CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Medicaid Managed Care Program

Rule Number(s): 5160-26-02, 5160-26-03, 5160-26-3.1, and 5160-26-09

Rules 5160-26-08.3 and 5160-26-11 are not subject to CSIO review, but are included for reference.

Date: September 21, 2017

Rule Type:

New	X 5-Year Review
X Amended	Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   In Ohio, approximately 86% of Medicaid recipients receive their Medicaid services through a Managed Care Plan (MCP) or MyCare Ohio Plan (MCOP). MCPs/MCOPs are health insurance companies licensed by the Ohio Department of Insurance and have a provider agreement (contract) with the Ohio Department of Medicaid (ODM) to provide coordinated health care to Medicaid beneficiaries. There are six MCPs/MCOPs (referred to as plans) in Ohio each with a network of

health care professionals. The rules outlined in Chapter 5160-26 of the Administrative Code set forth the requirements of MCPs and the Ohio Medicaid managed care program.

OAC rule 5160-26-02, entitled "Managed health care program: eligibility and enrollment," sets forth the eligibility criteria for individuals who are then enrolled in the managed care program and the enrollment process. This rule is being proposed for amendment to update policy related to the administration of the Medicaid managed care program. Updates include: in paragraph (B)(2) removed the January 1, 2017 effective date, removed paragraph (B)(4)(b) and moved it to paragraph (B)(6), removed paragraph (C)(2) related to voluntary service areas and other grammatical/technical edits.

OAC rule 5160-26-03, entitled "Managed health care programs: covered services," describes the services which must be covered by MCPs and addresses any exclusions or limitations for those services. This rule is being proposed for amendment to update policy related to the administration of the managed care program. Updates include: in paragraph (A) clarified that plans must cover Ohio Medicaid state plan services, updated the prior authorization language in (A)(3) to prevent plans from imposing "hard limits" on services, updated medical necessity language in (B)(1) to be member specific, in (E)(7) added a requirement that the MCP must reimburse for emergency services until the member is stabilized and can safely be discharged or transferred, in paragraph (H)(12) added language to include reference to payment for IMD stays when a member is no longer eligible for managed care, updated language in paragraph (I)(2) to allow plans to prior authorize additional services after the 100 hour limit has been reached, updated Healthchek language to remove notification requirements, removed respite payment language and other grammatical/technical edits.

OAC rule 5160-26-03.1, entitled "Managed health care program: primary care and utilization management," sets forth the requirements for MCPs related to members' primary care providers (PCPs) and of utilization management. This rule is being proposed for amendment to update policy related to the administration of the managed care program. Changes include: updated the prior authorization timeframes to comply with ORC 5160.34 (SB 129) requirements, in paragraph (B)(3)(h), removed language related to pharmacy prior authorization decision timeframes, removed duplicative language in paragraph (B)(5) related to the Coordinated Services Program and other grammatical/technical edits.

OAC rule 5160-26-09 "Managed health care programs: payment and financial responsibility," sets forth the policy for ODM payment to MCPs and the MCP financial responsibility. This rule is being proposed for amendment in accordance with five year rule review and to update CFR references.

The MCP provider agreement may be found online at:
http://www.medicaid.ohio.gov/PROVIDERS/ManagedCare/ProgramResourceLibrary/CombinedProviderAgreement.aspx

The MCOP provider agreement may be found online at:
http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Revised Code Section 5167.02

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Yes. 42 C.F.R. Part 438 imposes comprehensive requirements on the state regarding Medicaid managed care programs. Several changes are being made to align with changes implemented in the federal regulation.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   Federal regulations do not impose requirements directly on MCPs; instead they require state Medicaid agencies to ensure MCP compliance with federal standards. The rules are consistent with federal managed care requirements outlined in 42 C.F.R Part 438.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of this regulation is to ensure MCP members' rights and protections. The rules ensure the provision of medically necessary services, preventative care, emergency services, post stabilization services and respite to promote the best outcomes for individuals enrolled in the Medicaid managed care program by requiring MCPs to follow established guidelines and to ensure providers are paid appropriately for services delivered. In addition, the rules ensure compliance with federal regulations governing Medicaid managed care.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   Through reporting requirements established within the rules and provider agreements, ODM is able to monitor compliance with the regulation. Successful outcomes are measured through a finding of compliance with these standards as determined by monitoring and oversight.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

The Medicaid Managed Care and MyCare Ohio Plans listed below were provided with the draft rules on August 28, 2017. The rules were then reviewed during a meeting on August 29th. The plans were given until September 7, 2017 to comment.

