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5101:3-26-01      **Managed health care programs: Definitions.**

As used in Chapter 5101:3-26 of the Administrative Code:

- (A) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes consumer practices that result in unnecessary cost to the medicaid program.
- (B) "Advance directive" means written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.
- (C) "Assignment" means the process as described in rule 5101:3-26-02 of the Administrative Code by which the SSE, ODJFS, or other ODJFS-approved entity selects an MCP for eligible individuals in mandatory counties who fail to choose an MCP, or the MCP ~~enrollment~~ membership of eligible individuals in preferred option counties who fail to declare a choice between medicaid fee-for-service or MCP - ~~enrollment~~ membership, or ECMP membership for ECM eligibles who do not decline participation.
- (D) "Assistance group" means a group of consumers receiving benefits together under a specific category of assistance.
- (E) "Automatic renewal" means the process by which an eligible individual automatically terminated from ~~MCP~~ managed care membership has membership in the same MCP or ECMP renewed without the individual having to contact the SSE or ODJFS.
- (F) "Automatic termination" means the process as described in rule 5101:3-26-02.1 of the Administrative Code by which a member's ~~MCP~~ managed care membership is terminated not at the request of the member ~~or the~~ MCP, or EMCP, but for reasons described in ~~paragraph (B)(2) of rule 5101:3-26-02.1 of the Administrative Code~~ that rule.
- (G) "CAP" means corrective action plan.
- ~~(H) "Premium rate" means the monthly payment amount per member for which the managed care plan (MCP) is entitled as compensation for performing its obligations in accordance with Chapter 5101:3-26 of the Administrative Code and/or the provider agreement between ODJFS and the MCP.~~
- ~~(H)~~ (H) "Case" means one or more assistance groups living in the same household.

\*\*\* DRAFT – NOT FOR FILING \*\*\*

- ~~(I)~~(I) "Case management" means activities performed on behalf of members which include services described in paragraph (A)(8) of rule 5101:3-26-03.1 of the Administrative Code or in paragraph (E)(4) of rule 5101:3-26-12 of the Administrative Code.
- ~~(J)~~(J) "CCR" means the consumer contact record. The CCR contains demographic health-related information provided by an eligible individual, ~~MCP~~ managed care member, or ODJFS that is utilized by the SSE to process ~~MCP~~ membership transactions.
- ~~(K)~~(K) "CDJFS" means a county department of job and family services.
- ~~(L)~~(L) "CFR" means the Code of Federal Regulations, as amended, unless otherwise specified.
- ~~(M)~~(M) "CLIA" means the clinical laboratory improvement amendments regulated by the centers ~~of~~ for medicare and medicaid services under 42 CFR part 493, laboratory requirements.
- ~~(N)~~(N) "CMS" means the centers for medicare and medicaid services.
- (O) "Comprehensive managed care program (CMC)" means a managed health care program where ODJFS has entered a provider agreement on a risk basis for the delivery of health care services with an MCP.
- (P) "Coordination of benefits (COB)" means a procedure establishing the order in which health care entities pay their claims. For the purpose of this ~~rule~~ chapter, the MCP is the payer of last resort.
- (Q) "Covered services" means those medical services set forth in rule 5101:3-26-03 of the Administrative Code, ~~or~~ a subset of those medical services or other services set forth in rule 5101:3-26-12 of the Administrative Code.
- (R) "DBA" means doing business as, in accordance with ODI's designation.
- (S) "DEA" means drug enforcement administration.
- (T) "Eligible individual" means any medicaid consumer who is a legal resident of the - ~~MCP's~~ managed care service area and is in ~~a medicaid assistance category~~ one of the categories specified in the MCP's or ECMP's provider agreement with ODJFS.
- (U) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman,

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the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

(V) "Emergency services" means covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition as defined in paragraph (U) of this rule. As used in this chapter, providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCP.

(W) "Enhanced care management plan (ECMP)" means an organization, either a single entity or the representative of a collaborative of organizations, that has entered into a provider agreement with ODJFS in the ECM program to provide, perform, or arrange for the delivery of enhanced care management services as specified in rule 5101:3-26-12 of the Administrative Code.

(X) "Enhanced care management program (ECM)" means a managed health care program where ODJFS has entered a provider agreement for the delivery of case management services with an ECMP.

~~(W)~~(Y) "EQRO" means external quality review organization.

~~(X)~~(Z) "Family planning services" means those services and supplies provided in accordance with rule 5101:3-4-07 of the Administrative Code.

~~(Y)~~(AA) "FQHC (federally qualified health center)" means a health services entity determined by the U.S. secretary of health and human services to be an FQHC or having received a grant under section 329, 330, or 340 of the Public Health Service Act of 1999 as an FQHC and having contracted with ODJFS to provide medicaid-covered services.

~~(Z)~~(BB) "Fraud" means any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to himself, the entity, or some other person. This includes any act that constitutes fraud under applicable federal or state law. Member fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's ~~MCP~~ identification card to obtain services or supplies.

~~(AA)~~(CC) "Healthchek," otherwise known as the early and periodic screening, diagnosis, and treatment (EPSDT) program, is a program of comprehensive preventive health services available to medicaid consumers from birth through twenty years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems.

\*\*\* DRAFT – NOT FOR FILING \*\*\*

~~(BB)~~(DD) "HIC (health insuring corporation)" means a corporation as defined in section 1751.01 of the Revised Code.

~~(CC)~~(EE) "Hospital" means an institution located at a single site which is engaged primarily in providing to inpatients, by or under the supervision of an organized medical staff of physicians licensed under Chapter 4731. of the Revised Code, diagnostic services and therapeutic services for medical diagnosis and treatment or rehabilitation of injured, disabled, or sick persons. "Hospital" does not mean an institution which is operated by the United States government or the Ohio department of mental health.

~~(DD)~~(FF) "Hospital services" means those inpatient and outpatient services that are generally and customarily provided by hospitals.

~~(EE)~~(GG) "Inpatient facility" means an acute or general hospital, rehabilitation facility, or nursing or ICF-MR facility.

~~(FF)~~(HH) "Intermediate care facility for the mentally retarded (ICF-MR)" means a long-term care facility, or part of a facility, for the mentally retarded/developmentally disabled, currently certified by the Ohio department of health as being in compliance with the ICF-MR standards and medicaid conditions of participation.

~~(GG)~~(II) "LEP" means limited-English proficiency.

~~(HH)~~(JJ) "LRP" means limited-reading proficiency.

~~(II)~~(KK) "MCP (managed care plan)" also referred to as plan, means a HIC licensed in the state of Ohio or an alternative qualified entity which enters into a provider agreement with ODJFS [in the comprehensive managed health care program](#) pursuant to rule 5101:3-26-04 of the Administrative Code. For the purpose of this chapter, MCP does not include entities approved to operate as a PACE site, as defined in paragraph (AAA) of this rule [or ECMPs as defined in paragraph \(W\) of this rule](#).

~~(JJ) "MCP member" or "member" means a medicaid consumer who has selected MCP membership or has been assigned to an MCP for the purpose of receiving health care services.~~

~~(KK)~~(LL) "Medicaid" means medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

~~(LL)~~(MM) " "Medically necessary" otherwise known as medical necessity, as used in this chapter is the same as defined in paragraph (A) of rule 5101:3-1-01 of the Administrative Code.

~~(MM)~~(NN) "Medicare" is the federally financed medical assistance program determined under Title XVIII of the Social Security Act.

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

(OO) "Member" means a medicaid consumer who has selected MCP or ECMP membership or has been assigned to an MCP or ECMP for the purpose of receiving health care services.

(PP) "Membership" means selection of or assignment to an MCP or ECMP.

~~(NN)~~(QQ) "MFCU (medicaid fraud control unit)" means a state or federal governmental agency charged with the investigation and prosecution of fraud and related offenses within medicaid.

~~(OO)~~(RR) "MR/DD" means mental retardation or developmental disabilities.

~~(PP)~~(SS) "Nursing facility (NF)" means any long-term care facility (excluding intermediate care facilities for the mentally retarded/developmentally disabled), or part of a facility, currently certified by the Ohio department of health as being in compliance with the nursing facility standards and medicaid conditions of participation.

~~(QQ)~~(TT) "ODA" means the Ohio department of aging.

~~(RR)~~(UU) "ODADAS" means the Ohio department of alcohol and drug addiction services.

~~(SS)~~(VV) "ODI" means the Ohio department of insurance.

~~(TT)~~(WW) "ODJFS" means the Ohio department of job and family services.

~~(UU)~~(XX) "ODJFS approval" means written approval by ODJFS and does not constitute approval by any other state or federal agency.

~~(VV)~~(YY) "ODJFS-approved entity" means any entity other than the CDJFS which is under contract with or designated by ODJFS to perform the functions set forth in rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code.

~~(WW)~~(ZZ) "ODMH" means the Ohio department of mental health.

~~(XX)~~(AAA) "ODMR/DD" means the Ohio department of mental retardation and developmental disabilities.

~~(YY)~~(BBB) "Oral interpretation services" means services provided to LRP consumers to ensure that they receive MCP or ECMP information in a format and manner that is easily understood by those consumers.

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

~~(ZZ)~~(CCC) "Oral translation services" means services provided to LEP consumers to ensure that they receive MCP or ECMP information translated into the primary language of the consumer.

~~(AAA)~~(DDD) "PACE" means the program of all inclusive care for the elderly. The PACE program integrates the provision of acute and long-term care across settings for frail older adults who have been determined to require at least an intermediate level of care as defined in rule 5101:3-3-06 of the Administrative Code.

~~(BBB)~~(EEE) "PCP (primary care physician)" is an individual physician (M.D. or D.O.) or medical group practice contracting with ~~the MCP~~ an MCP or ECMP to provide ~~primary care and case management~~ services to ~~their members~~. members as specified in paragraph (B) of rule 5101:3-26-03.1 or paragraph (F) of rule 5101:3-26-12 of the Administrative Code.

(FFF) "Post-stabilization care services" means covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113 to improve or resolve the member's condition.

(GGG) "Premium" means the monthly payment amount per member to which the MCP or ECMP is entitled as compensation for performing its obligations in accordance with Chapter 5101:3-26 of the Administrative Code and/or the provider agreement with ODJFS.

(HHH) "Protected health information (PHI)" is information received from or on behalf of ODJFS that meets the definition of PHI as defined by the Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated by the United States department of health and human services, specifically 45 CFR 164.501, and any amendments thereto.

~~(CCC)~~(III) "Provider" means a physician or other health care professional or health care facility under employment or contractual arrangement with an MCP or ECMP for the purpose of providing covered services to their members.

(JJJ) "Provider agreement" means a formal agreement between ODJFS and an MCP or ECMP for the provision of services to medicaid consumers under the provider agreement.

~~(DDD)~~(KKK) "Provider panel" also referred to as ~~panel~~ "panel", means an MCP's providers as specified in paragraph (A)(3) of rule 5101:3-26-05 of the Administrative Code.

~~(EEE) "Post stabilization care services" means covered services related to an emergency medical condition that a treating physician views as medically necessary after an~~

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~~emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113 to improve or resolve the member's condition.~~

~~(FFF)~~ ~~"Protected health information (PHI)" is information received from or on behalf of ODJFS that meets the definition of PHI as defined by the Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated by the United States department of health and human services, specifically 45 CFR 164.501, and any amendments thereto.~~

~~(GGG)~~ ~~"Provider agreement" means a formal agreement between ODJFS and an MCP for the provision of medical services to medicaid consumers covered under the provider agreement —~~

~~(HHH)~~ (LLL) "QAPI" means a quality assessment and performance improvement program as described in rule 5101:3-26-07.1 of the Administrative Code.

~~(HH)~~ (MMM) "Qualified family planning provider (QFPP)" means any public or nonprofit health care provider that complies with federal Title X guidelines/standards, and receives either Title X funding or family planning funding from the Ohio department of health.

~~(JJJ)~~ (NNN) "Quality indicators" means measurable variables relating to a specified clinical or health services delivery area which are reviewed over a period of time to monitor the process or outcome of care delivered in that area.

~~(KKK)~~ (OOO) "Risk" or "underwriting risk" means the possibility that an MCP may incur a loss because the cost of providing services may exceed the payments made by ODJFS to the contractor for services covered under the provider agreement.

~~(LLL)~~ (PPP) "Rural health clinic" (RHC) means a clinic as defined in rule 5101:3-16-01 of the Administrative Code which is certified by the ODH as meeting the conditions of certification for rural health clinics under Title XVIII medicare and which has filed an agreement with the United States department of health and human services to provide rural health clinic services under medicare.

~~(MMM)~~ (QQQ) "Selection services entity (SSE)" means an organization or individual under contract with or designated by ODJFS to provide ~~MCP~~ managed care information and selection services to eligible individuals.

~~(NNN)~~ (RRR) "Self referral" is the process by which an MCP member may access certain services without the PCP's and/or MCP's prior approval.

~~(OOO)~~ (SSS) "Service area" is one or more counties specified in the MCP's or ECMP's provider agreement.

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

~~(PPP)~~(TTT) "SFY (state fiscal year)" means the period July first through June thirtieth, corresponding to the state of Ohio's fiscal year.

~~(QQQ)~~(UUU) "State cut-off" means the eighth state working day from the end of a calendar month.

~~(RRR)~~ "~~Subcontract~~" ~~means a written contract between an MCP and a third party or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the MCP's obligations under the provider agreement the MCP has with ODJFS.~~

(VVV) "Subcontract" means a written contract between an MCP or ECMP and a third party, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the provider agreement with ODJFS.

~~(SSS)~~(WWW) "Termination," ~~formerly known as disenrollment,~~ means the process by which an individual's ~~MCP~~ managed care membership is terminated. Terminations may be automatic, member-initiated, or ~~MCP-initiated~~ plan-initiated as described in rule 5101:3-26-02.1 of the Administrative Code.

