5160-26-03 **Managed ~~health~~ care ~~programs~~: covered services.**

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

~~(A)~~(B) Except as otherwise provided in this rule, a managed care ~~plan~~ organization~~(MCP)~~ (MCO) and the single pharmacy benefit manager (SPBM) must ensure members have access to all medically necessary services, as applicable, covered by Ohio medicaid under the state plan. ~~Specific coverage provisions for "MyCare Ohio" plans as defined in rule 5160-58-01 of the Administrative Code are described in Chapter 5160-58 of the Administrative Code.~~ The ~~MCP~~ MCO and SPBM must ensure:

(1) Services are sufficient in amount, duration, ~~or~~ and scope to reasonably be expected to achieve the purpose for which the services are ~~furnished~~provided;

(2) The amount, duration, ~~or~~ and scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) Prior authorization is available for services on which ~~an MCP~~the MCO or the SPBM has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary, unless the ~~MCP~~MCO or SPBM's ~~'s~~ limitation is also a limitation for fee-for-service medicaid coverage;

(4) Coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and

(5) If a member is unable to obtain medically necessary services offered by medicaid from ~~a~~ an ~~MCP~~MCO or SPBM ~~panel~~ network provider, the ~~MCP~~MCO or SPBM must adequately and timely cover the services out of ~~panel~~network, until the ~~MCP~~MCO or SPBM is able to provide the services from a ~~panel~~ network provider.

~~(B)~~(C) The ~~MCP~~MCO and SPBM may place appropriate limits on a service~~:~~;

(1) On the basis of medical necessity for the member's condition or diagnosis; 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)~~(B)(1) of this rule.

~~(C)~~(D) Upon implementation of the ~~The MCP~~SPBM will provide pharmacy services in compliance with rule 5160-9-03 of the Administrative Code, including all prescribing and prior authorization requirements, and any grandfathered drug classes

as established by the Ohio department of medicaid (ODM) preferred drug list located at https://pharmacy.medicaid.ohio.gov/. The ~~MCP~~SPBM ~~is~~will not ~~required to~~ charge co-pays unless directed by ODM. Until implementation of the SPBM, the provisions outlined in this paragraph are applicable to the MCO.

(E) Services covered by an MCO.

~~(D)~~(1) The ~~MCP~~MCO must cover annual physical examinations for adults.

~~(E)~~(2) At the request of the member, ~~an MCP~~the MCO must provide for a second opinion from a qualified health care professional within the ~~panel~~MCO's network. If such a qualified health care professional is not available within the ~~MCP~~MCO's ~~panel~~network, the ~~MCP~~MCO must arrange for the member to obtain a second opinion outside the ~~panel~~MCO's network, at no cost to the member.

~~(F)~~(3) The ~~MCP~~MCO must ensure emergency services as defined in rule 5160-26-01 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)~~(a) The ~~MCP~~MCO cannot deny payment for treatment obtained when a member had an emergency medical condition~~,~~ as defined in rule 5160-26-01 of the Administrative Code.

~~(2)~~(b) The ~~MCP~~MCO cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

~~(3)~~(c) The ~~MCP~~MCO must cover all emergency services without requiring prior authorization.

~~(4)~~(d) The ~~MCP~~MCO 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~~MCO, including but not limited to, the member's primary care provider (PCP) or the ~~MCP's~~ MCO's twenty-four-hour toll-free phone number.

~~(5)~~(e) The ~~MCP~~MCO 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)~~(f) ~~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 that provider has a medicaid provider agreement with the ODM. An MCP~~The MCO must cover emergency services as defined in 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 rule 5160-26-01 of the Administrative Code. Such services must be reimbursed by the ~~MCP~~MCO at the lesser of billed charges or one hundred per cent of the Ohio medicaid program 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 reimbursement rate) in effect for the date of service. If an inpatient admission results, the ~~MCP~~MCO is required to reimburse at this rate only until the member can be transferred to a provider designated by the ~~MCP~~MCO. Pursuant to section 5167.10 of the Revised Code, the ~~MCP~~MCO shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.

~~(7)~~(g) The ~~MCP~~MCO must cover emergency services until the member is stabilized and can be safely discharged or transferred.

~~(8)~~(h) The ~~MCP~~MCO must adhere to the judgment of the attending provider when requesting a member's transfer to another facility or discharge. ~~MCPs~~ The MCO may establish arrangements with hospitals whereby the ~~MCP~~MCO may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat, and transfer the member.

~~(9)~~(i) 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.

~~(C)~~(4) The ~~MCP~~MCO 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 upon request to non-contracting providers, including non-contracting providers of emergency services. ~~An MCP~~The MCO shall 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.

~~(H)~~(5) The ~~MCP~~MCO must ensure post-stabilization care services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week.

~~(1)~~(a) The ~~MCP~~MCO 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. ~~An MCP~~The MCO must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The ~~MCP~~MCO 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 the ~~MCP~~MCO communicated the decision in writing to the provider.

