicaid benefits.

(4) "Financial management service (FMS)" means a support that is provided to waiver participants who direct some or all of their waiver services. When used in conjunction with the employer authority, this support includes, but is not limited to, operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes, but is not limited to, paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.

(5) "Health and welfare" means a requirement that necessary safeguards are taken to protect the health and welfare of individuals enrolled in a home and community-based services (HCBS) waiver. It includes the following:

(a) Risk and safety planning and evaluations;

(b) Critical incident management;

(c) Housing and environmental safety evaluations;

(d) Behavioral interventions;

(e) Medication management; and

(f) Natural disaster and public emergency response planning.

(6) "Home and community-based services (HCBS)" means services available to individuals to help maintain their health and safety in a community setting in lieu of institutional care as described in 42 C.F.R. 440 subpart A (October 1, 2021).

(7) "Individual care plan" means an integrated, individualized, person-centered care plan developed by the member and his or her MyCare Ohio plan's trans-disciplinary care management team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.

(8) "Medicaid only member" or "opt-out member" means a member for whom a MyCare Ohio plan is responsible for coordination and payment of medicaid benefits, and, upon request, responsible to assist with coordination of medicare benefits.

(9) "MyCare Ohio plan (MCOP)" means a health insuring corporation (HIC) contracted to comprehensively manage medicaid benefits for medicare and medicaid eligible members, including HCBS. An MCOP is also a managed care organization as defined in rule 5160-26-01 of the Administrative Code. For the purpose of this chapter, an MCOP does not include entities approved to operate as a program for the all-inclusive care of the elderly (PACE) site as defined in rule 5160-36-01 of the Administrative Code.

(10) "Nursing facility-based level of care" means the intermediate and skilled levels of care, as described in rule 5160-3-08 of the Administrative Code.

(11) "Participant direction" means the opportunity for a MyCare Ohio waiver member to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

(12) "Significant change event" is a change experienced by a member that warrants further evaluation. Significant changes include, but are not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective service agency; institutionalization; and when the waiver-enrolled individual has not received MyCare Ohio waiver services for ninety calendar days.

(13) "Trans-disciplinary care management team" means a team of appropriately qualified individuals comprised of the member, the member's family/caregiver, the MyCare Ohio plan manager, the waiver service coordinator, if appropriate, the primary care provider, specialists, and other providers, as applicable, that is designed to effectively meet the enrollee's needs.

(14) "Waiver services plan" is a component of the care plan that identifies specific goals, objectives and measurable outcomes for a waiver-enrolled member's health and functioning expected as a result of HCBS provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the individual. At a minimum, the waiver services plan shall include:

(a) Essential information needed to provide care to the member that assures the member's health and welfare;

(b) Signatures indicating the member's acceptance or rejection of the waiver services plan. If the member is unable to provide the signature when the services plan is initially developed, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the case manager; and

(c) Information that the waiver services plan is not the same as the physician's plan of care.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5166.02, 5167.02
Rule Amplifies:	5164.02, 5166.02, 5167.02, 5167.01
Prior Effective Dates:	03/01/2014, 07/01/2017, 06/12/2020 (Emer.), 10/12/2020, 07/18/2022, 04/20/2024

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

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

(1) Rule 5160-26-05 of the Administrative Code;

(2) Rule 5160-26-05.1 of the Administrative Code;

(3) Rule 5160-26-06 of the Administrative Code;

(4) Rule 5160-26-08.3 of the Administrative Code;

(5) Rule 5160-26-09.1 of the Administrative Code;

(6) Rule 5160-26-10 of the Administrative Code; ~~and~~

(7) Rule 5160-26-11 of the Administrative ~~Code.~~ Code; and

(8) Rule 5160-26-12 of the Administrative Code.

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

(1) All cross-references to rule 5160-26-01 of the Administrative Code are replaced by cross-references to rule 5160-58-01 of the Administrative Code.

(2) All cross-references to rule 5160-26-02 of the Administrative Code are replaced by cross-references to rule 5160-58-02 of the Administrative Code.

(3) All cross-references to rule 5160-26-02.1 of the Administrative Code are replaced by cross-references to rule 5160-58-02.1 of the Administrative Code.

(4) All cross-references to rule 5160-26-03 of the Administrative Code are replaced by cross-references to rule 5160-58-03 of the Administrative Code.

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

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

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

(1) Rule 5160-26-02 of the Administrative Code,

(2) Rule 5160-26-02.1 of the Administrative Code,

(3) Rule 5160-26-03 of the Administrative Code,

(4) Rule 5160-26-03.1 of the Administrative Code, and

(5) Rule 5160-26-08.4 of the Administrative Code.

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

5160-58-02 **MyCare Ohio plans: eligibility, ineligibility, and optional enrollment.**

(A) Eligibility.

(1) An individual is enrolled in a MyCare Ohio plan (MCOP) if he or she meets all of the following criteria:

(a) Age twenty-one or older at the time of enrollment in the MCOP;

(b) Eligible for medicare parts A, B, and D, and full benefits under the medicaid program.

(2) The following individuals are not eligible for enrollment in an MCOP:

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

(b) Individuals who have other verified third-party creditable health care coverage, except medicare coverage as authorized by 42 U.S.C. 1395 (January 1, 2026);

(c) Individuals who are inmates of public institutions as defined in 42 CFR 435.1010 (October 1, 2025);

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

(e) Individuals with intellectual disabilities who receive services through an intermediate care facility for individuals with intellectual disabilities (ICF-IID).