~~(TTT)~~(XXX) "Third party administrator (TPA)" means any entity utilized in accordance with the provisions of ~~paragraph (A)(3) of rule 5101:3-26-05~~ this chapter of the Administrative Code to manage or administer a portion of services in fulfillment of the ~~MCP's~~ provider agreement with ODJFS.

~~(UUU)~~(YYY) "Third party payor" means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical services furnished under a state plan.

~~(VVV)~~(ZZZ) "Tort action," otherwise known as subrogation, means the right of ODJFS to recover payment received from a third party payor who may be liable for the cost of medical services and care arising out of an injury, disease, or disability to the member.

\*\*\* DRAFT – NOT FOR FILING \*\*\*

5101:3-26-02      **Managed health care programs: Eligibility, MCP membership and automatic renewal of MCP membership.**

(A) For the purpose of this rule authorized representative means an individual eighteen years of age or older who stands in the place of the consumer. The authorized representative may act on behalf of individuals inside or outside of the household in which the authorized representative lives. For the purposes of rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code, the authorized representative ~~maybe~~ may be the primary information person of the household, another member of the same assistance group, a custodial parent, or a person designated by custodial parent.

(B) Eligibility.

(1) For the purpose of this rule an eligible individual is a medicaid consumer who is subject to mandatory MCP membership, mandatory preferred option selection of MCP, ECMP, or medicaid fee-for-service healthcare choice, or may voluntarily select MCP membership based on their county of residence.

(2) Individuals identified as meeting the criteria for ECM are eligible for ECMP membership in the manner prescribed in this rule if ODJFS has a provider agreement with an ECMP in the eligible individual's county of residence.

~~(2)(3) Eligible individuals~~ Individuals are eligible for MCP membership in the manner prescribed in this rule if ODJFS has a provider agreement with an MCP(s) in the eligible individual's county of residence.

~~(3)(4)~~ (4) Nothing in this rule shall be construed to limit or in any way jeopardize an eligible individual's basic medicaid eligibility or eligibility for other non-medical benefits to which he or she may be entitled.

(C) Selection of MCP membership.

(1) An SSE shall assist the eligible individual or authorized representative of any eligible assistance group requesting help in selecting an MCP or other healthcare option.

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

(3) The following applies to membership selection:

(a) MCP membership must occur without regard to an eligible individual's race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services. No

# \*\*\* DRAFT – NOT FOR FILING \*\*\*

policy or procedure that has the effect of discrimination on the basis of race, color, or national origin shall be used.

- (b) MCP membership must occur at the assistance group level. All eligible individuals in the assistance group must be enrolled in the same MCP.
- (c) Eligible individuals or the authorized representative requesting MCP membership may change their choice up to the ninth working day from the end of the month in which the choice is made. Eligible individuals or the authorized representative must be informed of this provision when requesting MCP membership.
- (d) Newborn children whose mothers are MCP members at the time of birth are deemed eligible for medicaid and treated as an MCP member effective on the date of birth:
  - (i) The MCP must utilize the CDJFS-designated written format to inform the CDJFS of a birth to a member.
  - (ii) Within five working days of a birth, or immediately upon learning of the birth, the MCP must provide written notification to the appropriate CDJFS, forward a copy of such notice to the ODJFS, and notify the mother in writing of the need to apply to the CDJFS as soon as possible to have the newborn added to the assistance group to ensure ongoing MCP membership.
  - (iii) If the MCP has not received confirmation by ODJFS of a newborn's MCP membership within ninety days of the date of birth, the MCP must send an additional written notification to the CDJFS, ODJFS, and the mother. If at the end of one hundred twenty days from the date of birth no confirmation has been received, the MCP must again send written notification to the CDJFS, ODJFS, and the mother.
  - (iv) Notwithstanding the addition of the newborn to the assistance group by the CDJFS, the MCP must provide covered services to the newborn through the last day of the month in which the newborn reaches one hundred twenty days of age unless the provisions of paragraph (C) or (D) of rule 5101:3-26-02.1 of the Administrative Code apply.
- (e) In the case of newborns added by the CDJFS to the assistance group of a mother who is an MCP member ODJFS will provide retrospective premium back to the first day of the month of the child's birth provided that:
  - (i) The MCP has notified the CDJFS, ODJFS and the mother as described in paragraphs (C)(3)(d)(i) to (C)(3)(d)(iii) of this rule; and

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

- (ii) ODJFS has not paid claims under fee-for-service for the newborn. In the event that fee-for-service claims have been paid, the newborn will be covered under medicaid fee-for-service for the month(s) in question.
  - (f) In the case of newborns as described in paragraph (C)(3)(d)(iv) of this rule, ODJFS will provide premium payments to the MCP up to the end of the month in which the newborn reaches one hundred twenty days of age.
  - (g) Newborns or other eligible individuals who are automatically added to the assistance group after the assistance group's initial MCP membership effective date will be enrolled in the same MCP as the rest of the assistance group.
  - (h) The MCP must accept eligible individuals who request MCP membership without restriction, except as otherwise provided in this rule.
  - (i) In the event that an MCP member loses medicaid eligibility and is automatically terminated from the MCP but within a period of sixty days or less regains medicaid eligibility, membership in the same MCP shall automatically be renewed.
  - (j) The SSE will document via the CCR all information provided by the eligible individual or the authorized representative of each eligible assistance group requesting MCP membership. The SSE shall document via the CCR that verbal authorization of MCP membership was given and the date of the authorization.
  - (k) MCP membership requests and assignments as described in paragraphs (C)(5)(c) and (C)(6)(c) of this rule, and received by the SSE will be processed utilizing only information contained on the CCR. Following processing by the SSE a copy of the CCR will be forwarded to the MCP.
  - (l) ODJFS will confirm the eligible individual's MCP membership to the MCP via an ODJFS-produced roster of new members, continuing members, and terminating members on or before the fifth day prior to the end of the calendar month preceding commencement of coverage.
  - (m) The MCP will not be required to provide coverage until MCP membership is confirmed via an ODJFS-produced roster except as provided in paragraph (C)(3)(d) of this rule or upon mutual agreement between ODJFS and the MCP.
- (4) MCP membership is optional for eligible individuals who are residents of counties designated as voluntary by ODJFS.

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

- (5) In addition to the provisions of paragraphs (C)(1) to (C)(3) of this rule, the following applies to membership in mandatory counties.
- (a) MCP membership is required for eligible individuals who are residents of counties designated as mandatory by ODJFS.
  - (b) When a county is initially designated by ODJFS as a mandatory program county, the eligibility of each eligible individual is confirmed by ODJFS as prescribed in paragraph (C)(3)(i) of this rule. Upon the confirmation of eligibility:
    - (i) Eligible individuals residing in the designated county who are currently MCP members are deemed participants in the mandatory program.
    - (ii) All other eligible individuals residing in the designated mandatory county may request MCP membership at any time but must select an MCP following receipt of a notification of mandatory selection (NMS) issued by ODJFS following the eligible individual's authorization for medicaid.
  - (c) MCP membership selection procedures for the mandatory program:
    - (i) An eligible assistance group which does not make a choice following issuance of an NMS by ODJFS and one additional notice will be assigned to an MCP by ODJFS, the SSE, or other ODJFS-approved entity.
    - (ii) ODJFS or the SSE will assign the assistance group to an MCP based on available prior medicaid fee-for-service and/or MCP membership history, whenever available.
- (6) In addition to the provisions of paragraphs (C)(1) to (C)(3) of this rule, the following applies to MCP membership in preferred option counties:
- (a) Eligible individuals in counties designated as preferred option will be automatically assigned as members in the preferred option MCP unless they select medicaid fee-for-service or a non preferred option MCP.
  - (b) When a county is initially designated by ODJFS as a preferred option county, the eligibility of each eligible individual is confirmed by ODJFS. Upon the confirmation of eligibility:
    - (i) Current MCP members residing in the designated county are deemed participants in the preferred option program.

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

(ii) All other eligible individuals residing in the preferred option county must choose between MCP membership or remaining on medicaid fee-for-service following receipt of a notification of preferred option selection (NPOS) issued by ODJFS following the eligible individual's authorization for medicaid.

(c) Following issuance of an NPOS and one additional notice an eligible assistance group which does not make a choice will be assigned as members in the preferred option MCP by ODJFS, the SSE or other ODJFS-approved entity.

(D) Commencement of coverage.

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

(2) In no event shall an MCP notify a new member about coverage until MCP membership is confirmed by ODJFS as specified in paragraph (C)(3)(l) of this rule.

(3) An MCP may request deferment of coverage for any new member admitted to an inpatient facility prior to the effective date of coverage who remains an inpatient on the effective date of coverage in accordance with the following:

(a) The MCP must submit deferment requests to ODJFS in writing with required documentation, as specified in paragraph (D)(3)(c) of this rule, no later than six months from the assistance group member's original effective date with the MCP or the last automatic MCP renewal date, if applicable.

(b) MCPs coverage and responsibility for payment of medicaid covered services to a new MCP member may be deferred following MCP notification of the new member's inpatient admission to ODJFS as specified in paragraph (D)(3)(a) of this rule. and subject to approval by ODJFS.

(c) Documentation includes but is not limited to a copy of the inpatient admission form or other proof of inpatient admission and discharge as approved by ODJFS, along with the MCP's written request for deferral of the new member's effective date of MCP membership.

(d) In the event that a previous MCP member subject to automatic renewal or MCP membership as specified in paragraph (C)(3)(i) of this rule is admitted after their MCP membership is terminated to an inpatient facility prior to, and remains an inpatient on the effective date of automatic renewal of MCP

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

membership, the provisions of paragraphs (D)(3)(a) to (D)(3)(c) and paragraphs (D)(3)(f) to (D)(3)(i) of this rule apply.

- (e) In the event a new assistance group member, other than a newborn is admitted to an inpatient facility prior to, and remains an inpatient on, the effective date of MCP membership, the provisions of paragraphs (D)(3)(a) to (D)(3)(c) and paragraphs (D)(3)(f) to (D)(3)(i) of this rule apply.
  - (f) The MCP is responsible for the provision of all medicaid covered services for all other MCP members of the same assistance group as specified in paragraph (D)(1) of this rule.
  - (g) The MCP's liability for all medicaid covered services for the deferred MCP member begins the first day of the month following the deferred MCP member's date of discharge from the hospital.
  - (h) The eligible individual's copy of the CCR shall contain language that informs the assistance group of their obligation to notify the MCP about any assistance group member who is hospitalized prior to the effective date of MCP membership and remains hospitalized on the effective date of MCP membership.
  - (i) Premium payments for the MCP will be adjusted to reconcile the period of MCP membership deferral.
- (4) An eligible individual, MCP member or authorized representative may request deferment of initial MCP membership for the purposes of continuity of care.
- (a) Continuity of care deferments may be requested by women in their third trimester of pregnancy or by an eligible individual or MCP member having pre-scheduled or ongoing treatment.
  - (b) The ODJFS-approved length of deferment shall be for the purpose of completing treatment or arranging for the transition of such treatment to providers affiliated with the MCP.
  - (c) Deferments initiated by an eligible individual or an MCP member or their authorized representative shall be requested at the member level only.
  - (d) Requests may be made by an eligible individual, an MCP member, or authorized representative prior to or within the initial month of MCP membership. Requests can be made verbally or in writing.
  - (e) An eligible individual, MCP member, or authorized representative requesting deferment must provide supporting documentation as requested by ODJFS.

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

- (f) In the event an eligible individual or MCP member, other than a newborn, is added to the assistance group the eligible individual or MCP member may request deferment as specified in paragraph (D)(4)(a) of this rule.
  - (g) The MCP is responsible for the provision of covered services for other MCP members of the assistance group as specified in paragraph (D)(1) of this rule.
- (5) An eligible individual or MCP member may request exclusion from MCP membership as a result of a special health care condition and/or circumstances in accordance with the following:
- (a) An MCP membership exclusion initiated by an eligible individual, MCP member, or their authorized representative shall be requested at the member level only.
  - (b) Requests for MCP membership exclusion must be made directly to ODJFS or the SSE verbally or in writing.
  - (c) Requests must be received prior to or no later than ninety days following the MCP membership effective date.
  - (d) An eligible individual or MCP member must provide supporting documentation as requested by ODJFS.
  - (e) The MCP is responsible for the provision of covered services for other MCP members of the assistance group as specified in paragraph (D)(1) of this rule.

(E) Selection of ECMP membership.

- (1) An SSE shall assist the eligible individual or an authorized representative requesting help in selecting ECMP membership or other healthcare option.
  - (2) The ODJFS, SSE, or other ODJFS-approved entity must accept and process initial ECMP membership selection transactions on behalf of eligible individuals in accordance with paragraph (E)(3) of this rule.
- (3) The following applies to membership selection:
- (a) ECMP membership for those determined to meet ECM criteria must occur without regard to an eligible individual's race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services. No policy or procedure that has the effect of discrimination on the basis of race, color, or national origin shall be used.

