Ohio Administrative Code

Rule 5160-58-02.1 MyCare Ohio plans: termination of enrollment.

Effective: January 1, 2023

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

(1) The member becomes ineligible for full medicaid or medicare parts A or B or D. Termination of 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 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 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 third party coverage, excepting medicare coverage.. Termination of MCOP enrollment is effective the end of the last day of the month in which ODM identified the third party coverage.

(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) 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:

(1) All terminations occur at the individual level;

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

(3) If ODM fails to notify the MCOP of a member's termination from the plan, ODM shall continue to pay the MCOP the applicable monthly premium rate for the member. The MCOP shall remain 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.; and

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

(C) Member-initiated terminations.

(1) A dual-benefits member may request disenrollment from the MCOP and transfer between plans on a month-to-month basis any time during the year. MCOP coverage continues until the end of the month of disenrollment.

(2) A medicaid-only member may request a different MCOP 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 dual-benefits or 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) 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) The following provisions apply when a member requests a different MCOP in a mandatory service area:

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

(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 disenrolled after the member notifies the consumer hotline.

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

(e) In accordance with 42 C.F.R. 438.56 (October 1, 2021), 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 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 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 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 a decision within ten working days of receipt of all necessary documentation, or forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.

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

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

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

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

(viii) If a member submits a request to change 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. 423.100 (October 1, 2021) is precluded from changing MCOPs.

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

(1) An MCOP 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 MCOP's ability to provide services to either the member or other MCOP members.

(2) The MCOP may not request termination 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 covered services to a terminated member through the last day of the month in which the MCOP enrollment is terminated.

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

(E) Open enrollment

Open enrollment months will occur at least annually. At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals by mail of the opportunity to change enrollment in an MCOP and will explain how the individual can obtain further information.