(3) Indians, who are members of federally recognized tribes, may voluntarily choose to enroll in an MCOP, and may choose not to enroll. Verification of membership in a federally recognized tribe is needed for request of enrollment exclusion.

(4) If an individual meets eligibility requirements in paragraph (A)(1) of this rule and does not meet an exclusion in paragraph (A)(2) of this rule or an optional enrollment in paragraph (A)(3) of this rule, then the individual is enrolled into an MCOP for medicaid benefits.

(5) Nothing in this rule should 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 as the MyCare Ohio service area expands beginning January 1, 2026:

(a) When a service area is designated, in accordance with paragraphs (B)(1)(c) to (H)(2)(i) of this rule, by the Ohio department of medicaid (ODM) as mandatory for eligible individuals, ODM confirms the eligibility of each individual. Upon the confirmation of eligibility:

(i) Eligible individuals residing in the service area who are currently MCOP members are deemed participants in the mandatory program; and

(ii) All other eligible individuals residing in the mandatory service area may request MCOP membership at any time but must select a MCOP following receipt of a notification of mandatory enrollment (NME) issued by the Ohio department of medicaid (ODM).

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

(i) A newly eligible individual who does not make a choice following issuance of a NME by ODM and one additional notice, is assigned to a MCOP by ODM, the medicaid consumer hotline, or other ODM-approved entity.

(ii) ODM or the medicaid consumer hotline assigns the individual to a MCOP based on prior medicaid fee-for-service, managed care organization, or MCOP membership history, whenever available, or at the discretion of ODM.

(c) Effective January 1, 2026, the mandatory service area includes the following twenty-nine counties: Butler, Clark, Clermont, Clinton, Columbiana, Cuyahoga, Delaware, Geauga, Greene, Franklin, Fulton, Hamilton, Lake, Lorain, Lucas, Madison, Mahoning, Medina, Montgomery, Portage, Pickaway, Ottawa, Stark, Summit, Trumbull, Union, Wayne, Warren, and Wood.

(d) Effective April 1, 2026, the following counties are added to the mandatory service area: Ashtabula, Defiance, Erie, Fairfield, Fayette, Henry, Licking, Paulding, Sandusky, and Williams.

(e) Effective May 1, 2026, the following counties are added to the mandatory service area: Allen, Ashland, Auglaize, Champaign, Crawford, Darke,

Hancock, Hardin, Huron, Knox, Logan, Marion, Mercer, Miami, Morrow, Preble, Putnam, Richland, Seneca, Shelby, VanWert, and Wyandot.

(f) Effective June 1, 2026, the following counties are added to the mandatory service area: Adams, Brown, Gallia, Highland, Lawrence, Jackson, Pike, Ross, Scioto, and Vinton.

(g) Effective July 1, 2026, the following counties are added to the mandatory service area: Belmont, Carroll, Coshocton, Guernsey, Harrison, Holmes, Jefferson, Muskingum, and Tuscarawas.

(h) Effective August 1, 2026, the following counties are added to the mandatory service area: Athens, Hocking, Meigs, Monroe, Morgan, Noble, Perry, and Washington.

(i) The mandatory services area includes previously named counties from paragraph (B)(2)(c) of this rule, adding counties named in paragraphs (B)(2)(c) to (B)(2)(h) of this rule, until all eighty-eight counties are included.

(C) Commencement of coverage. Coverage of MCOP members is effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily or monthly enrollment file to the MCOP.

(D) All of the following apply to dual-benefits members in the MyCare Ohio program:

(1) Unless CMS implements a passive enrollment under 42 CFR 422.60 (October 1, 2025), and eligible individual's decision to enroll in the MCOP for medicare benefits is choice-based and ODM does not auto-assign MyCare Ohio members in an MCOP for medicare benefits.

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

(3) Subject to meeting the requirements in 42 CFR 422.66(c)(2) (October 1, 2025), individuals who are enrolled in an MCOP or ODM-contracted MCO with an affiliated MCOP, who become eligible for the MyCare Ohio program, and do not choose to receive their medicare benefits through another medicare payer, and are deemed to have elected the MCOP for both their medicare and medicaid benefits.

TO BE RESCINDED

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

(A) Eligibility.

(1) Except as specified in paragraph (A)(2) of this rule, in mandatory service areas as permitted by 42 C.F.R. 438.52 (October 1, 2021), an individual must be enrolled in a MyCare Ohio plan (MCOP) if he or she meets all of the following criteria:

(a) Age eighteen or older at the time of enrollment in the MCOP;

(b) Eligible for medicare parts A, B and D, and full benefits under the medicaid program; and

(c) Reside in a plan demonstration county in Ohio. A list of demonstration counties, and the MCOPs available in those counties, is available at http://medicaid.ohio.gov.

(2) Indians who are members of federally recognized tribes may voluntarily choose to enroll in an MCOP.

(3) The following individuals are not eligible for enrollment in an MCOP:

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

(b) Individuals who have other third party creditable health care coverage, except medicare coverage as authorized by 42 U.S.C. 1395 (July 1, 2022);

(c) Individuals who are inmates of public institutions as defined in 42 C.F.R. 435.1010 (October 1, 2021);

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

(e) Individuals with intellectual disabilities who receive services through an intermediate care facility for individuals with intellectual disabilities (ICF-IID).