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- (b) ECMP membership must occur at the eligible individual level. Individuals in the same assistance group who do not meet ECM criteria must not be enrolled in the ECMP.
  - (c) Eligible individuals or the authorized representative requesting ECMP membership may change their choice up to the ninth working day from the end of the month in which the choice is made. Eligible individuals or the authorized representative must be informed of this provision when requesting ECMP membership.
  - (d) The ECMP must accept eligible individuals who request ECMP membership without restriction, except as otherwise provided in this rule.
  - (e) In the event that an ECMP member loses medicaid eligibility and is automatically terminated from the ECMP but within a period of sixty days or less regains medicaid eligibility, membership in the same ECMP shall automatically be renewed.
  - (f) The SSE will document via the CCR all information provided by the eligible individual or an authorized representative requesting ECMP membership. The SSE shall document via the CCR that verbal authorization of ECMP membership was given and the date of the authorization.
  - (g) ECMP membership requests and assignments, as described in paragraph (E)(4) of this rule and received by the SSE, will be processed utilizing only information contained on the CCR. Following processing by the SSE, a copy of the CCR will be forwarded to the ECMP.
  - (h) ODJFS will confirm the eligible individual's membership to the ECMP via an ODJFS-produced, HIPAA-compliant change roster of new members, terminating members, and members whose demographic information has changed as well as a full roster of all members, on or before the fifth day prior to the end of the calendar month preceding commencement of coverage.
  - (i) The ECMP will not be required to provide coverage until ECMP membership is confirmed via an ODJFS-approved roster except upon mutual agreement between ODJFS and the ECMP.
- (4) In addition to the provisions of paragraph (E)(1) through (E)(3) of this rule, the following applies to ECMP membership in ECM counties:
- (a) In those counties served by an ECMP which has entered into a provider agreement with ODJFS, the ECM eligibility of each individual is determined by ODJFS.

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(b) Individuals determined ECM-eligible shall be sent a notice of ECMP selection (NECM). The NECM advises the eligible individual that they have met the ECM criteria, explains their options, and advises them that unless they select not to participate, they will be assigned to an ECMP.

(c) Following issuance of the NECM and one additional notice, an eligible individual will be assigned as an ECMP member by ODJFS, the SSE, or other ODJFS-approved entity, unless the individual has selected not to participate.

(F) Commencement of ECMP coverage.

(1) Coverage of ECMP members will be effective at the beginning of the first day of the calendar month following the confirmation of the member's effective date of ECMP membership via an ODJFS-approved roster to the ECMP.

(2) In no event shall an ECMP notify a new member about coverage until ECMP membership is confirmed by ODJFS as specified in paragraph (E)(3)(h) and (E)(3)(i) of this rule.

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5101:3-26-02.1 **Managed health care programs: Termination of MCP membership.**

- (A) For the purpose of this rule authorized representative means an individual eighteen years of age or older who stand in the place of the consumer. The authorized representative may act on behalf of individuals inside or outside of the household in which the authorized representative lives. For the purposes of rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code, the authorized representative may be the primary information person of the household, another member of the same assistance group, a custodial parent, or a person designated by a custodial parent.
- (B) Termination of MCP membership occurs through one of the following:
- (1) Automatic termination occurs due to a change in MCP member medicaid eligibility, residence, or other circumstance, as set forth in paragraph (C) of this rule.
  - (2) Member-initiated termination occurs as set forth in paragraph (D) of this rule.
  - (3) MCP-initiated termination occurs as set forth in paragraph (E) of this rule.
- (C) The following applies to all automatic terminations of MCP membership in voluntary, mandatory, and preferred option counties:
- (1) Automatic termination occurs at the individual level.
  - (2) Automatic termination occurs for one of the following reasons:
    - (a) The member becomes ineligible for medicaid; or
    - (b) The member's permanent place of residence is moved outside the county of current MCP membership; or
    - (c) The member dies, in which case the period of MCP membership ends on the date of death; or
    - (d) A minor MCP member has been placed in a residential treatment facility. When this occurs, following appropriate notification to ODJFS, termination is effective the last day of the month preceding placement; or
    - (e) The member is incarcerated for either more than fifteen working days or is incarcerated and has accessed non-emergent medical care. When this occurs and following MCP, CDJFS, or other public agency notification to ODJFS, termination is effective the last day of the month prior to incarceration; or

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- (f) The member has been found by ODJFS to meet the criteria for either a skilled, intermediate, or ICF-MR level of care and is then placed in a NF, or ICF-MR, except as specified in paragraph (H)(1) of rule 5101:3-26-03 of the Administrative Code. When this occurs and following MCP notification to ODJFS, membership termination is effective the last day of the month prior to the placement; or
  - (g) The member has been found by ODJFS to meet the criteria for placement in a home and community-based waiver program administered by ODJFS, ODA, or ODMR-DD. When this occurs, termination is effective no later than the last day of the month in which the member is determined to meet the criteria for placement; or
  - (h) A minor MCP member's custody has been legally transferred from the legal parent or guardian to another entity. When this occurs, following appropriate notification to ODJFS, membership termination is effective the last day of the month preceding the transfer; or
  - (i) The member becomes ineligible in an MCP medicaid-eligible category; or
  - (j) The member has third party coverage and ODJFS determines, following MCP, member, or other public agency notification to ODJFS and based on the type of coverage and the existence of conflicts between provider panels and access requirements, that continuing MCP membership may not be in the best interest of the member. When this occurs the effective date of termination shall be determined by ODJFS but in no event shall the termination date be later than the last day of the month in which ODJFS approves the termination; or
  - (k) The provider agreement between ODJFS and the MCP is terminated or ODJFS takes action as specified in paragraphs (G) and (H) of rule 5101:3-26-10 of the Administrative Code.
- (3) Automatic terminations of MCP membership do not require completion of a CCR.
- (4) Except as specified in paragraphs (C)(2)(c) to (C)(2)(h) of this rule, automatic membership termination will be effective at the end of the last day of the month in which the change in eligibility, residence, or other circumstance occurred.
- (5) If ODJFS fails to notify the MCP of a member's termination from an MCP, ODJFS will continue to pay the MCP the monthly premium rate with respect to such member, subject to the provisions of rule 5101:3-26-09 of the Administrative Code. The MCP will remain liable for the provision of covered services as set forth in rule 5101:3-26-03 of the Administrative Code, until such

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time as ODJFS provides the MCP with documentation of the member's termination.

- (6) ODJFS will recover from the MCP any premium paid for retroactive membership termination occurring as a result of paragraphs (C)(2)(c) to (C)(2)(h) of this rule.
- (7) In the event that an MCP member loses medicaid eligibility during an annual open selection period resulting in the temporary inability to change managed care plans, the member may request to change managed care plans within thirty days following automatic renewal of MCP membership.

(D) The following applies to MCP member-initiated termination of membership:

- (1) Member-initiated terminations must occur at the assistance group level except as provided in paragraph (D)(11)(e) of this rule. All individuals within an assistance group must be terminated at the same time.
- (2) Member-initiated termination in voluntary and mandatory counties may occur:
  - (a) During the initial three months of MCP membership; or
  - (b) During an open selection month for the member's county of residence as described in paragraph (D)(10) of this rule; or
  - (c) If the termination request meets one of the reasons for just cause termination of MCP membership as specified in paragraph (D)(11)(a) of this rule.
- (3) When requesting termination in mandatory counties, members must select membership in another participating MCP.
- (4) When requesting termination in voluntary counties, members will be returned to medicaid fee-for-service or may select membership in another participating MCP, if available.
- (5) When requesting termination in preferred option counties, members may choose to return to medicaid fee-for-service or may select membership in another participating MCP, if available.
- (6) The SSE will document via the CCR all information provided by the member or authorized representative of each eligible assistance group requesting termination. The SSE shall document via the CCR that verbal authorization was given and the date of the authorization.

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- (7) Member-initiated terminations in voluntary and mandatory counties will be effective the last day of the calendar month or the succeeding calendar month, subject to state cut-off.
- (8) Member-initiated terminations in counties designated by ODJFS as preferred option counties may occur at any time, and will be effective the last day of the calendar month or the succeeding calendar month, subject to state cut-off.
- (9) MCPs must:
  - (a) Provide information on MCP membership termination options, including reasons for just cause terminations as described in paragraph (D)(11)(a) of this rule, to eligible individuals and members as required in rules 5101:3-26-08 and 5101:3-26-08.2 of the Administrative Code.
  - (b) Continue to recognize the MCP identification card and not request its return from the member until the MCP receives documentation from ODJFS that the termination is effective. ODJFS will continue to pay the MCP the monthly premium until the termination is effective.
- (10) Open selection months will be designated for each voluntary and mandatory county by ODJFS or its designee at least annually. ODJFS will notify each assistance group by mail at least sixty days prior to the designated open selection month of the opportunity to terminate MCP membership and where to obtain further information.
- (11) MCP members or the authorized representative may request termination of MCP membership at any time for just cause.
  - (a) Membership termination for just cause includes the following:
    - (i) The member moves out of the MCP's service area;
    - (ii) The MCP does not, for moral or religious objections, cover the service the member seeks;
    - (iii) The member needs related services to be performed at the same time; not all related services are available within the MCP network, and the member's PCP or another provider determines that receiving services separately would subject the member to unnecessary risk;
    - (iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs;

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- (v) The PCP selected by a member leaves the MCP's panel and was the only available and accessible PCP speaking the primary language of the member, and another PCP speaking the language is available and accessible in another MCP in the member's county of residence;
  - (vi) A situation in which, as determined by ODJFS, continued membership in the MCP would be harmful to the interests of the member.
- (b) Requests for just cause termination of membership must be made directly to ODJFS or other ODJFS-approved entity verbally or in writing.
- (c) All requests for just cause termination will be reviewed by ODJFS within seven working days of receipt. ODJFS may request documentation as necessary from both the member and the MCP. A decision will be made within ten working days of receipt of all necessary documentation. ODJFS may establish retroactive termination dates and/or recover premium payments as determined necessary and appropriate. Regardless of the procedures followed, the effective date of an approved membership termination must be no later than the first day of the second month following the month in which the member requests termination. If ODJFS fails to make the determination within this timeframe the termination of membership request is considered approved.
- (d) If the request for just cause termination is not approved, ODJFS shall notify the member or the authorized representative of their right to a state hearing.
- (e) Terminations for just cause may be processed at the individual level or the assistance group level as ODJFS determines necessary and appropriate.
- (f) In the case of members who lose medicaid eligibility prior to ODJFS action to terminate membership for just cause, ODJFS shall assure that the member's MCP membership is not automatically renewed if eligibility for medicaid is reauthorized.
- (12) All member-initiated terminations must be voluntary. No member may be encouraged by an MCP to terminate due to an adverse change in the member's health status or need for health services, age, sex, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry. No policy or practice that has the effect of discrimination on the basis of race, color, or national origin shall be used.
- (E) The following applies to all MCP-initiated membership terminations :
- (1) In the following instances, the MCP may submit a request to ODJFS for the termination of a member:

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- (a) Fraudulent behavior by the member; or
  - (b) Uncooperative or disruptive behavior by the member or someone acting on their behalf to the extent that such behavior seriously impairs the MCP's ability to provide services to either the member or other MCP members.
- (2) All proposed MCP-initiated terminations of members must contain ODJFS-specified documentation .
- (3) The MCP may not request termination due to a change in the member's health status or need for health services, age, sex, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry.
- (4) There are no state hearing rights for a member(s) terminated from an MCP pursuant to paragraph (E)(1) of this rule.
- (5) The MCP must provide medicaid-covered services to a terminated member(s) through the last day of the month in which the MCP membership is effective, notwithstanding the date of ODJFS approval of the termination request.
- (6) For MCP-initiated termination of MCP membership in mandatory, voluntary, and preferred option counties:
- (a) Termination must occur at the assistance group level with all members returning to the fee-for-service medicaid program, if eligible.
  - (b) If ODJFS approves the MCP's request for termination, ODJFS will:
    - (i) Notify the member(s) or authorized representative, in writing, of the impending MCP-initiated termination of all members within the assistance group; and
    - (ii) Notify in writing the member(s) or authorized representative, the MCP, or other ODJFS-approved entity and the SSE, when applicable, of the decision to terminate all members within the assistance group, and initiate the process for returning the individuals to the fee-for-service medicaid program.
- (F) The following applies to the coverage of services for any member who is an inpatient on the date an MCP membership termination becomes effective.
- (1) MCPs shall remain liable for the provision of covered services for a member who is an inpatient on the date a member-initiated or MCP-initiated termination becomes effective. The MCP shall remain liable for the provision of covered services through the last day of the month in which the member is discharged, unless notified otherwise by ODJFS. The MCP is not responsible for the

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provision of covered services for other members of the assistance group that were disenrolled from the MCP.

- (2) If the termination was automatic as defined in paragraphs (C)(2)(a) to (C)(2)(f) of this rule, the MCP is only responsible for the coverage of services related to the member's inpatient stay through the date of discharge.
- (3) If the termination was automatic as defined in paragraphs (C)(2)(h) to ~~(C)(2)(j)~~ (C)(2)(k) of this rule, the MCP is only responsible for the coverage of services related to the inpatient stay through the date of MCP membership termination.
- (4) If the termination is initiated by the member or MCP as defined in this rule, the MCP will receive premium through the last day of the month of discharge if the inpatient stay is documented by the MCP to ODJFS. Such documentation must include a copy of the inpatient facility admission/discharge form or other items as requested by ODJFS.
- (5) An MCP must submit a notification of an inpatient admission and corresponding documentation to ODJFS, as specified in paragraph (F)(4) of this rule, within six months of the assistance group member's original MCP membership termination date.

(G) Termination of ECMP membership occurs through one of the following:

- (1) Automatic termination occurs due to a change in ECMP member medicaid eligibility, residence, or other circumstance, as set forth in paragraph (H) of this rule.
- (2) Member-initiated termination occurs as set forth in paragraph (I) of this rule.
- (3) ECMP initiated termination occurs as set forth in paragraph (J) of this rule.