- Aetna
- Buckeye Health Plan
- CareSource
- Molina Healthcare of Ohio
- Paramount Advantage
- UnitedHealthcare Community Plan of Ohio

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

As a result of MCP/MCOP outreach, no comments were received, and therefore, no changes were made to the rules.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

No scientific data was used to develop these rules or the measureable outcomes of the rules.

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

The changes to the rules include general updates to keep the rules current, changes to correspond with the C.F.R., clarifications and to streamline managed care plan requirements. No alternative regulations were discussed during the rule process for this reason.

11. Did the Agency specifically consider a performance-based regulation? Please explain. ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

A performance-based regulation would not be appropriate because ODM is required to comply with detailed federal requirements set forth in 42 C.F.R. Part 438.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

All Medicaid regulations governing MCPs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid program.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

ODM will notify MCPs and MCOPs of the final rule changes via email notification.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

These rules impact MCPs and MCOPs in the State including: Aetna, Buckeye, CareSource, Molina, Paramount and UnitedHealthcare. Certain MCP and MCOP providers are also impacted.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

Rule 5160-26-02 requires MCPs to notify ODM or its designee of the birth of any newborn whose mother is enrolled in an MCP.

OAC rule 5160-26-03 holds MCPs financially responsible for payment of certain services including respite for children. Requirements in addition to the payment for covered services as outlined in this rule include:

- Establishing, in writing, a process for the submission of claims for services delivered by non-contracting providers;
- Designating a telephone line to receive provider requests for coverage of certain services; and
- Submitting written requests or notifications to ODM, contracting providers and members.

Respite provider agencies are required to:

- Be accredited by at least one of several national accreditation entities;
- Hold a Medicaid provider agreement;
- Comply with applicable background check requirements; and
- Behavioral health provider agencies must be OhioMHAS certified.

Agency employees:

- Long-term care providers must obtain a certificate of completion from the Ohio Department of Health or a Medicare competency evaluation program;
- All providers must obtain first aid certification; and

- Long-term care providers must obtain evidence of completion of twelve hours of in-services continuing education each year.

Rule 5160-26-03.1 requires MCPs to share specific information with ODM and certain providers, to maintain a log, and to implement written policies and procedures.

- This report of information includes: MCP contact information, prior authorization procedures, a listing of panel labs and pharmacies, documentation of non-contracting providers upon ODM request and provider referral approvals/denials.
- The MCPs are also required to provide a toll-free 24/7 call-in system for MCP member access and must maintain a log of calls to that call-in system.
- MCPs are required to implement written policies and procedures with regard to their required utilization management (UM) program. The policies must be made available to ODM and providers upon request.
- The MCP's UM program must document: an annual review and update of the UM program, the use of certain health professionals and consultants including compensation information for these activities, the reason for each service denial, and that UM decisions are consistent with clinical practice guidelines (medical necessity).
- MCPs must send written notice to a member and provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in scope, duration or amount that is less than requested. Service authorization decisions for covered outpatient drugs must be made by telephone or other telecommunication device.
- MCPs must maintain and submit to ODM a record of all authorization requests.
- Regarding the mandatory coordinated services program (CSP), MCPs must notify members of their hearing rights when enrolled in this program.

Rule 5160-26-09 requires MCPs to submit to ODM certain documentation such as the MCPs license, financial statements, audited financial statement, cost reports, physician incentive program disclosure statements, and certain reinsurance documentation.

c. Quantify the expected adverse impact from the regulation. ***The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.***

Managed care plans (MCPs) are paid per member per month. ODM must pay MCPs and MCOPs rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.6(c) and CMS's "2017 Managed Care Rate Setting Consultation Guide."

Ohio Medicaid capitation rates are "actuarially sound" for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. Costs include but are not limited to expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government mandated assessments, fees, and taxes.

All rates and actuarial methods can be found on the ODM website in Appendix E of both the Medicaid Managed Care and MyCare Ohio provider agreements. Through the administrative component of the capitation rate paid to the MCPs and MCOPs by ODM, MCPs and MCOPs will be compensated for the cost of the requirements found in these rules. For CY 2017, the administrative component of the capitation rate varies by program/population and ranges from 3.5% to 8.48% for MCPs and from 2.0% to 8.5% for MCOPs.

Respite providers must hold a Medicaid provider agreement. The cost associated with obtaining a Medicaid provider agreement is currently $554. This fee may be paid to Ohio Medicaid, their designated agency or to Medicare. It is paid at initial application and then at revalidation every five years.