(4) Individuals are eligible for MCOP enrollment if the Ohio department of medicaid (ODM) has a provider agreement with the MCOP applicable to the eligible individual's county of residence.

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

(B) MyCare Ohio plan enrollment.

(1) The following applies to MCOP enrollment:

(a) The MCOP must accept eligible individuals without regard to race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. The MCOP will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.3(d) (October 1, 2021).

(b) The MCOP must accept eligible individuals who request MCOP membership without restriction.

(c) If an MCOP member loses managed care eligibility and is disenrolled from the MCOP, and subsequently regains eligibility, his or her membership in the same MCOP shall be re-instated back to the date eligibility was regained in accordance with procedures established by ODM.

(d) The MCOP must cover all members designated by ODM in an ODM-produced Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 834 daily or monthly enrollment file of new members, continuing members, and terminating members.

(e) The MCOP shall not be required to provide medicaid coverage to an individual until the individual's membership in the MCOP is confirmed via an ODM-produced HIPAA compliant 834 daily or monthly enrollment file or upon mutual agreement between ODM and the MCOP.

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

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

(i) Eligible individuals residing in the service area who are currently MCOP members are deemed participants in the mandatory program; and

(ii) All other eligible individuals residing in the mandatory service area may request MCOP membership at any time but must select a MCOP following receipt of a notification of mandatory enrollment (NME) issued by ODM.

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

(i) A newly eligible individual who does not make a choice following issuance of a NME by ODM and one additional notice, will be assigned to a MCOP by ODM, the medicaid consumer hotline, or other ODM-approved entity.

(ii) ODM or the medicaid consumer hotline shall assign the individual to a MCOP based on prior medicaid fee-for-service, managed care organization, or MCOP membership history, whenever available, or at the discretion of ODM.

(C) Commencement of coverage.

Coverage of MCOP members will be effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily or monthly enrollment file to the MCOP.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5166.02, 5167.02
Rule Amplifies:	5164.02, 5166.02, 5167.02, 5164.91
Prior Effective Dates:	03/01/2014, 08/01/2016, 01/01/2017, 07/18/2022

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

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

(1) The member becomes ineligible for full benefits under the medicaid program or medicare parts A or B or D. Termination of ~~MCOP~~ MyCare Ohio plan (MCOP) enrollment is effective the end of the last day of the month in which the member became ineligible.

(2) The member's permanent place of residence is moved outside the plan's service area. ~~Termination of~~ MCOP ~~enrollment~~ disenrollment is effective the end of the last day of the month in which the member moved from the service area.

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

(4) The member is found by the Ohio department of medicaid (ODM), or their designee, to meet the criteria for the developmental disabilities (DD) level of care and has a stay in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or is enrolled in a DD waiver. After the MCOP notifies ODM this has occurred, ~~termination of~~ MCOP ~~enrollment~~ disenrollment takes effect on the last day of the month preceding the ICF-IID facility stay or enrollment on the DD waiver.

(5) The member has creditable third party coverage, excepting medicare coverage.~~.~~ ~~Termination of~~ MCOP ~~enrollment~~ disenrollment is effective the end of the last day of the month in which ODM identified the third party coverage. Third party coverage must be reported to the county department of job and family services in accordance with rule 5160:1-2-08 of the Administrative Code.

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

~~(7)~~(6) The member is not eligible for enrollment in an MCOP for one of the reasons set forth in rule 5160-58-02 of the Administrative Code.

(B) ~~All of the following apply when enrollment in a MyCare Ohio plan is terminated for any of the reasons set forth in paragraph (A) of this rule:~~ Individual disenrollments.

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

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

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

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

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

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

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

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

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

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

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

(2) A medicaid-only member may request a different MCOP by contacting the Ohio medicaid consumer hotline ~~in a mandatory service area~~ as follows:

(a) From the date of initial enrollment through the first three months of plan enrollment, ~~whether the first three months of enrollment are~~

~~benefits or~~ for medicaid-only enrollment periods;

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

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph ~~(C)(4)(e)~~ (C)(3)(e) of this rule.

~~(3) A medicaid-only member may request a different MCOP if available as follows:~~

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

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

~~(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.~~

~~(4)~~(3) The following provisions apply when a member requests a different MCOP in a mandatory service area. Changes to the medicare coverage are made through medicare enrollment pathways (i.e. medicare.gov website, medicare call center, Ohio senior health insurance information program, licensed enrollment broker) and changes to medicaid-only enrollment are made through the Ohio medicaid consumer hotline:

(a) The request may be made by the member, or by the member's authorized representative. The request may not be made by a facility in accordance with 42 CFR 483 Subpart G (October 1, 2025).

(b) All member-initiated changes must be voluntary. MCOPs are not permitted to encourage members to change enrollment due to a member’s race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services. MCOPs may not use a policy or practice that has the effect of discrimination on the basis of the listed criteria.

(c) If a member requests disenrollment because he or she meets any of the requirements in rule 5160-58-02 of the Administrative Code, the member ~~will be~~ is disenrolled after the member notifies the consumer

hotline.

(d) Disenrollment ~~will take~~takes effect on the last day of the calendar month as specified by an ODM-produced HIPAA compliant 834 daily or monthly file sent to the plan.

