

5101:3-26-03

**Managed health care programs: covered services.**

- (A) Except as provided in this rule, managed care plans (MCPs) must ensure that members have access to all medically-necessary services covered by medicaid. The MCP must ensure that:
- (1) Services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished;
  - (2) The amount, duration, or scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;
  - (3) Coverage decisions are based on the coverage and medical necessity criteria published in ~~division~~agency 5101:35160 of the Administrative Code and practice guidelines specified in ~~paragraph (B) of rule 5101:3~~rule 5160-26-05.1 of the Administrative Code; and
  - (4) If a member is unable to obtain medically-necessary services offered by medicaid from a MCP panel provider, the MCP must adequately and timely cover the services out of panel, until the MCP is able to provide the services from a panel provider.
- (B) MCPs may place appropriate limits on a service;
- (1) On the basis of medical necessity; or
  - (2) For the purposes of utilization control, provided the services furnished can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.
- (C) MCPs must cover annual physical examinations for adults.
- (D) At the request of the member, MCPs must provide for a second opinion from a qualified health care professional within the panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.
- (E) MCPs must assure that emergency care services as defined in rule ~~5101:35160-26-01~~ of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:

- (1) MCPs may not deny payment for treatment obtained when a member had an emergency medical condition, as defined in rule 5160-26-01 of the Administrative Code ~~including cases in which the absence of immediate medical attention would not have resulted in the outcomes specified in paragraph (W) of rule 5101:3-26-01 of the Administrative Code.~~
- (2) MCPs cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- (3) MCPs must cover all emergency services without requiring prior authorization.
- (4) MCPs must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the MCP including but not limited to the member's PCP or the MCP's twenty-four-hour toll-free call-in-system.
- (5) MCPs cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.
- (6) For the purposes of this paragraph, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the MCP but provides emergency services to an MCP member, regardless of whether or not that provider has a medicaid provider agreement with ODM. An MCP must cover emergency services as defined in ~~paragraph (X) of rule 5101:35160-26-01~~ rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services and claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in ~~paragraph (W) of rule 5101:35160-26-01~~ rule 5160-26-01 of the Administrative Code. Such services must be reimbursed by the MCP at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the MCP is required to reimburse at this rate only until the member can be transferred to a provider designated by the MCP.
- (7) MCPs must adhere to the judgment of the attending provider when requesting a member's transfer to another facility or discharge. MCPs may establish arrangements with hospitals whereby the MCP may designate one of its contracting providers to assume the attending provider's responsibilities to

stabilize, treat and transfer the member.

- (8) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
- (F) MCPs must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services as described in paragraph (E)(6) of this rule. Such information must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. MCPs may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.
- (G) MCPs must assure that post-stabilization care services as defined in rule ~~5101:35160~~-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week.
- (1) The MCP must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day. MCPs must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The MCP must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time that the MCP communicated the decision in writing to the provider.
- (2) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:
- (a) MCPs must cover services obtained within or outside the MCP's panel that are pre-approved in writing to the requesting provider by a plan provider or other MCP representative.
- (b) MCPs must cover services obtained within or outside the MCP's panel that are not pre-approved by a plan provider or other MCP representative but are administered to maintain the member's stabilized condition within one hour of a request to the MCP for preapproval of further post-stabilization care services.
- (c) MCPs must cover services obtained within or outside the MCP's panel

that are not pre-approved by a plan provider or other MCP representative but are administered to maintain, improve or resolve the member's stabilized condition if:

- (i) The MCP fails to respond within one hour to a provider request for authorization to provide such services.
- (ii) The MCP cannot be contacted.
- (iii) The MCP's representative and treating provider cannot reach an agreement concerning the member's care and a plan provider is not available for consultation. In this situation, the MCP must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care until a plan provider is reached or one of the criteria specified in paragraph (G)(3) of this rule is met.