(H) The following applies to all automatic terminations of ECMP membership:

- (1) Automatic termination occurs at the individual level.
- (2) Automatic termination occurs for one of the following reasons:
  - (a) The member becomes ineligible for medicaid; or
  - (b) The member's permanent place of residence is moved outside the county of current ECMP membership; or
  - (c) The member dies, in which case the period of ECMP membership ends on the date of death; or

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- (d) A minor ECMP member has been placed in a residential treatment facility. When this occurs, following appropriate notification to ODJFS, termination is effective the last day of the month preceding placement; or
  - (e) The member is incarcerated for more than fifteen working days. When this occurs and following ECMP, CDJFS, or other public agency notification to ODJFS, termination is effective the last day of the month prior to incarceration; or
  - (f) The member has been found by ODJFS to meet the criteria for either a skilled, intermediate, or ICF-MR level of care and is then placed in a NF, or ICF-MR, unless the member is placed in a NF for a short-term rehabilitative stay as determined by ODJFS. When this occurs membership termination is effective the last day of the month prior to the placement; or
  - (g) The member has been found by ODJFS to meet the criteria for placement in a home and community-based waiver program administered by ODJFS, ODA, or ODMR-DD. When this occurs, termination is effective no later than the last day of the month in which the member is determined to meet the criteria for placement; or
  - (h) A minor ECMP member's custody has been legally transferred from the legal parent or guardian to another entity. When this occurs, following appropriate notification to ODJFS, membership termination is effective the last day of the month preceding the transfer; or
  - (i) The member becomes ineligible in an ECM medicaid-eligible category; or
  - (j) The member has third party coverage and ODJFS determines, following ECMP, member, or other public agency notification to ODJFS and based on the type of coverage and the existence of conflicts between provider panels and access requirements, that continuing ECMP membership may not be in the best interest of the member. When this occurs the effective date of termination shall be determined by ODJFS but in no event shall the termination date be later than the last day of the month in which ODJFS approves the termination; or
  - (k) The provider agreement between ODJFS and the ECMP is terminated or ODJFS takes action as specified in paragraphs (G) and (H) of rule 5101:3-26-10 of the Administrative Code.
- (3) Automatic terminations of ECMP membership do not require completion of a CCR.
- (4) Except as specified in paragraphs (H)(2)(c) to (H)(2)(h) of this rule, automatic ECMP membership termination will be effective at the end of the last day of the

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month in which the change in eligibility, residence, or other circumstance occurred.

(5) If ODJFS fails to notify the ECMP of a member's termination, ODJFS will continue to pay the ECMP the monthly premium rate with respect to such member, subject to the provisions of rule 5101:3-26-09 of the Administrative Code. The ECMP will remain liable for the provision of covered services as set forth in rule 5101:3-26-12 of the Administrative Code, until such time as ODJFS provides the ECMP with documentation of the member's termination.

(6) ODJFS will recover from the ECMP any premium paid for retroactive membership termination occurring as a result of paragraphs (H)(2)(c) to (H)(2)(h) of this rule.

(I) The following applies to ECMP member-initiated termination of membership:

(1) Member-initiated terminations must occur at the individual level.

(2) ECMP member-initiated termination may be requested at any time.

(3) The SSE will document via the CCR all information provided by the member requesting termination. The SSE shall document via the CCR that verbal authorization was given and the date of the authorization.

(4) ECMP member-initiated terminations will be effective the last day of the calendar month or the succeeding calendar month, subject to state cut-off.

(5) In the event an ECMP member loses medicaid eligibility prior to ODJFS action to terminate ECMP membership, ODJFS shall assure that the member's ECMP membership is not automatically renewed if eligibility for medicaid is reauthorized.

(6) The ECMP must provide information on membership termination options to eligible individuals and members as required in rules 5101:3-26-08 and 5101:3-26-08.2 of the Administrative Code.

(7) All member-initiated terminations must be voluntary. No member may be encouraged by an ECMP to terminate due to an adverse change in the member's health status or need for health services, age, sex, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry. No policy or practice that has the effect of discrimination on the basis of race, color, or national origin shall be used.

(J) The following applies to all ECMP-initiated membership terminations:

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- (1) In the following instances, the ECMP may submit a request to ODJFS for the termination of a member:

  - (a) Fraudulent behavior by the member; or
  - (b) Uncooperative or disruptive behavior by the member or someone acting on their behalf to the extent that such behavior seriously impairs the ECMP's ability to provide services to either the member or other ECMP members.
- (2) All proposed ECMP-initiated terminations of members must contain ODJFS-specified documentation.
- (3) The ECMP may not request termination due to a change in the member's health status or need for health services, age, sex, sexual orientation, disability, national origin, race, color, religion, veteran's status, or ancestry.
- (4) The ODJFS shall notify the ECMP member of the request to terminate his/her membership in the ECM program, and seek information concerning the request from the member.
- (5) If ODJFS approves the request for termination, the ECMP must provide ECM services to a terminated member through the last day of the month in which the ECMP membership is effective, notwithstanding the date of ODJFS approval of the termination request.
- (6) If ODJFS approves the ECMP's request for termination, ODJFS will:

  - (a) Notify in writing the member or authorized representative of the decision to approve the ECMP termination and the reason for the termination; and
  - (b) Notify in writing the ECMP, and the SSE, when applicable, of the decision to terminate the member from the ECM program.
- (7) There are no state hearing rights for members terminated from the ECM program pursuant to paragraph (J)(1) of this rule.

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5101:3-26-04

**Managed health care programs: Procurement and plan selection.**

(A) Comprehensive managed care program

- (1) ODJFS may conduct a procurement process for prospective MCPs to enter into provider agreements to serve eligible medicaid individuals. ODJFS may conduct separate procurements or otherwise consider applications if deemed necessary to provide services to special populations or for any other purpose necessary to achieve program objectives.
- (2) ODJFS will issue a notice to inform prospective MCPs and others of the procurement process.
- (3) ODJFS may determine a maximum number of MCPs in any service area provided that reasonable access to participating providers is assured.
- (4) ODJFS will not enter into a provider agreement with a prospective MCP or amend a provider agreement with an MCP to serve eligible medicaid individuals unless the MCP meets all applicable program requirements.
- (5) To participate in the comprehensive managed care program, prospective MCPs who are found by ODJFS to meet all applicable program requirements will be required to enter into a provider agreement.
- (6) If an MCP is terminated from the medicaid and/or medicare program or not renewed as a participating provider in the medicaid program, whether as a result of the MCP's initiative or ODJFS action, ODJFS retains the right not to consider that prospective MCP for a provider agreement for a period of two years from the date of the termination or nonrenewal.

(B) Enhanced care management program

- (1) ODJFS may conduct a procurement process for prospective ECMPs to enter into provider agreements to serve eligible medicaid individuals. ODJFS may conduct separate procurements or otherwise consider applications if deemed necessary to provide services to special populations or for any other purpose necessary to achieve program objectives.
- (2) ODJFS will issue a notice to inform prospective ECMPs and others of the procurement process.
- (3) ODJFS will not enter into a provider agreement with a prospective ECMP or amend a provider agreement with an ECMP to serve eligible medicaid individuals unless the ECMP meets all applicable program requirements.

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- (4) To participate in the enhanced care management program, prospective ECMPs who are found by ODJFS to meet all applicable program requirements will be required to enter into a provider agreement.
- (5) If an ECMP is terminated from the medicaid and/or medicare program or not renewed as a participating provider in the medicaid program, whether as a result of the ECMP's initiative or ODJFS action, ODJFS retains the right not to consider that prospective ECMP for a provider agreement for a period of two years from the date of the termination or nonrenewal.

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5101:3-26-06      **Managed health care programs: Program integrity - fraud and abuse, audits, reporting, and record retention.**

- (A) MCPs must have administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud and abuse.
- (1) These arrangements or procedures must include the implementation of sound business practices which support appropriate access to and appropriate payment for quality services and must include the following:
- (a) Written policies, procedures, and standards of conduct that articulate the MCP's commitment to comply with all applicable federal and state standards, including the prevention, identification, investigation, correction, and reporting of fraud and abuse;
  - (b) Designation of a compliance officer and a compliance committee that are accountable to senior management;
  - (c) Effective training and education for the compliance officer and the MCP's employees;
  - (d) Effective lines of communication between the compliance officer and the MCP's employees. To ensure effective communication, the MCP must organize resources to respond to complaints of fraud and abuse and have established procedures to process these complaints;
  - (e) Education of providers and delegated entities about fraud and abuse;
  - (f) Enforcement of MCP standards through well-publicized disciplinary guidelines;
  - (g) Provision for internal monitoring and auditing, including procedures to monitor service patterns of providers and subcontractors;
  - (h) Establishment and/or modification of internal MCP controls to ensure the proper submission and payment of claims;
  - (i) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCP's contract; and
  - (j) Prompt reporting of all instances of fraud and abuse to ODJFS and member fraud to the CDJFS.
- (2) These arrangements or procedures must be made available to ODJFS upon request.

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- (3) MCPs must annually submit to ODJFS a report which summarizes the MCP's fraud and abuse activities for the previous year and which identifies any proposed changes to the MCP's fraud and abuse program for the coming year.
- (B) ODJFS or its designee, the state auditor's office, the state attorney general's office, the MFCU and the U.S. department of health and human services may evaluate or audit a contracting MCP's or ECMP's performance for the purpose of determining compliance with the requirements of Chapter 5101:3-26 of the Administrative Code, fraud and abuse statutes, applicable state and federal regulations or requirements under federal waiver authority.
- (C) ODJFS or its designee may conduct on-site audits and reviews as deemed necessary based on periodic analysis of financial, utilization, provider panel, and other information.
- (D) The MCP or ECMP must submit required reports and additional information, as requested by ODJFS, as related to ~~the MCP's~~ their duties and obligations and where needed to assure ~~the MCP is operating~~ operation in accordance with all state and federal regulations or requirements.
- (E) Failure of the MCP or ECMP to submit any ODJFS-requested materials, as specified in paragraph (D) of this rule, without cause as determined by ODJFS, on or before the due date, may result in application of any or all of the sanctions listed in rule 5101:3-26-10 of the Administrative Code.
- (F) Record retention.

All hard copy or electronic records originated or prepared in connection with the MCP's or ECMP's performance of its obligations under the provider agreement, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, will be retained and safeguarded by the MCP or ECMP and its subcontractors in accordance with applicable sections of the federal regulations and the Administrative Code. Records stored electronically must be produced at the MCP's or ECMP's expense, upon request, in the format specified by state or federal authorities. All such records must be maintained for a minimum of six years from the termination date of the provider agreement or, in the event that the MCP or ECMP has been notified that state or federal authorities have commenced an audit or investigation of the provider agreement, or the provision of services by the MCP or ECMP, or its subcontractor, until such time as the matter under audit or investigation has been resolved, whichever is later.

- (G) ECMPs must report all instances of fraud and abuse to ODJFS and member fraud to the CDJFS.

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5101:3-26-07      **Managed health care programs: Annual external quality review survey.**

(A) ODJFS will select an external quality review organization (EQRO) to provide for an annual, external, and independent review of the quality, outcomes, timeliness of and access to services provided by MCPs.

(B) The external quality review (EQR) will include but not be limited to the following components [for MCPs](#):

(1) A review of the MCP's administrative quality functions including internal QAPI activities as described in rule 5101:3-26-07.1 of the Administrative Code.

(2) A performance review and outcome assessment of the MCP's case management system and other internal administrative programs,

(3) Clinical and non-clinical focused quality of care studies,

(4) Encounter data studies,

(5) Validation of performance measurement data and a comprehensive review of information systems,

(6) Validation of performance improvement projects (PIPs), and

(7) A member satisfaction survey.

(C) MCPs must timely submit at no cost to the member or ODJFS data and information, including member medical records, as requested by ODJFS or its designee for the annual external quality review.

(D) MCPs must develop and implement CAPs that are prior-approved by ODJFS and which address EQR survey deficiencies cited by the EQRO.

(E) MCPs accredited by a quality review organization during the time period under review may be eligible for deeming.

(F) MCPs must achieve a passing score(s) on the external quality review survey.

[\(G\) The ODJFS-selected EQRO will conduct an annual, external and independent review of ECMPs that may include, but is not limited to, the following:](#)

[\(1\) A review of ECMP's administrative functions,](#)

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- (2) A performance review and outcome assessment of the ECMP's case management system and other internal administrative programs,
- (3) Clinical and non-clinical focused quality of care studies,
- (4) Validation of performance measurement data and a comprehensive review of information systems,
- (5) A member satisfaction survey.
  
- (H) ECMPs must timely submit, at no cost to the member or ODJFS, data and information including member medical records, as requested by ODJFS or its designee, for the annual external quality review.
  
- (I) ECMPs must develop and implement CAPs that are prior-approved by ODJFS and which address EQR survey deficiencies cited by the EQRO.