(e) In accordance with 42 ~~C.F.R.~~CFR 438.56 (~~October 1, 2021~~ October 1, 2025), a change of MCOP enrollment may be permitted for any of the following just cause reasons:

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

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

(iii) The member needs related services to be performed at the same time in a coordinated manner; however, not all related services are available within the MCOP network, and the member's primary care provider (PCP) or another provider determines that receiving services separately would subject the member to unnecessary risk;

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

(v) The member receiving long-term services and supports would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to and out-of-network provider with the MCOP and, as a result, would experience a disruption in their residence or employment;

(vi) The member cannot access medically necessary medicaid-covered services, under rule 5160-58-03.1 of the Administrative Code, or cannot access the type of providers experienced in dealing with the member's health care needs;

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

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

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

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

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

(iv) ODM may establish retroactive ~~termination~~ disenrollment dates and/or recover premium payments as determined necessary and appropriate.

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

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

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

~~(viii) If a member submits a request to change enrollment for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall assure that the member's MCOP enrollment is not automatically renewed if eligibility for medicaid~~

~~is reauthorized.~~

(g) A member who is in a medicare Part D drug management program and is in a potentially at-risk or at-risk status as defined in 42 ~~C.F.R.~~CFR 423.100 (~~October 1, 2021~~October 1, 2025) is precluded from changing MCOPs.

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

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

(a) Fraudulent behavior by the member as defined in rule 5160-26-01 of the Administrative Code; or

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

(2) The MCOP may not request ~~termination~~ disenrollment due to a member's race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran's status, military status, genetic information, ancestry, ethnicity, mental ability, behavior, mental or physical disability, use of services, claims experience, appeals, medical history, evidence of insurability, geographic location within the service area, health status or need for health services.

(3) The MCOP ~~must provide~~provides covered services to a ~~terminated~~ disenrolled member through the last day of the month in which the MCOP enrollment ~~is terminated~~ ends.

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

(E) Open enrollment

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

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

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

5160-58-02.2 **MyCare Ohio waiver: eligibility and enrollment.**

(A) To be eligible for enrollment in the MyCare Ohio waiver, a member ~~must meet~~ meets all of the following requirements:

(1) ~~Be~~ Is enrolled in the MyCare Ohio ~~demonstration~~ program at the time of application for the MyCare Ohio waiver;

(2) ~~Be~~ Is determined to have a nursing facility-based level of care (i.e., intermediate or skilled) in accordance with rule 5160-3-08 ~~or 5160-3-09~~ of the Administrative Code;

(3) In the absence of the MyCare Ohio waiver, require hospitalization or institutionalization in a nursing facility to meet his or her needs;

(4) The member:

(a) Has a need for and agrees to receive at least one waiver service monthly that is otherwise unavailable through another source (including, but not limited to: private pay, community resources, and the medicaid state plan services) in an amount sufficient to meet the individual's assessed need; or

(b) Has a need for:

(i) Continuous nursing services more than four hours in length,

(ii) At least one waiver service annually, and

(iii) Monthly monitoring of the individual's health and welfare through a combination of telephonic and in-person contacts with the waiver service coordinator and agrees to cooperate with the monthly monitoring.

(5) ~~Reside~~Resides, or is able and agrees to reside, in a setting that possesses the home and community-based setting characteristics set forth in rule 5160-44-01 of the Administrative Code, and is not a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (~~October 1, 2020~~ January 1, 2026), residential care facility (except an assisted living facility as described in rule 173-39-02.16 of the Administrative Code), adult foster home or another group living arrangement subject to state licensure or

certification; and

~~(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. If the individual is unable to sign the agreement prior to waiver enrollment, the individual will submit an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the case manager; and~~

~~(7)~~(6) ~~Be~~ Is able to have waiver services that can be identified in a person-centered ~~services~~ care plan as described in rule 5160-44-02 of the Administrative Code that ~~will~~ safely ~~meet~~meets his or her assessed needs.

(B) To be enrolled, and maintain enrollment in the MyCare Ohio waiver, a member ~~must~~ should 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 ensured through the waiver as determined by the Ohio department of medicaid (ODM) or its designee;

(3) Participate in the development and implementation of an integrated, ~~individualized~~ individualized care plan ~~that includes a person-centered services plan~~ that includes a person-centered services plan, and waiver services plan, in accordance with the process and requirements set forth in rule 5160-44-02 of the Administrative Code, and sign and date the plan as a condition of its acceptance. If the individual is unable to sign the plan when initially developed, the individual ~~will submit~~ submits an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the ~~case manager~~ waiver services coordinator;

(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.~~waiver; and

(6) Sign an agreement prior to waiver enrollment confirming that the member was

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 services. If the individual is unable to sign the agreement prior to waiver enrollment, the individual submits an electronic signature and standard signature via regular mail, or otherwise provides a signature, in no instance any later than at the next face-to-face visit with the waiver services coordinator.

(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~~ is denied enrollment on the MyCare Ohio waiver.

(D) Once enrolled in the MyCare Ohio waiver, a member's level of care ~~shall be~~ is reassessed at least annually, and more frequently if there is a significant change in the member's situation that ~~may impact~~ impacts his or her health and welfare, including when the member is admitted to a hospital for inpatient services. If the reassessment determines the member no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, he or she ~~shall be~~ is disenrolled from the MyCare Ohio waiver.

(E) If a member enrolled in the MyCare Ohio waiver who requires monthly waiver service 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~~reassesses the member's need for waiver services. If it is determined the member no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, he or she ~~shall be~~ is disenrolled from the MyCare Ohio waiver.