Fees for the BCII criminal records check for all applicants considered for employment may vary depending on the location or agency providing the service, but on average cost approximately $22.00. The fee for criminal records check from the FBI for each applicant considered for employment, who has not resided in Ohio for five years is currently $24.00 which may vary depending on the location or agency providing the service. BCII accepts and processes FBI background checks. Fees associated with criminal records checks to be passed to the applicant/employee resulting in no impact to the agency.

Respite provider agencies must be certified through OhioMHAS. The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s), not their entire budget. When the agency has appropriate accreditation from The Joint Commission, CARF, or COA there is no certification fee owed to OhioMHAS.

Respite provider agencies are required to be accredited by at least one of several accreditation entities. The average cost of accreditation is between $1,295 and $2,300 annually. Costs vary depending on the size of the facility, the number of employees, facility type, the average daily population being served and whether there are satellite offices.

Individual respite providers working for an agency must be first aid certified. The City of Columbus Division of Fire offers a certification course for $30.00 per person. Individual providers also must obtain a certificate of completion of a competency evaluation program approved by the Ohio Department of Health (ODH) or a Medicare competency evaluation program for home health aides. Per ODH, the cost of this certification can range from approximately $200 to $500 depending on where they take the course and who is presenting the materials. Additionally, individual providers must maintain evidence of completion of twelve hours of in-service continuing education per year. On average, the cost for continuing education courses can range from free of charge to $12 per course.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The MCPs and MCOPs were aware of the federal requirements for covered services prior to seeking and signing their contracts with the state. More importantly, without the requirement of certain covered health care services, the State would be out of compliance with federal regulations.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

The requirements of these rules must be applied uniformly and no exception is made based on a plan's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

These rules impose no sanctions.

18. What resources are available to assist small businesses with compliance of the regulation?

While there are no small businesses impacted by this rule, the managed care plans may contact ODM directly through their assigned Contract Administrator.

5160-26-02 **Managed health care program: eligibility and enrollment.**

(A) This rule does not apply to "MyCare Ohio" plans as defined in rule 5160-58-01 of the Administrative Code. The eligibility and enrollment provisions for "MyCare Ohio" plans are described in rule 5160-58-02 of the Administrative Code.

(B) Eligibility for managed care plan enrollment.

(1) Except as specified in paragraphs ~~(B)(2) and~~ (B)(3)~~(b)~~ to (B)(6) of this rule, in mandatory service areas as permitted by 42 C.F.R. 438.52 (October 1, ~~2016~~2017), an individual must be enrolled in a managed care plan (MCP) if he or she has been determined medicaid eligible in accordance with ~~Chapter~~ division 5160:1 of the Administrative Code.

(2) ~~Effective January 1, 2017, managed~~ Managed care enrollment is mandatory for the following individuals:

(a) Children receiving Title IV-E federal foster care maintenance through an agreement between the local children services board and the foster care provider;

(b) Children receiving Title IV-E adoption assistance through an agreement between the local children services board and the adoptive parent;

(c) Children in foster care or other out-of-home placement by the local children services board; and

(d) Children receiving services through the Ohio department of health's bureau for children with medical handicaps (BCMH) or any other family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act, 42 U.S.C. 701(a)(1)(D) (as in effect January 1, 2017) and is defined by the state in terms of either program participation or special health care needs.

(3) Medicaid eligible individuals may voluntarily choose to enroll in an MCP if they are:

(a) Indians who are members of federally recognized tribes; or

(b) Individuals diagnosed with a developmental disability who have a level of care that meets the criteria specified in rule 5123:2-8-01 of the

Administrative Code and receive services through a 1915(c) home and community based services (HCBS) waiver.

(4) Except for individuals receiving medicaid in the adult extension category under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (as in effect January 1, 2017) and individuals who meet criteria in paragraph (B)(3)(b) of this rule, medicaid eligible individuals described in paragraph (B)(1) of this rule are excluded from MCP enrollment if they meet any of the following criteria:

(a) Residing in a nursing facility; or

~~(b) Receiving medicaid services through an intermediate care facility for individuals with intellectual disabilities (ICF-IID); or~~

~~(c)~~(b) Receiving medicaid services through a medicaid waiver component, as defined in section 5166.02 of the Revised Code; or

~~(d)~~(c) Dually eligible and enrolled in both the medicaid and medicare programs.