~~(2)~~(b) At a minimum, post-stabilization care services must be provided and reimbursed in accordance with the following:

~~(a)~~(i) The ~~MCP~~MCO must cover services obtained within or outside the ~~MCP's panel~~ MCO's network that are pre-approved in writing to the requesting provider by ~~a plan~~ an MCO provider or other ~~MCP~~MCO representative.

~~(b)~~(ii) The ~~MCP~~MCO must cover services obtained within or outside the ~~MCP's panel~~ MCO's network that are not pre-approved by ~~a plan~~ an MCO provider or other ~~MCP~~MCO representative but are administered to maintain the member's stabilized condition within one hour of a request to the ~~MCP~~MCO for pre-approval of further post-stabilization care services.

~~(c)~~(iii) The ~~MCP~~MCO must cover services obtained within or outside the ~~MCP's panel~~ MCO's network that are not pre-approved by ~~a plan~~ an MCO provider or other ~~MCP~~MCO representative but are administered to maintain, improve, or resolve the member's stabilized condition if:

~~(i)~~*(a)* The ~~MCP~~MCO fails to respond within one hour to a provider request for authorization to provide such services.

~~(ii)~~*(b)* ~~The MCP cannot be contacted.~~The provider has documented an attempt to contact the MCO to request authorization, but the MCO connot be contacted.

~~(iii)~~*(c)* The ~~MCP's~~ MCO's representative and treating provider cannot reach an agreement concerning the member's care and ~~a plan~~ an MCO provider is not available for consultation. In this situation, the ~~MCP~~MCO must give the treating provider the opportunity to consult with ~~a plan~~ an MCO provider and the treating provider may continue with care until ~~a plan~~ an MCO provider is reached or one of the criteria specified in paragraph (E)(5)(c)~~(G)(3)~~ of this rule is met.

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

~~(a)~~(i) ~~A plan~~ An MCO provider with privileges at the treating hospital assumes responsibility for the member's care;

~~(b)~~(ii) ~~A plan~~ An MCO provider assumes responsibility for the member's care through transfer;

~~(c)~~(iii) An ~~MCP~~MCO representative and the treating provider reach an agreement concerning the member's care; or

~~(d)~~(iv) The member is discharged.

~~(I) MCP responsibilities for payment of other services.~~

~~(1)~~(6) When an ~~MCP~~MCO member has a nursing facility (NF) stay, the ~~MCP~~MCO is responsible for payment of medically necessary NF services~~,~~ until the member is discharged or until the member is disenrolled in accordance with the processes set forth in rule 5160-26-02.1 of the Administrative Code.

~~(2)~~(7) The ~~MCP~~MCO is not responsible for payment of home and community-based services (HCBS) provided to a member who is enrolled in an HCBS waiver program administered by ODM, the Ohio department of aging (ODA), or the Ohio department of developmental disabilities (DODD).

~~(3)~~(8) ~~MCP~~MCO members are permitted to self-refer to Title X services provided by any qualified family planning provider (QFPP). The ~~MCP~~MCO is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the ~~MCP~~MCO 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.

~~(4)~~(9) The ~~MCP~~MCO must permit members to self-refer to any women's health specialist within the ~~MCP's panel~~ MCO's network for covered care necessary to

provide women's routine and preventive health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.

~~(5)~~(10) The ~~MCP~~MCO must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).

~~(6)~~(11) Where available, the ~~MCP~~MCO must ensure access to covered services provided by a certified nurse practitioner.

~~(7)~~(12) ODM may approve an ~~MCP's~~ MCO's members to be referred to certain ~~MCP~~MCO non-contracting hospitals, as specified in rule 5160-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODM permits such authorization, ODM will notify the ~~MCP~~MCO and the ~~MCP~~MCO non-contracting hospital of the terms and conditions, including the duration, of the approval and the ~~MCP~~MCO must reimburse the ~~MCP~~MCO 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~~MCO non-contracting hospital. ODM will base its determination of when an ~~MCP~~MCO's members can be referred to ~~MCP~~MCO non-contracting hospitals pursuant to the following:

(a) The ~~MCP's~~ MCO'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~~MCO. The request must document the ~~MCP's~~ MCO's contracting efforts and why the ~~MCP~~MCO believes it will be necessary for members to be referred to this ~~particular~~ hospital; and

(b) ODM consultation with the ~~MCP~~MCO non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the ~~MCP~~MCO, including but not limited to whether the ~~MCP's~~ MCO's contracting efforts were unreasonable and/or that contracting with the ~~MCP~~MCO would have adversely impacted the hospital's business.

~~(8)~~(13) Paragraph ~~(H)(7)~~(E)(12) of this rule is not applicable when ~~an MCP~~the MCO and an ~~MCP~~MCO non-contracting hospital have mutually agreed ~~to~~ that the non-contracting hospital will ~~providing~~ provide non-emergency hospital services to an ~~MCP's~~ MCO's members. The ~~MCP~~MCO must ensure that such arrangements comply with rule 5160-26-05 of the Administrative Code.

~~(9)~~(14) The ~~MCP~~MCO is not responsible for payment of services provided through medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. ~~An MCP~~The MCO must ensure access to medicaid-

covered services for members who are unable to timely access services or unwilling to access services through MSP providers.