(F) If, at any other time, it is determined that a member enrolled in the MyCare Ohio waiver no longer meets the requirements set forth in paragraph (A) or paragraph (B) of this rule, or fails to meet the member responsibilities set forth in rule 5160-58-03.2 of the Administrative Code, he or she ~~shall be~~ is 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, the member ~~will be~~ is afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

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

(A) A MyCare Ohio plan (MCOP) ~~must ensure~~ensures members have access to all medically-necessary medical, ~~drug~~medicaid-covered over the counter drugs, behavioral health, nursing facility and home and community-based services (HCBS) covered by Ohio medicaid. Prescription drug coverage for members is provided under the medicare part d program. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the MCOP ~~must ensure~~ensures:

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

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

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

(4) Medicaid coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code; and practice guidelines specified in ~~rule~~rules 5160-58-03.1 and 5160-26-05.1 of the Administrative Code; and

(5) ~~)~~ If a member is unable to obtain medically-necessary medicaid services from an MCOP network provider, the MCOP ~~must~~ adequately and timely ~~cover~~covers the services out of network until the MCOP is able to provide the services from a network provider.

(B) The MCOP may place appropriate limits on a service;

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

(2) Except as otherwise specified in this rule, to available network providers; or

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

(C) Services covered by an MCOP.

(1) The MCOP ~~must cover~~covers annual physical examinations for adults.

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

(3) The MCOP ~~must ensure~~ensures 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~~ are provided and reimbursed in accordance with the following:

(a) The MCOP may not deny payment for treatment obtained when a member had an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.

(b) The MCOP cannot limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

(c) The MCOP ~~must cover~~covers all emergency services without requiring prior authorization.

(d) The MCOP ~~must cover~~covers 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 MCOP including but not limited to the member's primary care provider (PCP) or the MCOP's twenty-four-hour toll-free call-in-system.

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

(f) The MCOP ~~must cover~~covers 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~~ are reimbursed by the MCOP at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of

graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the MCOP ~~is required to reimburse~~reimburses at this rate only until the member can be transferred to a provider designated by the MCOP. Pursuant to section 5167.10 of the Revised Code, the MCOP may not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by the Ohio department of medicaid (ODM).

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

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

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

(4) The MCOP ~~must establish~~establishes, 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. These written policies and procedures ~~must be~~ are made available to non-contracting providers, including non-contracting providers of emergency services, on request. The MCOP may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

(5) The MCOP ~~must ensure~~ensures 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.

(a) The MCOP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line ~~must be~~ is available twenty-four hours a day, seven days a week. The MCOP ~~must document~~documents the telephone number and process for obtaining authorization ~~has been~~ was provided to each emergency facility in the service area. The MCOP ~~must maintain~~maintains a record of any

request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the MCOP communicated the decision in writing to the provider.

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

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

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

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

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

(b) The provider ~~has~~ documented an attempt to contact the MCOP to request authorization, but the MCOP cannot be contacted.

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

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

(i) A network provider with privileges at the treating hospital assumes

responsibility for the member's care;

(ii) A network provider assumes responsibility for the member's care after the member is transferred to another facility;

(iii) An MCOP representative and the treating provider reach an agreement concerning the member's care; or

(iv) The member is discharged.

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

(7) The MCOP ~~must permit~~permits members to self-refer to any women's health specialist within the MCOP's network for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated primary care provider (PCP) if that PCP is not a women's health specialist.

(8) The MCOP ~~must ensure~~ensures access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).

(9) Where available, the MCOP ~~must ensure~~ensures access to covered services provided by a certified nurse practitioner.

~~(10) The MCOP must ensure that all eligible members receive all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with rule 5160-1-14 of the Administrative Code. The MCOP will ensure healthchek exams:~~

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

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

~~(11)~~(10) Pharmacy services ~~will be~~ are covered in accordance with rule 5160-9-03 of the Administrative Code and are limited to items in paragraph (A)(2) of this rule. All other prescription drugs are covered by medicare part D.

(D) MCOP service exclusions.

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

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

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

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

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

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

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

(b) Persistent symptoms ~~will be~~ are treated no later than the end of the following working day after their initial contact with the PCP site; and

(c) Requests for routine care ~~will be~~ seen within ~~six weeks~~ thirty business days.

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

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

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

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

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

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

(B) The MCOP ~~will have~~ operates a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. The MCOP ~~will ensure~~ensures decisions rendered through the UM program are based on medical necessity.

(1) The UM program, based on written policies and procedures, ~~will include~~includes, at a minimum:

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

necessity;

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

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

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

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

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

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

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

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

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

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

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

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

(h) Compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K (~~October 1, 2021~~October 1, 2025).

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

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

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

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

(d) That a written notice ~~will be~~ is sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member has to meet the requirements of division 5101:6 and rule ~~5160-26-08.4~~ 5160-58-08.4 of the Administrative Code.

(e) For standard authorization decisions, the MCOP ~~will provide~~provides notice to the provider and member as expeditiously as the member's health condition requires but no later than ~~ten~~ seven calendar days following receipt of the request for service. If requested by the member, provider, or MCOP, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCOP, the MCOP ~~has to submit~~submits to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCOP's extension request, the MCOP ~~will give~~gives the member written notice of the reason for the decision to

extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCOP ~~will carry~~ carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

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

(g) For prior authorization of covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (~~as in effect July 1, 2022~~January 1, 2026), the MCOP has to make a decision within the timeframes specified in 42 ~~C.F.R.~~CFR 423.568(b) (~~October 1, 2021~~October 1, 2025) for standard decisions and 42 ~~C.F.R.~~CFR 423.572(a) (~~October 1, 2021~~October 1, 2025) for expedited decisions. If the prior authorization request is for an emergency situation, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized while the MCOP reviews the prior authorization request.

