Ohio Administrative Code

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

Effective: January 1, 2026

(A) Disenrollment from the MyCare Ohio program occurs for the following reasons:

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

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

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

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

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

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

(B) Individual disenrollments.

(1) An individual's enrollment with an MCOP is terminated when the provider agreement between ODM and the MCOP is terminated or not renewed. The effective date of disenrollment is the date of the provider agreement termination or nonrenewal. The individual is reassigned to a new MCOP without a break in coverage in such a circumstance.

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

(3) All disenrollments occur at the individual level;

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

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

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

(C) Member-initiated disenrollments.

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

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

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

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

(a) From the date of initial enrollment through the first three months of plan enrollment, for medicaid-only enrollment periods;

(b) During an open enrollment month as described in paragraph (E) of this rule; or

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

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

(a) The request may be made by the member, or by the member's authorized representative as long as the authorized representative is not a provider for the member..

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

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

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

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

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

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

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

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

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

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

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

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

cause:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Open enrollment

Open enrollment for medicaid occurs at least annually. At least sixty days prior to the designated open enrollment month, ODM notifies eligible individuals of the opportunity to change enrollment in an MCOP and explains how the individual can obtain further information.

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

federal rules.