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5101:3-26-08      **Managed health care programs: Marketing.**

(A) Marketing means any communication from an MCP or ECMP to an eligible individual who is not a member of that MCP or ECMP that can reasonably be interpreted as intended to influence the individual to select **MCP** membership in that MCP or ECMP, or to not select **MCP** membership in or to terminate membership from another MCP or ECMP. ~~MCPs must comply with all of the following marketing requirements:~~

- ~~(1) The MCP's marketing or other representatives, as well as the MCP's materials and plans, must represent the MCP in an honest and forthright manner, and must not make statements which are inaccurate, misleading, confusing or otherwise misrepresentative, or which defraud the eligible individuals or ODJFS.~~
- ~~(2) No marketing activity directed specifically toward the medicaid population may begin prior to approval by ODJFS.~~
- ~~(3) MCPs are prohibited from directly or indirectly engaging in cold call marketing activities including, but not limited to, door to door or telephone contact. Cold call marketing means any unsolicited personal contact by the MCP with an eligible individual for the purpose of marketing as defined in paragraph (A) of this rule.~~
- ~~(4) MCPs are prohibited from making one on one marketing presentations in any setting unless requested by the eligible individual(s).~~
- ~~(5) Only ODJFS approved marketing representatives may make a marketing presentation as outlined in paragraph (D)(6)(e) of this rule to an eligible individual or in any way advise or recommend to an eligible individual that he/she select MCP membership in a particular MCP. As provided in Chapter 1751, and section 3905.01 of the Revised Code, and rule 3901-1-10 of the Administrative Code, all non licensed agents, including providers, are prohibited from advising or recommending to an eligible individual that he/she select MCP membership in a particular MCP as this would constitute the unlicensed practice of marketing.~~
- ~~(6) MCP informational displays do not require the presence of an MCP marketing representative if no marketing presentation will be made. MCPs must receive prior approval from the event/location where they wish to provide information on the MCP.~~
- ~~(7) MCPs are prohibited from offering material or financial gain, including but not limited to the offering of any other insurance, to an eligible individual as an inducement to select MCP membership. MCPs are also prohibited from~~

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~~offering inducements to CDJFS or SSE staff or to others who may influence an individual's decision to select MCP membership.~~

~~(8) MCPs are allowed to offer nominal gifts prior approved by ODJFS to an eligible individual as long as these gifts are offered whether or not the individual selects membership in the MCP.~~

~~(9) Member incentive/appreciation items, as specified in paragraph (B) of rule 5101:3-26-08.2 of the Administrative Code, may be referenced in an MCP's marketing presentations and materials; however, MCPs are not permitted to make these member items available to non-members.~~

## (B) MCPs and ECMPs:

(1) Must assure that representatives, as well as materials and plans, represent the MCP or ECMP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing or otherwise misrepresentative, or which defraud the eligible individuals or ODJFS.

(2) Must assure that no marketing activity directed specifically toward the medicaid population begins prior to approval by ODJFS.

(3) Are prohibited from engaging directly or indirectly in cold-call marketing activities including, but not limited to, door-to-door or telephone contact. Cold-call marketing means any unsolicited personal contact by the MCP or ECMP with an eligible individual for the purpose of marketing as defined in paragraph (A) of this rule.

(4) Must receive prior approval from any event or location where the MCP or ECMP plans to provide information to eligible individuals.

(5) Are prohibited from offering material or financial gain, including but not limited to, the offering of any other insurance, to an eligible individual as an inducement to select MCP or ECMP membership.

(6) Are prohibited from offering inducements to CDJFS or SSE staff or to others who may influence an individual's decision to select MCP or ECMP membership.

(7) Are allowed to offer nominal gifts prior-approved by ODJFS to an eligible individual as long as these gifts are offered whether or not the individual selects membership in the MCP or ECMP.

(8) May reference member incentive/appreciation items, as specified in paragraph (B) of rule 5101:3-26-08.2 of the Administrative Code, in marketing

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presentations and materials; however, such member items must not be made available to non-members.

## (C) MCPs must comply with the following requirement:

- (1) Only ODJFS-approved MCP marketing representatives may make a marketing presentation as outlined in paragraph (F)(6)(e) of this rule to an eligible individual or in any way advise or recommend to an eligible individual that he/she select MCP membership in a particular MCP. As provided in Chapter 1751. and section 3905.01 of the Revised Code, and rule 3901-1-10 of the Administrative Code, all non-licensed agents, including providers, are prohibited from advising or recommending to an eligible individual that he/she select MCP membership in a particular MCP as this would constitute the unlicensed practice of marketing.
- (2) Must assure that marketing representatives represent the MCP in an honest and forthright manner, and do not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud the eligible individuals or ODJFS.
- (3) MCPs are prohibited from making one-on-one marketing presentations in any setting unless requested by the eligible individual.
- (4) MCP informational displays do not require the presence of a marketing representative if no marketing presentation will be made.

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

- (1) All MCP and ECMP marketing materials must be available in a manner and format that may be easily understood.
- (2) Written materials developed to promote membership selection in an MCP or ECMP must be available in:
  - (a) The prevalent non-English languages of eligible individuals in the ~~MCP's~~ service area.
  - (b) Alternative formats in an appropriate manner that takes into consideration the special needs of eligible individuals including but not limited to visually-limited and LRP eligible individuals.

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- (3) Oral interpretation and oral translation services must be available for the review of marketing materials at no cost to [CMC or ECM](#) eligible individuals.
- (4) [The mailing/distribution of all MCP or ECMP marketing materials must be prior-approved by ODJFS and may contain no information or text on the outside of the mailing that identifies the addressee as a medicaid consumer. Marketing materials must be distributed to the MCP's or ECMP's entire service area.](#)
- (5) [ODJFS or its designee will, at an MCP's or ECMP's request, mail MCP or ECMP marketing materials to eligible individuals. Postage and handling for each mailing will be charged to the requesting MCP or ECMP. Any return address used in mailings to eligible individuals processed by ODJFS will be the ODJFS address.](#)
- (4)(6) MCPs must have a solicitation brochure available to eligible individuals which contains, at a minimum:
- (a) Identification of the medicaid consumers eligible for the MCP's coverage.
  - (b) A list or map of the counties included in the MCP's provider agreement.
  - (c) Information that the MCP's identification card replaces the member's monthly medicaid health card.
  - (d) A statement that all medically-necessary medicaid-covered services including healthchek (EPSDT) services, as well as any additional services provided by the MCP, will be available to all members.
  - (e) Information that membership selection in a particular MCP is voluntary, that a decision to select MCP membership or to not select MCP membership in the MCP will not affect eligibility for medicaid or other public assistance benefits, and that individuals may terminate membership or change MCPs under certain circumstances.
  - (f) Information on how the individual can request or access additional MCP information or services, including ~~at a minimum~~ [clarification on how this information can be requested or accessed through](#):
    - (i) Sign language, oral interpretation and oral translation services at no cost to the eligible individual;
    - (ii) Written information in the prevalent non-English languages of eligible individuals or members in the MCP's service area;
    - (iii) Written information in alternative formats.

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- (g) Information clearly identifying corporate or parent company identity when a trade name or DBA is used for the medicaid product.
- (h) A statement that this brochure contains only a summary of the relevant information and that more details, including at a minimum a list of providers, and any physician incentive plans the MCP operates will be provided upon request.
- (i) Information that an individual must choose a PCP from the MCP's provider panel and that the PCP will coordinate the member's health care.
- (j) Information that a member may change PCPs ~~no less often than~~ at least monthly.
- (k) A statement that all medically-necessary health care services must be obtained in or through the MCP facilities and/or providers except emergency care, behavioral health services provided through the ODMH or at ODADAS-certified-facilities which are medicaid providers , and any other services or provider types designated by ODJFS.
- (l) A description of how to access emergency services and a description of the MCP's out-of-area coverage.
- (m) Information that in a voluntary program county, eligible individuals may choose to select MCP membership in an ODJFS-contracting MCP to receive their medicaid-covered services.
- (n) Information that in a preferred option county, eligible individuals will be automatically assigned as members in a designated MCP unless another MCP or fee-for-service is chosen by the eligible individuals.
- (o) Information that in a mandatory program county, eligible individuals must select MCP membership in an ODJFS-contracting MCP to receive their medicaid-covered services.
- (p) Information on member-initiated termination options in accordance with paragraph (D) of rule 5101:3-26-02.1 of the Administrative Code.
- (q) Information on the availability of, and reasons for, a member-initiated MCP membership deferment in accordance with paragraph (D)(4) of rule 5101:3-26-02 of the Administrative Code.
- (r) Information on the procedures an eligible individual must follow to select MCP membership in an MCP.

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(7) ECMPs must have an information brochure available to eligible individuals that contains, at a minimum:

(a) Identification of the medicaid consumers eligible for membership in the ECMP.

(b) A list or map of the counties included in the ECMP's provider agreement.

(c) Information that membership selection in a particular ECMP is voluntary, that membership or non-membership in the ECMP will not affect eligibility for medicaid or other public assistance benefits, and that individuals may terminate membership in the ECMP.

(d) Information that membership will not restrict the individual's access to any provider otherwise available through the medicaid benefit package but that the individual may be encouraged to use providers specified by the ECMP.

(e) Information on how the individual can request or access additional ECMP information or services, including clarification on how this information can be requested or accessed through:

(i) Sign language, oral interpretation and oral translation services at no cost to the eligible individual:

(ii) Written information in the prevalent non-English languages of eligible individuals or members in the ECMP's service area;

(iii) Written information in alternative formats.

(f) Information clearly identifying the ECMP parent or company.

(g) A statement that the brochure contains only a summary of the relevant information and that more details, including at a minimum information on providers, and any physician incentive plans the ECMP operates will be provided upon request.

(h) Information that an individual must choose a PCP and that the PCP will coordinate the member's care.

(i) Information that a member may change PCPs at least monthly.

(j) Information on how an eligible individual can select ECMP membership, that an eligible individual will automatically become a member of an ECMP unless the individual chooses not to participate, and process for termination of ECMP membership.

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(k) Information on the benefits of selecting an ECMP.

(l) Information that members will receive a medicaid card with ECMP membership indicated.

(m) A statement that all medically-necessary medicaid-covered services will be available to all members.

~~(5) The mailing/distribution of all MCP marketing materials must be prior approved by ODJFS and may contain no information or text on the outside of the mailing that identifies the addressee as a medicaid consumer. Marketing materials must be distributed to the MCP's entire service area.~~

~~(6) ODJFS or its designee will, at an MCP's request, mail MCP marketing materials to eligible individuals. Postage and handling for each mailing will be charged to the requesting MCP. The MCP is prohibited from using the MCP's address as the return address on any ODJFS processed mailing.~~

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

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

(1) All marketing representatives must be employees of the MCP. A copy of the representative's job description(s) must be submitted to ODJFS.

(2) Marketing representatives must be trained and duly licensed by ODI to perform such activities. A copy of the MCP's current list of medicaid marketing representatives and a copy of each representative's ODI license must be submitted to ODJFS. This list must be updated by the MCP with each change in the composition of the MCP's marketing staff.

(3) The MCP must develop and submit to ODJFS for prior-approval a marketing representative training program. This training program must include, at a minimum:

(a) A training curriculum that includes at a minimum:

(i) A full review of the MCP's solicitation brochure, provider directory and all other marketing materials including all video, audio, electronic and print materials.

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- (ii) An overview of applicable public assistance benefits, designed to familiarize and impart a working knowledge of these programs.
  - (iii) The MCP's process for providing sign language, oral interpretation and oral translation services to an eligible individual to whom a marketing presentation is being made, including a review of the MCP's written marketing materials.
  - (iv) Instruction on acceptable and appropriate marketing tactics, including that the marketing representatives may not discriminate on the basis of age, sex, sexual orientation, disability, race, color, religion, national origin, veteran's status, ancestry, health status, or the need for health services.
  - (v) An overview of the ramifications to the MCP and/or the marketing representatives if ODJFS rules are violated.
  - (vi) Review of the MCP's code of conduct/ethics.
- (b) Methods the MCP will utilize to determine initial and ongoing competency with the training curriculum.
- (c) Any revisions to the ODJFS-approved training program must be submitted to ODJFS for review and prior approval.
- (4) MCPs must submit written documentation verifying successful completion of the ODJFS-approved training program, and receive written approval from ODJFS, prior to any individual performing the activities specified in paragraph ~~(D)(6)(e)~~ (F)(6)(e) of this rule on behalf of the MCP.
- (5) No more than fifty per cent of each marketing representative's total annual compensation, including salary, benefits, and bonuses may be paid on a commission basis. For the purpose of this rule, any performance-based compensation would be considered a form of commission. The MCP must make available for inspection, upon request by ODJFS, the compensation package(s) for marketing representatives as its assurance of compliance with this requirement.
- (6) Any MCP staff providing information on the MCP or making marketing presentations to an eligible individual(s) must comply with the following:
- (a) The MCP must not discriminate on the basis of age, sex, sexual orientation, race, color, religion, national origin, veteran's status, ancestry, disability, health status, or the need for health services.

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- (b) No MCP may ask eligible individual(s) questions related to health status or the need for health services.
- (c) The MCP staff must visibly wear or display an identification tag and offer a business card when speaking to an eligible individual(s) and provide information which ensures that the staff is not mistaken for an SSE or federal, state or county employee.
- (d) Inform eligible individuals that the following MCP information or services are available and how the eligible individual can access the information or services:
  - (i) Sign language, oral interpretation, and oral translation services at no cost to the member;
  - (ii) Written information in the prevalent non-English languages of eligible individuals or members in the MCP's service area; and
  - (iii) Written information in alternative formats.
- (e) For the purposes of this rule a marketing presentation is defined as a one-on-one interaction between an MCP's marketing representative and an eligible individual(s). MCP marketing representatives must offer the ODJFS-approved solicitation brochure to the eligible individual(s) at the time of the marketing presentation and must provide, at a minimum:
  - (i) An explanation of the importance of reviewing the information in the ODJFS-approved solicitation brochure, how they can receive additional information about the MCP prior to making a MCP membership selection and the process for contacting ODJFS to select an MCP.
  - (ii) Information that membership in the particular MCP is voluntary and that a decision to select or not select the MCP will not affect eligibility for medicaid or other public assistance benefits.
  - (iii) Information that each member must choose a PCP and must access providers and services as directed in the MCP's member handbook and provider directory.
  - (iv) Information that all medically-necessary medicaid-covered services, as well as any additional services provided by the MCP, will be available to all members.

(7) Any ECMP staff providing information on the ECMP to an eligible individual must comply with the following:

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- (a) The ECMP must not discriminate on the basis of age, sex, sexual orientation, race, color, religion, national origin, veteran's status, ancestry, disability, health status, or need for health services.
- (b) No ECMP may ask eligible individual(s) questions related to health status or the need for health services.
- (c) The ECMP staff must visibly wear or display an identification tag and offer a business card when speaking to an eligible individual(s) and provide information which ensures that the staff is not mistaken for an SSE or federal, state, or county employee.
- (d) The ECMP must inform the eligible individuals that the following ECMP information or services are available and how the eligible individual can access the information or services:
  - (i) Sign language, oral interpretation, and oral translation services at no cost to the member;
  - (ii) Written information in the prevalent non-English languages of eligible individuals or members in the ECMP's service area; and
  - (iii) Written information in alternative formats.
- (e) The ECMP must offer the eligible individual a copy of its ODJFS-approved information brochure.