(5) Individuals who are inmates of public institutions as defined in 42 C.F.R. 435.1010 (October 1, ~~2016~~2017) are excluded from MCP enrollment unless otherwise specified by the Ohio department of medicaid (ODM).

(6) Medicaid eligible individuals are excluded from MCP enrollment when prohibited under a federally approved state plan or state law such as individuals receiving services in an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or who are enrolled in the program of all-inclusive care for the elderly (PACE).

(7) 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-medicaid benefits to which he or she may be entitled.

(C) Enrollment in a managed care plan.

(1) The following applies to enrollment in an MCP:

(a) The MCP must accept eligible individuals without regard to race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services. The MCP will not use any discriminatory policy or practice in accordance with 42 C.F.R. 438.3(d) (October 1, ~~2016~~2017).

(b) The MCP must accept eligible individuals who request MCP enrollment without restriction.

(c) If an MCP member loses managed care eligibility and is disenrolled from the MCP, and subsequently regains eligibility, his or her enrollment in the same MCP may be re-instated back to the date eligibility was regained, in accordance with procedures established by ODM.

(d) ODM shall confirm the eligible individual's MCP enrollment via the ODM-produced Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 834 daily and monthly enrollment files of new members, continuing members, and terminating members.

(e) The MCP shall not be required to provide coverage until MCP enrollment is confirmed via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files except as provided in paragraph ~~(C)(3)~~(C)(2) of this rule or upon mutual agreement between ODM and the MCP.

~~(2) Should a service area change from voluntary to mandatory, the notice requirements in this rule must be followed.~~

~~(a) When a service area is initially designated by ODM as mandatory for eligible individuals specified in paragraph (B) of this rule, ODM shall confirm eligibility as prescribed in paragraph (C)(1)(d) of this rule. Upon the confirmation of eligibility:~~

~~(i) Eligible individuals residing in the service area who are currently MCP members are deemed participants in the mandatory program; and~~

~~(ii) All other eligible individuals residing in the mandatory service area are required to enroll in an MCP following receipt of a notification of mandatory enrollment (NME) issued by ODM.~~

~~(b) MCP enrollment selection procedures for the mandatory program:~~

~~(i) An individual that does not make an MCP choice following issuance of an NME by ODM will be assigned to an MCP by ODM, the Ohio medicaid consumer hotline, or other ODM-approved entity.~~

~~(ii) ODM or the Ohio medicaid consumer hotline shall assign the individual to an MCP based on prior medicaid fee-for-service or MCP enrollment history, whenever available, or at the discretion of ODM.~~

~~(3)~~(2) Newborn notification and enrollment.

(a) The MCP must notify ODM's designee, as directed by ODM, of the birth of any newborn whose mother is enrolled in an MCP.

(b) Newborns born to mothers enrolled in an MCP are enrolled in an MCP from their date of birth through at least the end of the month of the child's first birthday, or until such time that the MCP is notified of the child's disenrollment via the ODM-produced HIPAA compliant 834 daily or monthly enrollment files.

(D) Commencement of coverage.

(1) Coverage of MCP members will be effective on the first day of the calendar month specified on the ODM-produced HIPAA compliant 834 daily and monthly enrollment files to the MCP, except as specified in paragraph (C)~~(3)~~(2) of this rule.

(2) When an eligible individual is admitted to an inpatient facility prior to the effective date of MCP enrollment and remains in an inpatient facility on the enrollment effective date, the following responsibilities apply:

(a) The admitting medicaid payer, either fee-for-service or the admitting MCP, is responsible for all inpatient facility charges, pursuant to rule 5160-2-07.11 of the Administrative Code, through the date of discharge.

(b) The enrolling MCP is responsible for all other medically necessary medicaid covered services including professional services related to the inpatient stay, beginning on the enrollment effective date.

Effective:

Five Year Review (FYR) Dates: 8/1/2021

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5167.02
Rule Amplifies:	5164.02, 5167.10, 5167.03
Prior Effective Dates:	4/1/85, 2/15/89 (Emer.), 5/18/89, 5/1/92, 5/1/93, 11/1/94, 7/1/96, 7/1/97 (Emer.), 9/29/97, 12/10/99, 7/1/00, 7/1/01, 7/1/02, 7/1/03, 7/1/04, 10/31/05, 6/1/06, 1/1/07, 7/1/07, 1/1/08, 8/26/08 (Emer.), 10/9/08, 7/1/09, 8/1/11, 7/1/13, 4/1/15, 8/1/16, 7/1/2017

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

(A) Except as otherwise provided in this rule, a managed care ~~plans (MCPs)~~ plan (MCP) must ensure ~~that~~ 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;

~~(3)~~(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

~~(4)~~(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) ~~MCPs~~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) ~~MCPs~~The MCP must cover annual physical examinations for adults.