(3) The MCP's financial responsibility for post stabilization care services it has not pre-approved ends when:

- (a) A plan provider with privileges at the treating hospital assumes responsibility for the member's care;
- (b) A plan provider assumes responsibility for the member's care through transfer;
- (c) A MCP representative and the treating provider reach an agreement concerning the member's care; or
- (d) The member is discharged.

(H) Exclusions, limitations and clarifications.

(1) When an MCP member is placed in a nursing facility (NF) and is not using a hospice service, the MCP is responsible for payment of medically necessary NF services as described in rule ~~5101:35160-3-02.3~~ of the Administrative Code. MCP members may be disenrolled upon request to ODM by the MCP in accordance with ~~paragraph (C) of rule 5101:35160-26-02.1~~ of the Administrative Code if all of the following are met:

- (a) The MCP has authorized NF services for the month of NF admission and

for one complete consecutive calendar month thereafter;

- (b) For the entire period in (a) above, the member has remained in the NF without any admission to an inpatient hospital or long-term acute care (LTAC) facility;
  - (c) The member's discharge plan documents that NF discharge is not expected in the foreseeable future and the member has a need for long-term NF care.
- (2) MCPs are not responsible for payment of services provided to a member that has been enrolled in a home and community-based waiver program administered by ODM, the Ohio department of aging (ODA), or the Ohio department of developmental disabilities (ODODD). MCP members enrolled in a waiver program will be disenrolled in accordance with ~~paragraph (C)(2)(h) of rule 5101:35160-26-02.1~~ of the Administrative Code.
- (3) MCPs are not responsible for payment of habilitation services as described in 42 U.S.C. 1396n(c)(5) (~~April 15~~ August 9, 2013).
- (4) MCP members are permitted to self-refer to mental health services and substance abuse services offered through the Ohio department of mental health and addiction services (MHA) community mental health centers and MHA-certified medicaid providers. MCPs must ensure access to medicaid-covered behavioral health services for members who are unable to timely access services or unwilling to access services through community providers.
- (5) MCP members are permitted to self-refer to Title X services provided by any qualified family planning provider (QFPP). The MCP is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the MCP at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges, in effect for the date of service.
- (6) MCPs must permit members to self-refer to any women's health specialist within the MCP's panel for covered care necessary to provide women's routine and preventative health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.
- (7) MCPs must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).

- (8) Where available, MCPs must ensure access to covered services provided by a certified nurse practitioner.
- (9) ODM may approve an MCP's members to be referred to certain MCP non-contracting hospitals, as specified in rule ~~5101:35160~~-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODM permits such authorization, ODM will notify the MCP and the MCP non-contracting hospital of the terms and conditions, including the duration, of the approval and the MCP must reimburse the MCP non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the MCP non-contracting hospital. ODM will base its determination of when an MCP's members can be referred to MCP non-contracting hospitals pursuant to the following:
- (a) The MCP's submission of a written request to ODM for the approval to refer members to a hospital that has declined to contract with the MCP. The request must document the MCP's contracting efforts and why the MCP believes it will be necessary for members to be referred to this particular hospital; and
  - (b) ODM consultation with the MCP non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the MCP, including but not limited to whether the MCP's contracting efforts were unreasonable and/or that contracting with the MCP would have adversely impacted the hospital's business.
- (10) Paragraph (H)(9) of this rule is not applicable when an MCP and an MCP non-contracting hospital have mutually agreed to that hospital providing non-emergency hospital services to an MCP's members. MCPs must ensure that such arrangements comply with ~~paragraph (A)(9) of rule 5101:35160~~-26-05 of the Administrative Code.
- (11) MCPs are not responsible for payment of services provided through medicaid school program (MSP) providers pursuant to Chapter ~~5101:35160~~-35 of the Administrative Code. MCPs must ensure access to medicaid-covered services for members who are unable to timely access services or unwilling to access services through MSP providers.
- (12) MCPs are responsible for providing respite services to eligible members, as described in this paragraph. "Respite services" are services that provide short-term, temporary relief to the informal unpaid caregiver of an individual

under the age of twenty-one in order to support and preserve the primary caregiving relationship. The service provides general supervision of the child, and meal preparation and hands-on assistance with personal care that are incidental to supervision of the child during the period of service delivery. Respite services can be provided on a planned or emergency basis and shall only be furnished in the child's home. The provider must be awake during the provision of respite services and the services shall not be provided overnight.