(h) The MCOP ~~will maintain~~maintains and ~~submit~~submits as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. The MCOP's records ~~will include~~includes member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

(4) Turnaround times for authorization decisions in paragraph (B)(3) of this rule

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

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

5160-58-03.2 **MyCare Ohio waiver: member choice, control, responsibilities and ~~participant~~ self-direction.**

(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 pursuant to paragraph (B) of rule 5160-58-04 of the Administrative Code.

(B) A member receiving waiver services from any MyCare Ohio waiver provider ~~will~~:

(1) ~~Participate~~Participates with the waiver service coordinator in the development of the person-centered services plan as defined in rule 5160-44-02 of the Administrative Code.

(2) ~~Decide~~Decides who from their ~~trans-disciplinary~~ interdisciplinary care management team ~~will participate~~participates in the development of the person-centered services plan.

(3) ~~Communicate~~Communicates to the service provider and, as appropriate, the provider's management staff, personal preferences about the way duties, tasks and procedures are to be performed.

(4) ~~Work~~Works collaboratively 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 to meet the member's specific needs.

(5) ~~Not~~ Does not direct the provider to act in a manner that is contrary to any relevant MyCare Ohio waiver requirements, medicaid rules and regulations, or the provider's policies and procedures.

(6) ~~Understand~~Understands and adheres to the incident management and reporting responsibilities of the member as set forth in rule 5160-44-05 of the Administrative Code.

(7) ~~Communicate~~Communicates to the waiver service coordinator ~~and/or~~ and MyCare Ohio plan care manager any significant changes, as applicable, as defined in rule 5160-58-01 of the Administrative Code, that may affect service provision or result in a need for more or fewer hours of service.

(8) ~~Sign~~Signs a complete and accurate timesheet or other documentation, as appropriate, to verify services have been furnished. The member ~~will never~~ may not approve blank timesheets, or timesheets that ~~have been~~ were

completed before services ~~have been~~ were furnished. Verification may be written or electronic at the discretion of the MyCare Ohio plan, unless otherwise required by rule 5160-1-40 of the Administrative Code. If the individual is unable to provide the signature required to verify a service at the time of the service, the individual ~~will submit~~submits an electronic signature or standard signature via regular mail, or otherwise ~~provide~~provides a signature in no instance any later than at the next face-to-face visit with the provider.

(9) ~~Participate~~Participates in the recruitment, selection and dismissal of providers in collaboration with the ~~trans-disciplinary~~ interdisciplinary care management team.

(10) ~~In the manner specified by the waiver service coordinator, notify~~ Notifies the provider if the member is going to miss a scheduled visit in the manner specified by the waiver services coordinator.

(11) ~~Notify~~ Notifies the waiver service coordinator if the assigned provider misses a scheduled visit.

(12) ~~Notify~~ Notifies the waiver service coordinator when any change in provider is necessary. Notification ~~will include~~includes the desired end date of the current provider.

(13) ~~Participate~~Participates in the monitoring of the performance of the provider.

(14) ~~Understand~~Understands and ~~abide~~abides by the rules governing the MyCare Ohio program.

(C) Members who choose to exercise ~~participant-direction~~ self-direction for their waiver services, as outlined in paragraph (F) of rule 5160-58-04 of the Administrative Code ~~will~~ have the following additional requirements as appropriate to the service being furnished:

(1) ~~Take~~ Taking a proactive role in the delivery of their MyCare Ohio waiver services. This includes identifying and recruiting prospective providers, training on tasks to meet the member's needs and preferences, and scheduling and managing the delivery of services.

(2) ~~Designate~~ Designating a location in their home in which the member and, as appropriate, 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) ~~Work~~ Working with ODM's designated financial management service and the waiver service coordinator ~~and/or~~ and MyCare Ohio care ~~manager~~ , as applicable, to coordinate the authorized service delivery.

(D) Members who elect ~~participant-directed~~ self-directed services ~~will~~ demonstrate the ability and willingness to:

(1) Understand the service elements the provider furnishes;

(2) Understand how to direct the provider; and

(3) Perform employer-related responsibilities, including:

(a) Completing required training;

(b) ~~Select~~Selecting and ~~dismiss~~dismissing ~~participant-directed~~ self-directed service providers;

(c) ~~Enter~~Entering into written agreements with ~~participant-directed~~ self-directed service providers for specific activities;

(d) ~~Train~~Training ~~participant-directed~~ self-directed service providers to meet the member's specific needs;

(e) ~~Supervise~~ Supervising and ~~monitor~~ monitoring the ~~participant-directed~~ self-directed service provider's performance of specific activities, including written approval of the provider's time sheets;

(f) ~~Manage~~ Managing the ~~participant-directed~~ self-directed service provider when they furnish a service.

(E) If the waiver service coordinator, in consultation with the ~~trans-disciplinary~~ interdisciplinary care management team, determines that the member ~~and/~~or the member's authorized representative cannot meet the requirements set forth in paragraph (C) or (D) of this rule, or the health and welfare of the member cannot be ensured, the waiver service coordinator may require the member to receive services from agency or non-agency providers. The member ~~will be~~ is afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

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

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

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

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

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

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

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

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

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

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

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

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

of the Administrative Code;

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

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

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

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

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

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

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

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

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

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

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

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

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

Administrative Code;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Alternative meals;

(b) Choices home care attendant services;

(c) Home care attendant services;

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

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

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

(g) Self-directed goods and services;

(h) Waiver nursing; and

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

5160-58-05 **MyCare Ohio: care coordination.**

(A) Member care coordination.