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

~~(F)~~(H) Alleged marketing violations.

- (1) The MCP or ECMP must ~~will~~ immediately notify ODJFS in writing of its discovery of an alleged/suspected marketing violation.
- (2) ODJFS will forward information pertaining to alleged marketing violations to ODI and the MFCU as appropriate.

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5101:3-26-08.1      **Managed health care programs: Information and selection services.**

- (A) ODJFS may contract with or designate one or more entities to provide information and selection services to eligible individuals. Such services include informing eligible individuals about managed care and ~~MCP~~ membership options and performing activities related to the selection of an MCP, ECMP, or other health care option.
- (B) Any entity providing information and selection services must submit all related policies, procedures, and materials in writing to ODJFS for approval prior to use.
- (C) All initial MCP or ECMP selection and MCP or ECMP membership termination request transactions will be processed in accordance with rules 5101:3-26-02 and 5101:3-26-02.1 of the Administrative Code.

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5101:3-26-08.2      **Managed health care programs: Member services.**

(A) ~~Member~~ MCP member services program.

(1) Each MCP must establish and operate a member services toll-free telephone number which is accessible to members within the state of Ohio to members during normal business hours. This telephone line must have services available to assist-;

(a) Hearing-impaired members; and

(b) LEP members in the primary language of the member.

(2) The member services program must, at a minimum, assist MCP members, and, as applicable, eligible individuals seeking information about MCP membership, with the following:

(a) Accessing medicaid-covered services;

(b) Obtaining or understanding information on the MCP's policies and procedures;

(c) Understanding the requirements and benefits of the plan;

(d) Resolution of concerns, questions and problems ;

(e) Filing of grievances and appeals as specified in rule 5101:3-26-08.4 of the Administrative Code;

(f) Obtaining information on state hearing rights;

(g) Appealing to or filing directly with the United States department of health and human services office of civil rights any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services;

(h) Appealing to or filing directly with the ODJFS office of civil rights any complaints of discrimination on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services; and

(i) Accessing sign language, oral interpretation and oral translation services.-. MCPs must ensure that these services are provided at no cost to the eligible individual or member. MCPs must designate a staff person, to coordinate and document the provision of these services.

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(3) In the event the CCR does not identify a member-selected PCP for each assistance group member, or if the member-selected PCP is not available, the MCP must select a PCP for each member prior to the effective date of coverage. MCPs must notify members of the name of their PCP prior to the effective date of coverage and pursuant to the provisions of paragraphs (D)(1) and (D)(2) of rule 5101:3-26-02 of the Administrative Code. MCPs must also simultaneously notify members with an MCP-selected PCP of the ability within the first month of initial MCP membership to change the MCP-selected PCP effective on the date of contact with the MCP and explain that PCP change requests after the initial month of MCP membership shall be processed according to the procedures outlined in the MCP member handbook.

(B) ~~Member~~ MCP member materials.

(1) The MCP must develop and disseminate member materials, including at a minimum member materials specified in paragraph (B)(3) of this rule. All MCP member materials, including but not limited to those used for member education, member appreciation and member incentive programs, and changes thereto must be prior-approved in writing by ODJFS.

(2) Member materials must be:

(a) Provided in a manner and format that may be easily understood.

(b) Printed in the prevalent non-English languages of members in the MCP's service area.

(c) Available in alternative formats in an appropriate manner that takes into consideration the special needs of members including but not limited to visually-limited and LRP members.

(d) Consistent with the practice guidelines specified in paragraph (B) of rule 5101:3-26-05.1 of the Administrative Code.

(3) At a minimum, MCPs must provide the following materials to each member or assistance group, as applicable, prior to the initial effective date of coverage:

(a) A copy of the MCP's provider directory, as specified in paragraph ~~(E)~~ (G) of rule 5101:3-26-08 of the Administrative Code.

(b) The MCP's member handbook as specified in paragraph (B)(4) of this rule.

(c) ~~A~~ An MCP identification card bearing unique features, clearly listing:

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- (i) The MCP's name as stated in its article of incorporation and any other trade or DBA name used;
  - (ii) The name(s) of the member(s) enrolled in the MCP, their medicaid management information system billing number(s) and their effective date(s) of coverage;
  - (iii) The MCP's emergency procedures, which must be consistent with those approved in the member handbook, including the toll-free call-in system phone numbers as specified in paragraph (A)(6) of rule 5101:3-26-03.1 of the Administrative Code;
  - (iv) The MCP's toll-free member services number(s) as specified in paragraph (A)(1) of this rule.
  - (v) The name(s) of the PCP(s) assigned to the member(s).
- (d) Information concerning a member's right to formulate, at the member's option, advance directives including a description of applicable state law.
- (4) The MCP's member handbook must be clearly labeled as such and include, at a minimum:
- (a) The rights of members that include at a minimum, all rights found in rule 5101:3-26-08.3 of the Administrative Code and any member responsibilities specified by the MCP. With the exception of any prior-authorization requirements the MCP stipulates in the member handbook, the MCP cannot establish any member responsibility which would preclude the MCP's coverage of a medicaid-covered service.
  - (b) Information regarding services that are excluded from MCP coverage and the services and benefits that are available at or through the MCP, and how to obtain them, including at a minimum:
    - (i) All services and benefits requiring prior-authorization or referral by the MCP or the member's PCP;
    - (ii) Self-referral services, including at a minimum qualified family planning services, and women's routine and preventative health care services provided by a woman's health specialist as specified in paragraphs (H)(5) and (H)(6) of rule 5101:3-26-03 of the Administrative Code; and
    - (iii) FQHC/RHC and certified nurse practitioner services as specified in paragraphs (H)(7) and (H)(8) of rule 5101:3-26-03 of the Administrative Code.

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- (c) The procedures for accessing after hours and emergency healthcare coverage in and out of the member's county of residence and directives as to the appropriate utilization, including at a minimum:
  - (i) Explanation of emergency medical condition, emergency services, and post stabilization services as defined in rule 5101:3-26-01 of the Administrative Code;
  - (ii) Prior authorization is not required for emergency services;
  - (iii) The availability of the 911-telephone system or its local equivalent;
  - (iv) Members have a right to use any hospital or other appropriate setting for emergency services; and
  - (v) The post-stabilization care services requirements specified in paragraph (G) of rule 5101:3-26-03 of the Administrative Code.
- (d) The procedure for members to express their recommendations for change to the MCP's staff.
- (e) Identification of the medicaid consumers eligible for MCP membership.
- (f) Information stating that the MCP's identification card replaces the member's monthly medicaid health card, how often the card is issued and how to use it.
- (g) A statement that medically- necessary health care services must be obtained in or through the MCP facilities and/or providers except emergency care, behavioral health services provided through the ODMH or at ODADAS-certified facilities which are medicaid providers , and any other services or provider types designated by ODJFS.
- (h) Information on the member's responsibility to select a PCP from the MCP provider directory, how to change PCPs including the ability to change PCPs no less often than monthly and how the MCP will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change.
- (i) A description of the healthchek (EPSDT) program, including who is eligible and how to obtain healthchek (EPSDT) services through the MCP.
- (j) Information on how to arrange for MCP-provided transportation, if applicable.

**\*\*\* DRAFT – NOT FOR FILING \*\*\***

- (k) An explanation of, and procedures for, the receipt of medical services out of the member's county of residence.
- (l) Information on member-initiated termination options in accordance with paragraph (D) of rule 5101:3-26-02.1 of the Administrative Code.
- (m) Information on the availability of, reasons for, and procedures to request a member-initiated MCP membership deferment in accordance with paragraph (D)(4) of rule 5101:3-26-02 of the Administrative Code.
- (n) An explanation of automatic renewal of MCP membership in accordance with paragraph (C)(3)(i) of rule 5101:3-26-02 of the Administrative Code..
- (o) The procedure for members to file an appeal, a grievance, or a state hearing as specified in rules 5101:3-26-08.4, and 5101:3-26-08.5, of the Administrative Code.
- (p) Information about MCP-initiated terminations.
- (q) The issuance date of the member handbook.
- (r) A statement that the MCP may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services in the receipt of health services.
- (s) An explanation of subrogation and coordination of benefits.
- (t) A clear identification of corporate or parent identity when a trade name or DBA is used for the medicaid product.
- (u) Information on the procedures for members to access behavioral health services.
- (v) Information on the MCP's policies respecting the implementation of the member's rights regarding advance directives, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- (w) Information stating that the MCP provides covered services to members through a provider agreement with ODJFS, and how members can contact ODJFS, by mail or by telephone, if they so desire.
- (x) The toll-free call-in system phone numbers specified in paragraph (A)(1) of this rule and paragraph (A)(6) of rule 5101:3-26-03.1 of the Administrative Code.

\*\*\* DRAFT – NOT FOR FILING \*\*\*

- (y) A statement that additional information is available from the MCP upon request including, at a minimum, the structure and operation of the MCP and any physician incentive plans that the MCP operates.
- (z) Information on how the member can request or access additional MCP information or services including , at a minimum:
  - (i) Oral interpretation and oral translation services;
  - (ii) Written information in the prevalent non-English languages of members in the MCP's service area; and
  - (iii) Written information in alternative formats.
- (5) If a member's MCP membership is automatically renewed as specified in paragraph (C)(3)(i) of rule 5101:3-26-02 of the Administrative Code, the MCP must issue an identification card as specified in paragraph (B)(3) of this rule prior to the new effective date of coverage. Additionally, in the event the member handbook and/or provider directory have been revised since the initial MCP membership date of the member's assistance group, the MCP must issue a new member handbook and/or provider directory to the member.
- (6) At least annually, MCPs must determine the predominant health care needs of their medicaid members and provide health education materials as indicated by these assessments. MCPs must provide ODJFS a summary of the results of the health care needs assessment and a list of the materials distributed to members as a result of the assessment.
- (7) No information or text that identifies the addressee as a medicaid recipient may appear on the outside of any MCP or MCP subcontractor mailing.

(C) ECMP member services program

- (1) Each ECMP must establish and operate a member services toll-free telephone number which is accessible to members within the state of Ohio during normal business hours. This telephone line must have services available to assist :
  - (a) Hearing-impaired members; and
  - (b) LEP members in the primary language of the member.
- (2) The member services program must, at a minimum, assist ECMP members, and, as applicable, eligible individuals seeking information about ECMP membership, with the following:

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- (a) Accessing services;
- (b) Obtaining or understanding information on the ECMP's policies and procedures;
- (c) Understanding the requirements of the plan;
- (d) Resolution of concerns, questions, and problems ;
- (e) Appealing to or filing directly with the United States department of health and human services office of civil rights any complaints of discrimination on the basis of race, color, national origin, age, or disability in the receipt of health services;
- (f) Appealing to or filing directly with the ODJFS office of civil rights any complaints of discrimination on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services; and
- (g) Accessing sign language, oral interpretation and oral translation services. ECMPs must ensure that these services are provided at no cost to the eligible individual or member. ECMPs must designate a staff person to coordinate and document the provision of these services.

(3) ECMPs must assure that each member has selected or has been assigned a PCP within the first month of ECMP membership.

## (D) ECMP member materials.

(1) The ECMP must develop and disseminate member materials, including at a minimum member materials specified in paragraph (D)(3) of this rule. All ECMP member materials, including but not limited to those used for member education, member appreciation and member incentive programs, and changes thereto must be prior-approved in writing by ODJFS.

### (2) Member materials must be:

- (a) Provided in a manner and format that may be easily understood.
- (b) Printed in the prevalent non-English languages of members in the ECMP's service area.
- (c) Available in alternative formats in an appropriate manner that takes into consideration the special needs of members including, but not limited to, visually-limited and LRP members.

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(3) At a minimum, ECMPs must provide the following materials to each member or assistance group, as applicable, prior to the initial effective date of membership:

(a) The ECMP's member information packet as specified in paragraph (D)(4) of this rule.

(b) PCP information as follows:

(i) The name of the member's PCP if available;

(ii) Instructions on how and by what date the member is to select a PCP if not already identified;

(iii) Instructions on how to obtain assistance from the ECMP in the selection of a PCP.

(iv) Information on how to change PCPs.

(c) Care management information as follows:

(i) Notification of when and how the member can expect to be contacted to initiate the assessment process;

(ii) Information on who the member can contact for any immediate care coordination needs.

(4) The ECMP's member information packet must be clearly labeled and include, at a minimum:

(a) A statement that the member is entitled to all the rights available to those eligible for and receiving medicaid benefits;

(b) A statement that the member will continue to receive a medicaid card with ECMP membership indicated;

(c) A statement that the member is able to use the medicaid card to obtain services but may be encouraged to access providers designated by the ECMP in the care treatment plan;

(d) Information regarding the services available to ECMP members and how they can be obtained;

(e) The procedure for members to express to the ECMP's staff their recommendations for change;

(f) Identification of the medicaid consumers eligible for ECMP membership;

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- (g) Information on how to terminate ECMP membership;
- (h) Information about the circumstances under which the ECMP may propose member termination;
- (i) The issuance date of the information packet;
- (j) A statement that the ECMP may not discriminate in the receipt of services on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services in the receipt of health services;
- (k) A statement that the ECMP provides services to members through a provider agreement with ODJFS and how members can contact ODJFS, by mail or telephone;
- (l) The toll-free call-in system phone numbers specified in paragraph (C)(1) of this rule and in paragraph (E)(3) of rule 5101:3-26-12 of the Administrative Code;
- (m) A statement that additional information is available from the ECMP upon request including, at a minimum, the structure and operation of the ECMP and any physician incentive plans that the ECMP operates;
- (n) Information on how the member can request or access additional ECMP information or services including, at a minimum:

  - (i) Oral interpretation and oral translation services;
  - (ii) Written information in the prevalent non-English languages of members in the ECMP's service area; and
  - (iii) Written information in alternative formats.
- (o) An explanation of automatic renewal of ECMP membership in accordance with paragraph (E)(3)(e) of rule 5101:3-26-02 of the Administrative Code.
- (5) No information or text that identified the addressee as a medicaid recipient may appear on the outside of any ECMP or ECMP subcontractor mailing.