(D) At the request of the member, ~~MCPs~~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) ~~MCPs~~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) ~~MCPs~~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) ~~MCPs~~The MCP cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

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

(4) ~~MCPs~~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. ~~call-in-system.~~

(5) ~~MCPs~~ 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 ~~or not~~ 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.

~~(7)~~(8) ~~MCPs~~ 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.

~~(8)~~(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) ~~MCPs~~ 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. ~~MCPs~~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) ~~MCPs~~ 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. ~~MCPs~~ 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 ~~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~~ 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) ~~MCPs~~ 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) ~~MCPs~~ 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 ~~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) 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) ~~MCPs are~~ 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 mental health services and substance abuse services offered through the Ohio department of mental health and addiction services (OhioMHAS) community mental health centers and OhioMHAS-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.

(4) 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.

(5) ~~MCPs~~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 preventative health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.

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

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

(8) 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.

(9) Paragraph ~~(H)(8)~~(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.

(10) ~~MCPs are~~ The MCP is not responsible for payment of services provided through medicaid school program (MSP) ~~providers~~ pursuant to Chapter 5160-35 of the Administrative Code. ~~MCPs~~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.

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

(12) 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. ~~ODM will allocate a limited amount of funds to the MCPs annually for respite services. MCPs~~The MCP shall be responsible for payment for respite services~~ to the extent funds for such services are available~~.

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 care management program; 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 her-self 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 ~~no more than~~ 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, ~~2016~~2017), 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) ~~MCPs~~An MCP 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 5160-14~~rule 5160-1-14 of the Administrative Code, to eligible ~~individuals~~members and ~~assure that services are delivered and monitored as follows:~~ensure healthchek exams:

(1) ~~Healthchek exams must include~~ Include ~~those~~ the components specified in ~~Chapter 5160-14~~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) The MCP or its contracting provider must notify members of the appropriate healthchek exam intervals as specified in Chapter 5160-14 of the Administrative Code.~~

~~(3)~~(2) ~~Healthchek exams are to be~~ 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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5160-26-03.1 **Managed health care programs: primary care and utilization management.**

(A) ~~Managed~~A managed care ~~plans~~ plan ~~(MCPs)~~(MCP) must ensure each member has a primary care provider (PCP) who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member's needs.

(1) An ~~MCPs~~MCP must ensure PCPs are in compliance with the following triage requirements:

(a) Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site;

(b) Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site; and

(c) Members with requests for routine care must be seen within six weeks.

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

(a) Assisting with coordination of the member's overall care, as appropriate for the member;

(b) Providing services which are medically necessary as described in rule 5160-1-01 of the Administrative Code;

(c) Serving as the ongoing source of primary and preventative care;

(d) Recommending referrals to specialists, as required; and

(e) Triaging members as described in paragraph (A)(1) of this rule.

(B) ~~The~~An MCP must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. ~~MCPs~~An MCP must ensure decisions rendered through the UM program are based on medical necessity.

(1) The UM program must be based on written policies and procedures that include, at a minimum~~, the following~~:

(a) The ~~specification of the~~ information sources used to make determinations of medical necessity;

(b) The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria;

(c) A specification that written UM criteria will be made available to both contracting and non-contracting providers; and

(d) A description of how the MCP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(2) ~~The~~ An MCP's UM program must also ensure and document the following:

(a) An annual review and update of the UM program.

(b) The involvement of a designated senior physician in the UM program.

(c) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions.

(d) The use of board-certified consultants to assist in making medical necessity determinations, as necessary.

(e) That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Administrative Code. An ~~MCPs~~MCP may not impose conditions around the coverage of a medically necessary medicaid-covered service unless they are supported by such clinical practice guidelines.

(f) The reason for each denial of a service, based on sound clinical evidence.

(g) That compensation by the MCP to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member.

(3) An ~~MCPs~~MCP must process requests for initial and continuing authorizations of services from their providers and members. An ~~MCPs~~MCP must have written policies and procedures to process requests and, upon request, the MCP's policies and procedures must be made available for review by the Ohio department of medicaid (ODM). The MCP's written policies and procedures for initial and continuing authorizations of services must also be made available to contracting and non-contracting providers upon request. The ~~MCPs~~MCP must ensure and document the following occurs when processing requests for initial and continuing authorizations of services:

(a) Consistent application of review criteria for authorization decisions.