(1) All MyCare Ohio members are assigned a care coordinator to assist with management of their care and navigation of services. MyCare Ohio members who are not receiving long-term care services through the MyCare Ohio waiver or in a nursing facility may choose not to participate in care coordination.

(a) Care coordinator outreach frequency may vary based on a member's needs.

(b) Members may request a change in care coordinator through their MyCare Ohio plan (MCOP).

(2) MyCare Ohio members are assured of access to medical advice, behavioral health crisis, and care management support through a centralized, toll-free telephonic system.

(a) Calls are answered by or forwarded to members' care coordinators or other team members designated to act on behalf of the care coordinator.

(b) The MyCare Ohio plan (MCOP) ensures the care coordinator or designee can access to the member's person-centered care plan, ensures the member's health welfare, and safety is considered when determining resolution and completion in address of the member's needs or concerns, including in-person support, if warranted.

(3) MyCare Ohio members are assigned a waiver services coordinator if enrolled in the MyCare Ohio home and community-based services waiver in accordance with rule 5160-58-04 of the Administrative Code. In some situations, the care coordinator and waiver services coordinator may be the same person.

(B) Interdisciplinary care team.

(1) The interdisciplinary team works together to achieve common health care goals with the member.

(2) The interdisciplinary team creates comprehensive treatment plans that consider all aspects of the member's medical, social, and behavioral needs and preferences.

(3) The care coordinator may be part of a member's interdisciplinary care team for the purpose of providing support with care coordination activities and assisting the member with navigation of the healthcare system.

(C) MyCare Ohio plan.

(1) The MCOP may choose to delegate all or some care coordination activities to the area agency on aging (AAA) for all members, or to another entity for members under the age of sixty years. If a member selects or requests a change in their waiver services coordination entity, or if the MCOP of the Ohio department of medicaid (ODM) identifies a performance issue affecting the member's health, safety, or welfare, the MCOP then assists by linking the member with another waiver service coordination entity or performs the function themselves, if the member so chooses.

(2) For waiver services coordination the MCOP:

(a) Contracts with the area agency on aging (AAA). The AAA acts as the primary waiver service coordination entity for members aged sixty years and older who are also enrolled in the MyCare Ohio HCBS program;

(b) May contract with the AAA for members under the age of sixty years who are enrolled in the MyCare Ohio HCBS program or with other entities which have experience working with people who have disabilities; or

(c) May contract with another care coordination entity if the member requests that care coordination activities are not provided by the AAA.

(d) MCOPs are responsible for ensuring that members' waiver services meet members' needs through delegation oversight activities regardless of the delegation model.

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

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

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

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

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

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

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

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

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

(3) An MCOP reviews and resolves all grievances as expeditiously as the member's health condition requires. Grievance resolutions, including member notification, meet the following time frames:

(a) Within two business days of receipt if the grievance is regarding access to services.

(b) Within thirty calendar days of receipt for all other grievances that are not regarding access to services.

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

grievance resolution. If an MCOP is unable to speak directly with the member, or the resolution includes information that needs confirmed in writing, the resolution is provided in writing simultaneously with the MCOP's resolution.

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

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

(1) The NOA explains:

(a) The adverse benefit determination the MCOP has taken or intends to take;

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

(c) The member's right to file an appeal to the MCOP;

(d) Information related to exhausting the MCOP appeal;

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

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

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

(h) If applicable, the member's right to have benefits continue, pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of those services; and

(i) The date the notice is issued.

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

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

member;

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

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

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

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

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

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

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

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

(ii) Under the circumstances set forth in 42 CFR 431.213 (October 1, 2025), the MCOP gives notice on or before the effective date of the adverse benefit determination.

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

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

Administrative Code constitute a denial and is thus considered to be an adverse benefit determination. Notice is given on the date the authorization decision time frame expires.

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

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

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

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

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

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

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

(2) Any provider acting on the member's behalf will provide the member's written consent to file an appeal. MCOPs will begin processing the appeal upon receipt of the written consent.

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

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

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

(6) An MCOP reviews and resolves each appeal as expeditiously as the member's health condition requires, but the resolution time frame may not exceed fifteen calendar days from the receipt of the appeal unless the resolution time frame is extended .

(7) An MCOP provides written notice of the appeal's resolution to the member, and to the member's authorized representative if applicable. At a minimum, the written notice includes the resolution decision and date of the resolution.

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

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

(b) How to request a state hearing; and if applicable:

(i) The right to continue to receive benefits pending a state hearing; and

(ii) How to request the continuation of benefits.

(c) Oral interpretation is available for any language;

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

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

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

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

(a) Authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date, if the services were not furnished while the appeal was pending.

(b) Pays for the disputed services if the member received the services while the appeal was pending.

(E) Expedited appeals to an MCOP.

(1) An MCOP establishes and maintains an expedited review process to resolve appeals when the member requests and the MCOP determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could

seriously jeopardize the member's life, physical or mental or health or ability to attain, maintain, or regain maximum function.

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

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

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

(c) Informs the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;

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

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

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

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

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

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

(F) Grievance and appeal resolution extensions.