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5101:3-26-09      **Managed health care programs: Reimbursement and financial responsibility.**

(A) Reimbursement.

- (1) MCPs and ECMPs will receive a monthly premium payment for each member. If the services to be provided or arranged by MCPs include maternity coverage, a separate payment will be made for each reimbursable delivery. These payments will be in effect for the duration of the agreement unless restricted in accordance with rule 5101:3-26-10 of the Administrative Code.
- (2) The premium rates are computed on an actuarially sound basis. This rate does not include any amount for risks assumed under any other existing or any previous agreement or contract. The premium rate will be reviewed at least ~~bi-annually~~ at least once every two years and may be modified based on existing actuarial factors and experience.
- (3) Under full-risk arrangements the amounts paid in accordance with paragraph (A)(1) of this rule represent the total obligation of ODJFS to the MCP for the costs of medical care and services provided. Any savings remaining after costs have been deducted from the premium will be wholly retained by the MCP, except as provided in paragraph (A)(5) of this rule.
- (4) Under partial-risk arrangements, the MCP and ODJFS will partially share the risk for the cost of medical care and services provided. Any savings which accrue will also be shared.
- (5) ODJFS may establish financial incentive programs based on ~~MCP~~ performance for MCPs and ECMPs.

(B) Fiscal responsibility requirements.

- (1) Each MCP and each ECMP must maintain a fiscally-sound operation and meet ODFJS performance standards.
- (2) Each MCP must make provisions against the risk of insolvency.—~~Neither members nor ODJFS shall be liable for any MCP debts, including those that remain in the event of MCP insolvency or the insolvency of any subcontractors.~~
- (3) Neither members nor ODJFS shall be liable for any MCP or ECMP debts, including those that remain in the event of MCP or ECMP insolvency or the insolvency of any subcontractors.
- ~~(3)~~(4) Each MCP must pay providers in accordance with 42 CFR 447.46.

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~~(4)~~(5) The following requirements apply to MCPs licensed as a HIC by ODI:

- (a) A copy of the MCP's current license or certificate of authority must be submitted to ODJFS annually, no later than thirty days after issuance;
- (b) Copies of all annual and quarterly financial statements and any revision to such copies must be submitted to ODJFS. For purposes of this rule, "Annual financial statement" is the annual "National Association of Insurance Commissioners" (NAIC) statutory filing of financial condition as adopted and required by the Ohio department of insurance (ODI).
- (c) Each MCP must submit to ODJFS a copy of its audited financial statement as compiled by an independent auditor and including the statement of reconciliation with statutory accounting principles as required by ODI. The statement must be submitted annually to ODJFS.

(6) The following requirements apply to ECMPs:

- (a) Copies of all annual and quarterly financial statements and any revision to such copies must be submitted to ODJFS. Financial statements should be compiled in accordance with generally accepted accounting principles (GAAP);
- (b) Each ECMP must submit to ODJFS a copy of its audited financial statement as audited by an independent auditor in accordance with GAAP. The statement must be submitted annually to ODJFS.

(7) The following items must be submitted by each MCP and ECMP as so indicated:

- (a) Each MCP must submit cost reports on ODJFS forms annually, no later than ninety days after the close of the calendar year or as otherwise specified by ODJFS. The annual cost report must be audited by an independent licensed auditor and include a statement of reconciliation with statutory accounting principles. The annual cost report must also include a description of the methodology used to calculate incurred but not reported (IBNR) claims and an annual certification signed by an independent accredited actuary or licensed auditor that the methodology is valid. Such certification must be signed within the preceding twelve months and must be accompanied by a signed statement from the MCP that the methodology has not materially changed since the date the certification was signed by the independent actuary or auditor;
- (b) Each ECMP must submit cost reports on ODJFS forms annually, no later than ninety days after the close of the calendar year or as otherwise specified by ODJFS. The annual cost report must be audited by an independent licensed auditor in accordance with GAAP;

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(c) Financial disclosure statements to be submitted in conjunction with cost report submissions as specified in paragraph (B)(5)(b) of this rule for MCPs and paragraph (B)(6)(a) of this rule for ECMPs. The MCP and the ECMP must also submit copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP or ECMP, or an indirect interest of five percent or more or a combination of direct and indirect interest equal to five percent or more in the MCP or ECMP; and

(d) MCP physician incentive plan disclosure statements and other information as required by 42 CFR 417.

~~(5) Each MCP must submit the following to ODJFS:~~

~~(a) Cost reports on ODJFS forms annually, no later than ninety days after the close of the calendar year or as otherwise specified by ODJFS. The annual cost report must be compiled by an independent licensed auditor and include a statement of reconciliation with statutory accounting principles. The annual cost report must also include a description of the methodology used to calculate incurred but not reported (IBNR) claims and an annual certification signed by an independent accredited actuary or licensed auditor that the methodology is valid. Such certification must be signed within the preceding twelve months and must be accompanied by a signed statement from the MCP that the methodology has not materially changed since the date the certification was signed by the independent actuary or auditor;~~

~~(b) Financial disclosure statements to be submitted in conjunction with cost report submissions as specified in paragraph (B)(4)(b) of this rule. The MCP must also submit copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP or an indirect interest of five percent or more, or a combination of direct and indirect interest equal to five percent or more in the MCP; and~~

~~(c) Physician incentive plan disclosure statements and other information as required by 42 CFR 417.~~

(C) Reinsurance requirements.

- (1) All MCPs must carry reinsurance coverage from a licensed commercial carrier to protect against catastrophic inpatient-related medical expenses incurred by medicaid members.
- (2) To the extent that the risk for such expenses is transferred to a subcontractor the MCP must provide proof of reinsurance coverage for that subcontractor in accordance with the provisions of this paragraph.

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- (3) A copy of the fully-executed reinsurance agreement to provide the specified coverage must be submitted to ODJFS prior to the effective date of the provider agreement. No provider agreement will be signed in the absence of such documentation.
- (4) The annual deductible must be specified in the reinsurance agreement and must not exceed the amount specified by ODJFS.
- (5) The reinsurance coverage must remain in force during the term of the provider agreement with ODJFS and must contain adequate provisions for contract extensions.
- (6) Each MCP shall provide written notification to ODJFS, specifying ~~he~~ the dates of admission, diagnoses, and estimates of the total claims incurred for all medicaid ~~enrollees~~ members for which reinsurance claims have been submitted. The MCP must provide such notification to ODJFS as part of the ODJFS "Medicaid Managed Care Plan Cost Report."
- (7) The MCP must give ODJFS prior written notice of any proposed changes or modifications in the reinsurance ~~agreement~~ agreements for ODJFS review and approval. Such notice shall be submitted to ODJFS thirty days prior to the intended effective date of any proposed change and must include the complete and exact text of the proposed change. MCPs must provide copies of new or modified reinsurance agreements to ODJFS within thirty days of execution.
- (8) In the event of termination of the reinsurance agreement due to insolvency of the MCP or the reinsurance carrier, the MCP will be fully responsible for all pending or unpaid claims.
- (9) Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency must include medicaid members as a covered class.
- (10) Reinsurance requirements for partial-risk arrangements may differ from those specified in this paragraph.

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5101:3-26-10      **Managed health care programs:– Sanctions and provider agreement actions.**

(A) If the MCP or ECMP fails to fulfill its duties and obligations under Chapter 5101:3-26 of the Administrative Code and/or the MCP or ECMP provider agreement, ODJFS will provide timely written notification to the MCP or ECMP identifying the **MCP's** violations/deficiencies, and may impose any of the following sanctions in addition to or instead of any sanctions specified in the provider agreement:

(1) Corrective action in accordance with the following:

(a) If requested by ODJFS, the MCP or ECMP must submit, within the specified time frame, a proposed CAP for each cited violation/deficiency.

(b) The CAP must contain the proposed correction date, describe the manner in which each violation/deficiency will be resolved, and address all items specified in the ODJFS notification.

(c) The CAP must be reviewed and approved by ODJFS.

(d) Following the approval of the CAP, ODJFS will monitor the correction process until all violations/deficiencies are corrected to the satisfaction of ODJFS.

(e) Failure to submit an approvable CAP within the ODJFS-specified time frames may result in the imposition of an ODJFS-developed CAP and/or additional sanctions.

(f) If ODJFS has already determined the specific action which must be implemented by the MCP or ECMP, ODJFS may require the MCP or ECMP to comply with an ODJFS-developed or directed CAP.

~~(g)~~ Failure to successfully complete the correction process and correct the violations/deficiencies to the satisfaction of ODJFS may lead to the imposition of any or all of the sanctions listed in paragraphs (A)(2) to (A)(5) of this rule.

(2) Suspension of further ~~enrollments except newborns, case additions and auto-reenrollments~~ membership except ECMP and MCP automatic renewals, and MCP newborns and case additions.

(3) ODJFS notification to the MCP's or ECMP's members that they may ~~disenroll - terminate~~ from the MCP or ECMP without cause.

(4) Reduction of the premium rate.

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- (5) Retention of premium payments or a portion thereof by ODJFS until violations/deficiencies are corrected.
- (B) Sanction selection will be determined based on a pattern of repeated violations/deficiencies, the severity of cited violations/deficiencies, and/or the failure of the MCP or ECMP to meet the requirements of an approved CAP.
- (C) Sanctions in paragraphs (A)(2) to (A) (5) of this rule are subject to reconsideration as specified in paragraph (B) of rule 5101:3-1-57 of the Administrative Code, with the exception of the sanction in paragraph (A)(3) of this rule when such notification occurs in conjunction with action taken under paragraph (D) of this rule.
- (D) Regardless of any other sanction that may be imposed, ODJFS shall appoint a temporary manager for any MCP that has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438 subpart I. Such temporary management shall be imposed in accordance with the following:
- (1) The MCP must pay the costs of a temporary manager for performing the duties of a temporary manager, as determined by ODJFS.
  - (2) Any costs or liabilities incurred on behalf of an MCP by a temporary manager shall be paid by the MCP and the MCP shall be solely responsible for such costs or liabilities.
  - (3) The imposition of temporary management is not subject to the appeals process provided under Chapter 119. of the Revised Code but the MCP may request that the deputy director for the medicaid program reconsider this action. ODJFS will not delay imposition of temporary management to provide reconsideration prior to imposing this sanction.
  - (4) Unless the deputy director for the medicaid program determines through the reconsideration process that temporary management should not have been imposed, the temporary management will remain in place until such time as ODJFS determines that the MCP can ensure that the sanctioned behavior will not recur.
  - (5) Regardless of the imposition of temporary management, the MCP retains the right to appeal any proposed termination or nonrenewal of their provider agreement under Chapter 119. of the Revised Code. The MCP also retains the right to initiate the sale of the MCP or its assets.
  - (6) If temporary management is imposed, ODJFS will notify the MCP's members that such action has occurred and inform them that they therefore have the right to ~~disenroll from~~ terminate their membership in the MCP without cause.

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(E) ODJFS will provide an MCP or ECMP with written notice before imposing any sanction. The notice will include specification of any reconsideration or appeal rights that are available to the MCP or ECMP.

(F) Regardless of whether ODJFS imposes a sanction, MCPs or ECMPs are to initiate corrective action for any MCP or ECMP program violations/deficiencies as soon as they are identified by either the MCP, ECMP, or ODJFS.

(G) ODJFS may terminate, nonrenew, deny or amend a provider agreement if at any time ODJFS determines that continuation or assumption of a provider agreement is not in the best interest of recipients or the state of Ohio. For the purposes of this rule, an amendment to an MCP's or ECMP's provider agreement is defined as and limited to the elimination of one or more service areas included in that MCP's or ECMP's current agreement. ~~The phrase "best interest" includes but is not limited to the following:~~

(1) For MCPs, the phrase "best interest" includes, but is not limited to, the following:

(a) The MCP's delivery system does not assure adequate access to services for their members.

(b) The MCP's delivery system does not assure the availability of all services covered under the provider agreement.

(c) The MCP fails to provide all medically-necessary covered services.

(d) The MCP fails to provide proper assurances of financial solvency.

(e) The MCP fails to comply with the provisions of:

(i) Paragraph (C) of rule 5101:3-1-17.6 or Chapter 5101:3-26 of the Administrative Code;

(ii) The provider agreement; and/or

(iii) The applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (1935).

(2) For ECMP's, the phrase "best interest" includes, but is not limited to, the following:

(a) The ECMP's delivery system does not assure the availability of all services covered under the provider agreement.

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(b) The ECMP fails to provide proper assurances of financial solvency.

(c) The ECMP fails to comply with the provisions of:

(i) Paragraph (C) of rule 5101:3-1-17.6 or Chapter 5101:3-26 of the Administrative Code;

(ii) The provider agreement; and/or

(iii) The applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (1935).

