

5160-26-03

Managed health care programs: covered services.

- (A) Except as otherwise provided in this rule, a managed care plan (MCP) must ensure members have access to all medically-necessary services 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 must ensure:
- (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) Prior authorization is available for services on which an MCP has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary, unless the MCP'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 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) The MCP 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)(1) of this rule.
- (C) The MCP must cover annual physical examinations for adults.
- (D) At the request of the member, an MCP 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) The MCP 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) The MCP 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) The MCP cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- (3) The MCP must cover all emergency services without requiring prior authorization.
- (4) The MCP 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 primary care provider (PCP) or the MCP's twenty-four-hour toll-free phone number.
- (5) The MCP 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 that provider has a medicaid provider agreement with the Ohio department of medicaid (ODM). An MCP 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 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 is required to reimburse at this rate only until the member can be transferred to a provider designated by the MCP. Pursuant to section 5167.10 of the Revised Code, the MCP shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.

- (7) The MCP must cover emergency services until the member is stabilized and can be safely discharged or transferred.
 - (8) The MCP 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.
 - (9) 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) The MCP 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 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.
- (G) The MCP 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) 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. An MCP 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 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) The MCP 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) The MCP 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 pre-approval of further post-stabilization care services.
- (c) The MCP 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 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) An MCP representative and the treating provider reach an agreement concerning the member's care; or
 - (d) The member is discharged.
- (H) MCP responsibilities for payment of other services.
 - (1) When an MCP member has a nursing facility (NF) stay, the MCP is responsible for payment of medically necessary NF services, until discharge or until the member is disenrolled in accordance with the processes set forth in rule 5160-26-02.1 of the Administrative Code.

- (2) The MCP 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) 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.
- (4) The MCP 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 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) The MCP must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).
- (6) Where available, the MCP must ensure access to covered services provided by a certified nurse practitioner.
- (7) ODM may approve an MCP's members to be referred to certain MCP 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 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.
 - (8) Paragraph (H)(7) 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. The MCP must ensure that such arrangements comply with rule 5160-26-05 of the Administrative Code.
 - (9) The MCP is not responsible for payment of services provided through medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. An MCP 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) When a member is determined to be no longer eligible for enrollment in an MCP during a stay in an institution for mental disease (IMD), the MCP is not responsible for payment of that IMD stay after the date of disenrollment from the plan.
- (I) "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 ~~enrolled in the MCP's~~ participating in a care management program/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, ~~2017~~2018), 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.
- (J) An MCP must 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 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.

Effective:

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Certification

Date

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