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

(2) An MCOP may request that the time frame to resolve a grievance, standard

appeal, or expedited appeal be extended up to fourteen calendar days. The following requirements apply:

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

(b) The MCOP request is supported by documentation of the need for additional information and that the extension is in the member's best interest; and

(c) If ODM approves the extension, the MCOP immediately gives the member written notice of the extension, and includes the following components in the notice:

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

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

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

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

(G) Access to state's hearing system.

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

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

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

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

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

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

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

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

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

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

(c) If benefits were continued through the appeal process then the MCOP, continues or reinstates the benefit(s) if the MCOP is notified the member's state hearing request was received within fifteen calendar days from the date of the appeal resolution.

(6) An MCOP participates in the state hearing, in person or by telephone, on the date indicated on the "Notice to Appear for a Scheduled Hearing" (JFS 04002) sent to the MCOP by the bureau of state hearings.

(7) An MCOP complies with the state hearing decision provided to the MCOP via the "State Hearing Decision" (JFS 04005). If the state hearing decision sustains the member's appeal, the MCOP submits the information required by the "Order of Compliance" (JFS 04068) to the bureau of state hearings. The information, including applicable supporting documentation, is due to the bureau of state hearings, and the designated ODM contact by no later than the compliance date specified in the hearing decision. If applicable, the MCOP:

(a) Authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the date it receives notice reversing the adverse benefit determination if services were not furnished while the appeal was pending.

(b) Pays for the disputed services if the member received the services while the appeal was pending.

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

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

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

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

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

(d) The authorization period has not expired.

(2) If an MCOP continues or reinstates the member's benefits while the appeal or state hearing are pending, the benefits are continued until one of the following occurs:

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

(b) The member fails to request a state hearing within fifteen calendar days after the MCOP issues an adverse appeal resolution; or

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

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

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

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

(a) Explaining the MCOP's process to be followed in resolving the member's appeal or grievance;

(b) Completing forms and taking other procedural steps as outlined in this rule; and

(c) Providing oral interpretation and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) An MCOP ensures the individuals who make decisions on appeals and grievances are individuals who:

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

(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease, if deciding any of the following:

(i) An appeal of a denial based on lack of medical necessity;

(ii) A grievance regarding the denial of an expedited resolution of an appeal; or

(iii) An appeal or grievance involving clinical issues.

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

TO BE RESCINDED

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

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

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

(2) The NOA shall explain:

(a) The adverse benefit determination the MCOP has taken or intends to take;

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

(c) The member's right to file an appeal to the MCOP;

(d) Information related to exhausting the MCOP appeal;

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

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

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

(h) If applicable, the member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of those services;

(i) The date the notice is issued;

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

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

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

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

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

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

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

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

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

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

(ii) Under the circumstances set forth in 42 CFR 431.213 (October 1, 2022), the MCOP shall give notice on or before the effective date of the adverse benefit determination.

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

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

an adverse benefit determination. Notice shall be given on the date the authorization decision time frame expires.

(B) Grievances to an MCOP.

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

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

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

(a) Within two business days of receipt if the grievance is regarding access to services.

(b) Within thirty calendar days of receipt for all other grievances that are not regarding access to services.

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

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

(C) Standard appeal to an MCOP.

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

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

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

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

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

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

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

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

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

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

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

(b) How to request a state hearing; and if applicable:

(i) The right to continue to receive benefits pending a state hearing; and

(ii) How to request the continuation of benefits.

(c) Oral interpretation is available for any language;

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

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

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

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

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the appeal resolution date, if the services were not furnished while the appeal was pending.

(b) Pay for the disputed services if the member received the services while the appeal was pending.

(D) Expedited appeals to an MCOP.

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

(2) In utilizing an expedited appeal process, an MCOP shall comply with the standard appeal process specified in paragraph (C) of this rule, except the MCOP shall:

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

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

(c) Inform the member of the limited time available for the member to present evidence and allegations of fact or law in person or in writing;

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

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

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

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

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

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

(E) Grievance and appeal resolution extensions.

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

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

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

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

(c) If ODM approves the extension, the MCOP shall immediately give the member written notice of the extension, and include the following components in the notice:

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

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

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

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

(F) Access to state's hearing system.

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

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

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

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

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

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

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

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

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

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

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

(6) An MCOP shall participate in the state hearing, in person or by telephone, on the date indicated on the "Notice to Appear for a Scheduled Hearing" (JFS 04002) sent to the MCOP by the bureau of state hearings.

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

(a) Authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two hours from the date it receives notice reversing the adverse benefit determination if services were not furnished while the appeal was pending.

(b) Pay for the disputed services if the member received the services while the appeal was pending.

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

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

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

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

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

(d) The authorization period has not expired.

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

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

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

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

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

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

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

(a) Explaining the MCOP's process to be followed in resolving the member's appeal or grievance;

(b) Completing forms and taking other procedural steps as outlined in this rule; and

(c) Providing oral interpretation and oral translation services, sign language assistance, and access to the grievance system through a toll-free number with text telephone yoke (TTY) and interpreter capability.

(2) An MCOP shall ensure the individuals who make decisions on appeals and grievances are individuals who:

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

(b) Are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease, if deciding any of the following:

(i) An appeal of a denial based on lack of medical necessity;

(ii) A grievance regarding the denial of an expedited resolution of an appeal; or

(iii) An appeal or grievance involving clinical issues.

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

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

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