~~(1) The MCP's delivery system does not assure adequate access to services for their members.~~

~~(2) The MCP's delivery system does not assure the availability of all services covered under the provider agreement.~~

~~(3) The MCP fails to provide all medically necessary covered services.~~

~~(4) The MCP fails to provide proper assurances of financial solvency.~~

~~(5) The MCP fails to comply with the provisions of:~~

~~(a) Paragraph (C) of rule 5101:3-1-17.6 or Chapter 5101:3-26 of the Administrative Code;~~

~~(b) The provider agreement; and/or~~

~~(c) The applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (1935).~~

(H) If ODJFS has proposed termination, nonrenewal, denial, or amendment of a provider agreement pursuant to paragraph (I)(2) of this rule, ODJFS may notify the MCP's or ECMP's members of this proposed action and inform the members of their right to immediately disenroll from the MCP or ECMP without cause. If ODJFS has proposed termination, nonrenewal, denial, or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODJFS may propose ~~the disenrollment~~ membership termination of all the MCP's or ECMP's - members. This proposed action would be subject to appeal by the MCP or ECMP - and reconsideration by the deputy director for the medicaid program. If the proposed action is not appealed or if upheld by the deputy director upon appeal, the ~~- disenrollment~~ membership termination would occur at the earliest possible effective date.

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- (I) If ODJFS determines that the termination, nonrenewal, denial or amendment of a provider agreement is warranted:
- (1) Notification will be given, at a minimum, forty-five days prior to the effective date of the proposed action, in accordance with Chapter 5101:6-50 of the Administrative Code;
  - (2) The action will be in accordance with and subject to Chapter 5101:6-50 and rules 5101:3-1-57 and 5101:3-1-17.6 of the Administrative Code; and
  - (3) All such actions will be effective at the end of the last day of a calendar month.
- (J) Notwithstanding the preceding paragraphs of this rule, provider agreements may be terminated effective on the last day of the calendar month in which any of the following occur:
- (1) The determination by ODJFS that the loss or reduction of federal or state funding has reduced funding to a level which is insufficient to maintain the activities or services agreed to in the provider agreement; or
  - ~~(2) The suspension, revocation or nonrenewal of the MCP's certificate of authority or license; or~~
  - ~~(3)~~(2) The exclusion from participation of the MCP or ECMP in the medicare, medicaid or Title XX program due to criminal conviction or the imposition of civil monetary penalties in accordance with 42 CFR 455 subpart B, 42 CFR 1002 subpart A, and rule 5101:3-1-17.3 of the Administrative Code; or
  - ~~(4)~~(3) The suspension, revocation or nonrenewal of ODJFS' authority to operate the program under waivers of certain federal regulations granted by CMS or congress; or;
  - (4) For MCPs only, the suspension, revocation or nonrenewal of their certificate of authority or license.
- (K) MCPs or ECMPs whose provider agreements are amended, terminated or nonrenewed are required to fulfill all duties and obligations under Chapter 5101:3-26 of the Administrative Code and/or the provider agreement through the last day of the agreement.

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5101:3-26-12

Managed health care programs: ECMP obligations.

(A) ECMPs must provide or arrange for the delivery of ECM services and must assure that all of the requirements of Chapter 5101:3-26 of the Ohio Administrative Code, the ECMP provider agreement, and all applicable federal, state, and local regulations are met.

(B) ECMPs must meet the obligations specified in paragraph (A) of this rule and provide or arrange for the services specified in paragraphs (D) through (F) of this rule either through direct employment relationships or through fully executed subcontracts with associated entities performing delegated activities and/or services. For the purposes of this rule, the following terms are defined as:

(1) "Subcontractor" means providers or other entities contracted with the ECMP or parts of the ECM collaborative to meet the ECM program requirements;

(2) "Fully executed" means that the legal written agreement between an ECMP and its subcontractors includes dated signatures by both parties. These signatures must be by persons legally authorized to represent those parties, including each signee's formal title.

(C) Subcontracts.

(1) All subcontracts must fulfill the requirements of 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract.

(2) A subcontract does not terminate the ECMP's legal responsibility to ODJFS to assure that all of the ECMP's program obligations are performed in accordance with 5101:3-26 and the ECM provider agreement.

(3) For subcontractors other than PCPs that are performing delegated activities, the ECMP must:

(a) Assure prior to entering the subcontract that the entity is capable of performing the delegated activity in accordance with all applicable program requirements;

(b) Provide the entity with all information, materials, and documentation necessary for the entity to meet the delegated program requirements;

(c) Arrange with the entity regular reporting, at least monthly, that summarizes program activities and performance status;

(d) Monitor and document the entity's performance on an ongoing basis and provide copies of such documentation to ODJFS;

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- (e) Complete an annual assessment of the entity's performance and satisfaction of delegated program requirements and submit to ODJFS within thirty days of completion;
  - (f) Include in the subcontract any provisions for assessing or sharing incentive or penalty payments related to either the entity's or ECMP's performance; and
  - (g) Include in the subcontract sanctions that will be imposed for unauthorized use of PHI.
- (4) For subcontractors who are PCPs the ECMP must:
- (a) Assure that the physician has a Medicaid provider agreement and is a provider in good standing.
  - (b) Not discriminate in regard to the participation, reimbursement, or indemnification of any physician who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If an ECMP declines to include a physician as a PCP, it must inform the affected physician in writing of its reasons for the decision. This paragraph may not be construed to:
    - (i) Preclude the ECMP from using different reimbursement amounts for different specialties or different practitioners in the same speciality; or
    - (ii) Preclude the ECMP from establishing measures that are designed to maintain or improve quality of services and/or achieve the performance and cost-effectiveness objectives of ECM.
  - (c) Assure and document that subcontracting PCPs have been credentialed/recredentialed using the standardized form and process prescribed by the Ohio department of insurance under Chapter 1753 of the Revised Code. Upon ODJFS request, ECMPs must demonstrate the record-keeping associated with maintaining this documentation.
- (5) ECMP subcontracts must include a Medicaid addendum that has been prior-approved by ODJFS. All addendums must contain the following:
- (a) An agreement by the subcontractor to comply with the provisions for record keeping and auditing in accordance with Chapter 5101:3-26 of the Administrative Code;
  - (b) Specification of the population and county to be served;
  - (c) Specification of the services to be provided;

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- (d) Specification that the subcontract contains the same terms that are applicable to the contracted service, be governed by, and construed in accordance with all laws, regulations, and contractual obligations of the ECMP:

  - (i) ODJFS will notify the ECMP and the ECMP shall notify the subcontractor of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the ECMP; and
  - (ii) The subcontract shall be automatically amended to conform to such changes without the necessity for executing written amendments;
- (e) Specification of the terms of the subcontract including the beginning date and expiration date, or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination;
- (f) Specification of the procedures to be employed upon the ending, nonrenewal, or termination of the subcontract, including the agreement to promptly supply all records necessary for the settlement of any outstanding claims;
- (g) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the ECMP;
- (h) An agreement not to discriminate in the delivery of services based on the member's race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services;
- (i) An agreement by the subcontractor to hold harmless both ODJFS and members in the event that the ECMP cannot or will not pay for the ECM services performed by the subcontractor pursuant to the subcontract;
- (j) An agreement by the subcontractor that the ECMP's payment constitutes payment in full for the ECM service and that the subcontractor will not charge the member or ODJFS any copayment, cost sharing, down-payment, or similar charge, refundable or otherwise;
- (k) A specification that the provider is duly licensed or certified under applicable state and federal statutes and regulations to provide the services that are the subject of the subcontract;
- (l) A stipulation that the ECMP give the subcontractor at least sixty days prior notice for the nonrenewal or termination of the subcontract except in cases where an adverse finding by a regulatory agency or quality of care concerns dictate that the subcontract be terminated sooner;

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- (m) A stipulation that the subcontractor may nonrenew or terminate the subcontract if:

  - (i) The subcontractor gives the ECMP at least sixty days prior notice for the nonrenewal or termination of the subcontract. The effective date for any subcontractor's nonrenewal or termination must be the last day of the month; or
  - (ii) ODJFS has proposed action in accordance with paragraph (G) of rule 5101:3-26-10 of the Administrative Code, regardless of whether this action is appealed, or if a quality of care concern dictates that the subcontract be terminated sooner than sixty days. The subcontractor's termination or nonrenewal notice must be received by the ECMP within fifteen working days prior to the end of the month in which the subcontractor is proposing termination or nonrenewal. If the notice is not received by this date, the subcontractor must agree to extend the termination or nonrenewal date to the last day of the subsequent month;
- (n) The subcontractor's agreement to serve members through the last day the subcontract is in effect;
- (o) The subcontractor's agreement to make member care management and medical records available for transfer to new providers as necessary to assure continuity of care coordination at no cost to the member;
- (p) A specification that PCPs and other subcontractors must allow the ECMP access to all member medical records for a period of not less than six years from the date of service and allow access to all record-keeping, audits, financial records, and medical records to ODJFS or its designee or other entities as specified in paragraph (B) of rule 5101:3-26-06 of the Administrative Code;
- (q) A specification that the subcontractor must cooperate with ODJFS quality reviews identified in rule 5101:3-26-07 of the Administrative Code;
- (r) A specification that the subcontractor must be bound by the same standards of confidentiality which apply to ODJFS and the state of Ohio as described in rule 5101:1-1-03 of the Administrative Code, including unauthorized uses of or disclosures of PHI;
- (s) A specification that any third party administrator (TPA) must include the elements of paragraph (D) of this rule in its subcontracts and ensure that its subcontractors will forward information to ODJFS as requested;

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- (t) A specification that home health providers must meet the eligible provider requirements specified in rules 5101:3-12-05 and 5101:3-12-06 of the Administrative Code;
- (u) A specification that PCPs must participate in the care coordination requirements outlined in this rule;
- (v) A specification that the subcontractor in providing services to members must identify and where indicated arrange for the following at no cost to the member:
  - (i) Sign language services; and
  - (ii) Oral interpretation and oral translation services.
- (w) A specification that the ECMP may not prohibit, or otherwise restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:
  - (i) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - (ii) Any information the member needs in order to decide among all relevant treatment options.
  - (iii) The risks, benefits, and consequences of treatment versus non-treatment.
  - (iv) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- (x) A stipulation that the subcontractor must not identify the addressee as a medicaid consumer on the outside of the envelope when contacting members by mail;
- (y) An agreement by the subcontractor that members will not be billed for missed appointments;
- (z) An agreement by the subcontractor that in the performance of the subcontract or in the hiring of any employees for the performance of services under the subcontract, shall not by reason of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status or ancestry, discriminate against any citizen of Ohio in the employment of a

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person qualified and available to perform the services to which the subcontract relates

(aa) An agreement by the subcontractor that it shall not in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the subcontract on account of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.

(6) ECMPs must notify ODJFS of the addition, deletion, or modification of subcontracts as they occur and in accordance with the notification requirements below:

(a) Notify ODJFS of additions or modifications to subcontracts at least thirty calendar days after the effective date of the subcontract;

(b) Notify ODJFS of subcontract expirations, nonrenewals, or terminations at least thirty calendar days prior to the effective date of such expiration, nonrenewal, or termination, or within one day of becoming aware of such action if less than thirty days prior to the effective date;

(c) If the deletion affects a PCP, the ECMP must notify, in writing, all members who are served by the PCP. This notice must:

(i) inform the member of the PCP's name and last date of ECMP service;

(ii) be sent at least forty-five calendar days prior to the PCP's last date of ECMP service;

(iii) include information on how the member can select a new PCP or will be assigned to one if no new selection is made by a date specified by the EMCP;

(iv) include an ECMP telephone number that the member may call for more information, assistance, and to make a new PCP selection.

(7) For subcontractors who are members of the ECM collaborative or PCPs, the ECMP must conduct at least annual surveys to assess satisfaction and identify areas for improvement. The ECMP must submit a report to ODJFS with the results and proposed action to improve any identified deficiencies within ninety days of survey completion.

(D) ECM services must include but are not limited to:

(1) Member outreach, assessment, and treatment plan development;

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(2) Care management and coordination;

(3) Twenty-four hour, seven day toll-free health advice line;

(4) Provider relations and education;

(5) Member education and services; and

(6) Promotion of best clinical practices.

(E) ECMP care coordination responsibilities include but are not limited to:

(1) Assurance that each member has a PCP who will manage overall care appropriate to the member's needs as specified in paragraph (F) of this rule;

(2) Information sharing among members of the ECM collaborative and non-member entities to assure care coordination occurs for each member;

(3) Provision of a centralized twenty-four hour toll-free call-in system which is available nationwide:

(a) The call-in system must be staffed by trained medical professionals who will provide members with medical advice and direct members to the appropriate care setting. Such system must also provide information to members and/or providers as necessary to assure access, including, but not limited to, membership status. ECMPs may not require members to contact their PCP or any other entity prior to contacting the twenty-four hour toll-free call-in system for advice or direction concerning emergency and/or after-hours services.

(b) A log for the twenty-four hour toll-free call-in system must be maintained, and accessible, by the ECMP and must include at a minimum:

(i) Identification of the member;

(ii) Date and time of call;

(iii) Member's question, concern or presenting problem;

(iv) Disposition of call;

(v) PCP or other provider if contacted by ECMP; and

(vi) Name and title of person taking the call.

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(c) The twenty-four hour toll-free call-in system must have services available to assist:

(i) Hearing impaired members; and

(ii) LEP members in the primary language of the member.

(4) Provision or arrangement of case management (CM) services to coordinate and monitor treatment delivered to members according to their diagnosis and/or related circumstances.

(a) ECMPs must notify all members of the CM services they are eligible to receive;

(b) ECMPs must provide or arrange for and document the following, at a minimum:

(i) Outreach to the member and assessment of the member's health condition;

(ii) Convening of a CM team appropriate to the member's condition and including, at a minimum, the member's PCP, a designated care manager, and the member or member's representative;

(iii) Development and implementation of a written care treatment plan for each member.

(c) ECMPs must report CM data to ODJFS, as required.

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

(1) Assisting with the coordination of the member's overall care;

(2) Participating in the development of the member's care treatment plan;

(3) Participating on the member's CM team; and

(4) Serving as the source of primary and preventive care for the member.