Ohio Administrative Code

Rule 5160-26-02.1 Managed care: termination of enrollment.

Effective: January 1, 2023

(A) This rule does not apply to MyCare Ohio plans as defined in rule 5160-58-01 of the Administrative Code or the Ohio resilience through integrated systems and excellence (OhioRISE) plan as defined in rule 5160-59-01 of the Administrative Code.

(B) The Ohio department of medicaid (ODM) will terminate a member from enrollment in a managed care organization (MCO) for any of the following reasons:

(1) The member's permanent place of residence is moved outside the MCO service area. When this occurs, termination of MCO enrollment takes effect on the last day of the month in which the member moved from the service area.

(2) The member becomes ineligible for medicaid. When this occurs, termination of MCO enrollment takes effect on the last day of the month in which the member became ineligible.

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

(4) The member is not receiving medicaid in the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (July 1, 2022), is authorized for nursing facility services, and the following criteria are met:

(a) The MCO has authorized nursing facility services for no less than the month of nursing facility admission and for two complete consecutive calendar months thereafter;

(b) For the entire period in paragraph (B)(4)(a) of this rule, the member has remained in the nursing facility without any admission to an inpatient hospital or long-term acute care facility;

(c) The member's discharge plan documents that nursing facility discharge is not expected in the foreseeable future and the member has a need for long-term nursing facility care;

(d) For the entire period in paragraph (B)(4)(a) of this rule, the member is not using hospice services; and

(e) The MCO has requested disenrollment, and ODM has approved the request.

(f) The member is found by ODM to meet the criteria for the developmental disabilities level of care as specified in rule 5123-8-01 of the Administrative Code and resides in an intermediate care facility for individuals with intellectual disabilities (ICF-IID). Following MCO notification to ODM and written approval by ODM, termination of MCO membership takes effect on the last day of the month preceding the individual's stay in the ICF-IID.

(5) The member has third party coverage, and ODM determines that continuing MCO enrollment may not be in the best interest of the member. This determination may be based on the type of coverage the member has, the existence of conflicts between provider networks, or access requirements. When this occurs, the effective date of termination of MCO enrollment shall be determined by ODM but in no event shall the termination date be later than the last day of the month in which ODM approves the termination.

(6) The member is not eligible for MCO enrollment for one of the reasons set forth in rule 5160-26-02 of the Administrative Code.

(7) The provider agreement between ODM and the MCO is terminated.

(C) Upon implementation of the single pharmacy benefit manager (SPBM), ODM will terminate a member from enrollment in the SPBM when a member is terminated from enrollment in an MCO as specified in paragraph (B) of this rule or if the contract between ODM and the SPBM is terminated.

(D) All of the following apply when enrollment in an MCO or the SPBM is terminated for any of the reasons set forth in paragraph (B) or (C) of this rule:

(1) Such terminations may occur either in a mandatory or voluntary service area.

(2) All such terminations occur at the individual level.

(3) Such terminations do not require completion of a consumer contact record (CCR).

(4) If ODM fails to notify the MCO or the SPBM of a member's termination from an MCO or the SPBM, ODM shall continue to pay the MCO or the SPBM the applicable monthly capitation rate for the member. The MCO or the SPBM shall remain liable for the provision of covered services as set forth in rule 5160-26-03 of the Administrative Code, until such time as ODM provides the MCO or the SPBM with documentation of the member's termination.

(5) ODM shall recover from the MCO or the SPBM any capitation paid for retroactive enrollment termination occurring as a result of paragraph (B) or (C) of this rule.

(6) A member may lose medicaid eligibility during an annual open enrollment period, and thus become unable to change to a different MCO. If the member then regains medicaid eligibility, the member may request to change plans within thirty days following reenrollment in the MCO.

(E) Member-initiated MCO terminations.

(1) An MCO member who qualifies as a mandatory managed care enrollment population as specified in rule 5160-26-02 of the Administrative Code may request a different MCO as follows:

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

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

(c) At any time, if the member is a child receiving Title IV-E federal foster care maintenance or is in foster care or other out of home placement. The change must be initiated by the local public children's services agency (PCSA) or the local Title IV-E juvenile court; or

(d) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (E)(3)(f) of this rule;

(2) An MCO member who qualifies as a voluntary managed care enrollment population as specified in rule 5160-26-02 of the Administrative Code may request a different MCO, if available, or be returned to medicaid fee-for-service (FFS) as follows:

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

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

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (E)(3)(f) of this rule;

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

(a) The request may be made by the member, or by the member's authorized representative.

(b) All member-initiated changes or terminations must be voluntary. The MCO is not permitted to encourage members to change or terminate enrollment due to a member's age, gender, gender identity, sexual orientation, disability, national origin, race, color, religion, military status, ancestry, genetic information, health status or need for health services. The MCO may not use a policy or practice that has the effect of discrimination on the basis of the criteria listed in this rule.

(c) If a member requests disenrollment because he or she meets the requirements of paragraph (B)(3) of rule 5160-26-02 of the Administrative Code, the member will be disenrolled after the member notifies the Ohio medicaid consumer hotline.

(d) Disenrollment will take effect on the last day of the calendar month in which the request for disenrollment was made.

(e) In accordance with 42 C.F.R. 438.56(d)(2) (October 1, 2021), a change or termination of MCO enrollment may be permitted for any of the following just cause reasons:

(i) The member moves out of the MCO's service area and a non-emergency service must be provided out of the service area before the effective date of the member's termination as described in paragraph (B)(1) of this rule;

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

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

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

(v) The member cannot access medically necessary medicaid-covered services or cannot access the type of providers experienced in dealing with the member's health care needs;

(vi) The PCP selected by a member leaves the MCO's network and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCO in the member's service area; and

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

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

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

(ii) ODM shall review all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the member and the MCO. ODM shall make a decision within forty-five days from the date ODM receives the just cause request. If ODM fails to

make the determination within this timeframe, the just cause request is considered approved.

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

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

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

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

(vii) If a member submits a request to change or terminate enrollment for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall ensure that the member's MCO enrollment is not automatically renewed if eligibility for medicaid is reauthorized.

(F) MCO initiated terminations.

(1) The MCO may submit a request to ODM for the termination of a member for the following reasons:

(a) Fraudulent behavior by the member; or

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

(2) The MCO may not request termination due to the member's age, gender, gender identity, sexual orientation, disability, national origin, race, color, religion, military status, genetic information, ancestry, health status or need for health services.

(3) The MCO must provide medicaid-covered services to a terminated member through the last day of the month in which the MCO enrollment is terminated, notwithstanding the date of ODM written approval of the termination request. Inpatient facility services must be provided in accordance with rule 5160-26-02 of the Administrative Code.

(4) If ODM approves the MCO's request for termination, ODM shall notify in writing the member, the authorized representative, the Ohio medicaid consumer hotline, and the MCO.

(G) MCO open enrollment.

(1) Open enrollment months will occur at least annually.

(2) At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals by mail of the opportunity to change or terminate MCO enrollment and will explain where to obtain further information.