~~(10) The MCP is not required to cover services provided to members outside the United States.~~

~~(11)~~(15) When a member is determined to be no longer eligible for enrollment in an ~~MCP~~MCO during a stay in an institution for mental disease (IMD), the ~~MCP~~MCO is not responsible for payment of that IMD stay after the date of disenrollment from the ~~plan~~MCO.

(16) The MCO must provide two dental cleanings per year to pregnant members of the eligibility group described in section 5163.06 of the Revised Code.

~~(J)~~(17) The MCO must cover respite services as described in rule 5160-26-03.2 of the Administrative Code.~~"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 MCP shall be responsible for payment for respite services. Respite services can be provided on a planned or emergency basis. The provider must be awake when the member is awake during the provision of respite services.~~

~~(1) To be eligible for respite services, the member must:~~

~~(a) 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;~~

~~(b) Not be a foster child, as defined in Chapter 5101:2-1 of the Administrative Code;~~

~~(c) Be under twenty-one years of age;~~

~~(d) Currently be participating in a care management /coordination arrangement; and~~

~~(e) Meet either of the following:~~

~~(i) Have long-term service and support (LTSS) needs as determined by the MCP through an institutional level of care determination as set forth in rule 5123:2-8-01, 5160-3-08 or 5160-3-09 of the Administrative Code, and~~

(a) Require skilled nursing or skilled rehabilitation services at least once per week,

(b) Be determined eligible for social security income for children with disabilities or supplemental security income,

(c) Had a need for at least fourteen hours per week of home health aide services for at least two consecutive months immediately preceding the date respite services are requested, and

(d) The MCP must have determined that the member's primary caregiver has a need for temporary relief from the care of the member as a result of the member's LTSS needs, or in order to prevent an inpatient, institutional or out-of-home stay; or

(ii) Have behavioral health needs as determined by the MCP through the use of a nationally recognized standardized functional assessment tool, and

(a) Be diagnosed with serious emotional disturbance as described in the appendix to this rule resulting in a functional impairment,

(b) Not be exhibiting symptoms or behaviors that indicate imminent risk of harm to himself or herself or others, and

(c) The MCP must have determined that the member's primary caregiver has a need for temporary relief from the care of the member as a result of the member's behavioral health needs, either:

(i) To prevent an inpatient, institutional or out-of-home stay; or

(ii) Because the member has a history of inpatient, institutional or out-of-home stays.

(2) Respite services are limited to one hundred hours per calendar year per member, however, this may be exceeded through MCP prior authorization on the basis of medical necessity.

~~(3) LTSS respite services must be provided by individuals employed by medicaid enrolled agency providers that are either medicare-certified home health agencies pursuant to Chapter 3701-60 of the Administrative Code, or accredited by the "Joint Commission," the "Community Health Accreditation Program," or the "Accreditation Commission for Health Care."~~

~~(a) LTSS respite providers must comply with the criminal records check requirements set forth in rules 5160-45-07 and 5160-45-11 of the Administrative Code.~~

~~(b) Before commencing service delivery, the LTSS provider agency employee must:~~

~~(i) 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 C.F.R. 484.36 (October 1, 2019), and~~

~~(ii) 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.~~

~~(c) After commencing service delivery, the LTSS provider agency employee must:~~

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

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

~~(4) Behavioral health respite services must be provided by individuals employed by OhioMHAS-certified and medicaid enrolled agency providers that are also accredited by the "Joint Commission," "Council on Accreditation" or "Commission on Accreditation of Rehabilitation Facilities."~~

~~(a) Behavioral health respite providers must comply with the criminal records check requirements set forth in rule 5160-43-09 of the Administrative Code when the service is provided in an HCBS setting.~~

~~(b) Before commencing service delivery, the behavioral health provider agency employee must:~~

~~(i) Either be credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board or received training for or education in mental health competencies and have demonstrated, prior to or within ninety days of hire, competencies in basic mental health skills along with competencies established by the agency; and~~

~~(ii) 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.~~

~~(c) After commencing service delivery, the behavioral health provider agency employee must receive supervision from an independently licensed behavioral health professional credentialed by the Ohio counselor, social worker and marriage and family therapist board, the state of Ohio psychology board, the state of Ohio board of nursing or the state of Ohio medical board.~~

~~(5) Respite services must not be delivered by the member's "legally responsible family member" as that term is defined in rule 5160-45-01 of the Administrative Code or the member's foster caregiver.~~

(18) The MCO is not responsible for covering services described in rule 5160-59-03 of the Administrative Code for a member enrolled in the OhioRISE plan.

(F) The MCO and SPBM are not required to cover services provided to members outside the United States.

~~(K)~~(G) ~~An~~ The ~~MCP~~MCO and SPBM must ensure that eligible members receive ~~provide~~ all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with rule 5160-1-14 of the

Administrative Code.~~, to eligible members~~ The MCO will ~~and~~ ensure healthchek exams:

(1) Include the components specified in rule 5160-1-14 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.

(2) Are completed within ninety days of the initial effective date of enrollment for those children found to have a possible ongoing condition likely to require care management services.

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CERTIFIED ELECTRONICALLY

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