(a) To be eligible for respite services, the member must meet all of the following criteria:

(i) The member must reside with his or her informal, unpaid primary caregiver in a home or an apartment that is not owned, leased or controlled by a provider of any health-related treatment or support services.

(ii) The member must not be residing in foster care.

(iii) The member must be under the age of twenty-one and determined eligible for social security income for children with disabilities or supplemental security disability income for adults disabled since childhood.

(iv) The member must be enrolled in the MCP's care management program.

(v) The member must be determined by the MCP to meet an institutional level of care as set forth in rules 5160-3-07 and 5160-3-08 of the Administrative Code.

(vi) The member must require skilled nursing or skilled rehabilitation services at least once per week.

(vii) The member must have received at least fourteen hours per week of home health aide services for at least six consecutive months immediately preceding the date respite services are requested.

(viii) The MCP must have determined that the child's primary caregiver has a need for temporary relief from the care of the child as a result of the child's long term services and support needs/disabilities, or in order to prevent the provision of institution or out-of-home placement.

(b) Respite services are limited to no more than twenty-four hours per month and no more than two hundred fifty hours per calendar year.

(c) Respite services must be provided by individuals employed by enrolled

medicaid providers that are either medicare-certified home health agencies pursuant to Chapter 3701-60 of the Administrative Code, or otherwise-accredited agencies (i.e., accredited by the "Joint Commission", the "Community Health Accreditation Program", or the "Accreditation Commission for Health Care") as that term is defined in rule 5160-45-01 of the Administrative Code.

(i) Before commencing service delivery, the provider agency employee must:

(a) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under Section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 CFR 484.36 (August 14, 2013), and

(b) Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

(ii) After commencing service delivery, the provider agency employee must:

(a) Maintain evidence of completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation, and

(b) Receive supervision from an Ohio-licensed RN and meet any other additional supervisory requirements pursuant to the agency's certification or accreditation.

(d) Respite services must not be delivered by the child's legally responsible family member or foster caregiver.

~~(12)~~(13) MCPs must provide all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with the periodicity schedule identified in Chapter ~~5101:35160~~-14 of the Administrative Code, to eligible individuals and assure that services are delivered and monitored as follows:

(a) Healthchek exams must include those components specified in Chapter ~~5101:35160~~-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual



external quality review.

(b) The MCP or its contracting provider must notify members of the appropriate healthcheck exam intervals as specified in Chapter ~~5101:3~~5160-14 of the Administrative Code.

(c) Healthcheck exams are to be completed within ninety days of the initial effective date of membership for those children found to have a possible ongoing condition likely to require care management services.

(I) Out-of-country coverage

MCPs are not required to cover services provided to members outside the United States.

Effective:

R.C. 119.032 review dates: 07/01/2018

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Certification

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Date

Promulgated Under: 119.03  
Statutory Authority: 5167.02  
Rule Amplifies: 5162.03, 5167.03, 5167.20, 5167.201, 5167.10, 5167.12  
Prior Effective Dates: 4/1/85, 5/2/85, 10/1/87, 2/15/89 (Emer), 5/8/89, 11/1/89 (Emer), 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer), 9/27/97, 5/14/99, 12/10/99, 7/1/00, 7/1/01, 7/1/02, 7/1/03, 1/1/06, 6/1/06, 1/1/07, 7/1/07, 1/1/08, 9/15/08, 2/1/10, 1/1/13, 7/1/13