(b) Consultation with the requesting provider, when necessary.

(c) ~~That any~~Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

(d) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must meet the requirements of ~~rules~~ division 5101:6~~-2-35~~ and rule 5160-26-08.4 of the Administrative Code.

(e) For standard authorization decisions, the MCP must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than ~~fourteen~~ten calendar days following receipt of the request for service, except as specified in paragraph (B)(3)(g) of this rule. If requested by the member, provider, or MCP, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(f) If a provider indicates or the MCP determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCP must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than ~~three working days~~ forty-eight hours after receipt of the request for service. If requested by the member or MCP, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry

out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(g) Service authorization decisions not reached within the timeframes specified in paragraphs (B)(3)(e) and (B)(3)(f) of this rule constitute a denial, and the MCPs must give notice to the member as specified in ~~paragraph (C) of~~ rule 5160-26-08.4 of the Administrative Code.

(h) Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect January 1, 2017) must be made by telephone or other telecommunication device within twenty-four hours of the initial request. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the MCP is unable to obtain the information needed to make the prior-authorization decision within seventy-two hours, the decision timeframe has expired and the MCP must give notice to the member as specified in ~~paragraph (C) of~~ rule 5160-26-08.4 of the Administrative Code. ~~All other pharmacy prior authorization decisions must be made by no later than the end of the second working day following receipt of the request, or as expeditiously as the member's condition warrants.~~

(i) MCPs must maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. MCP records must include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

(4) MCPs must implement the ODM-required emergency department diversion program for frequent users.

(5) Pursuant to section 5167.12 of the Revised Code, ~~MCPs~~ an MCP may, subject to ODM prior approval, implement strategies for the management of drug utilization. At a minimum, ~~MCPs~~an MCP must implement a coordinated services program (CSP) as described in rule 5160-20-01 of the Administrative Code. ~~MCPs must provide members with a notice of their right to a state hearing in accordance with rule 5101:6-2-40 of the Administrative Code before enrolling or continuing the enrollment of a member in CSP. If a member requests a state hearing regarding CSP enrollment within the fifteen day prior notice period set forth in rule 5101:6-4-01 of the Administrative Code, an MCP shall enroll the member into CSP no sooner than the hearing decision mail date. If a member requests a timely hearing regarding continued enrollment in CSP, CSP enrollment shall continue until the hearing decision is rendered.~~ ~~MCPs~~An

MCP must ~~also provide~~ offer care management services to any member enrolled in CSP.

(6) ~~MCPs~~An MCP may develop other ~~utilization management~~UM programs subject to ODM prior approval.

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5160-26-09 **Managed health care programs: payment and financial responsibility.**

(A) Payment.

(1) The Ohio department of medicaid (ODM) will compute managed care plan (MCP) premium rates on an actuarially sound basis in accordance with 42 C.F.R. 438.5 (October 1, 2017). The premium rates do not include any amount for risks assumed under any other existing or any previous agreement or contract. ODM will review the premium rates at least annually and the ~~rate(s)~~rates may be modified based on existing actuarial factors and experience.

(2) The MCP will receive a monthly premium payment for each member from ODM.

(3) When an MCP provides or arranges for maternity coverage, ODM will make a separate payment to the MCP for each reimbursable delivery for applicable covered populations described in rule 5160-26-02 of the Administrative Code.

(4) The amounts paid by ODM in accordance with this paragraph represent a full-risk arrangement and the total obligation of ODM to the MCP for the costs of medical care and services provided. Any savings or losses remaining after costs have been deducted from the premium will be wholly retained by the MCP.

(5) Payments made by ODM in accordance with this paragraph will be in effect for the duration of the provider agreement entered into between ODM and the MCP unless restricted in accordance with rule 5160-26-10 of the Administrative Code or the terms of the provider agreement.

(6) ODM may establish financial incentive programs based on performance for MCPs.

(B) Fiscal responsibility requirements.

(1) ~~-~~An MCP must maintain a fiscally-sound operation and meet ODM performance standards.

(2) ~~-~~An MCP must make provisions against the risk of insolvency.

(3) Neither members nor ODM shall be liable for any MCP debts, including those that remain in the event of MCP insolvency or the insolvency of any subcontractors.

(4) An MCP must pay providers in accordance with 42 C.F.R. 447.46 (October 1, ~~2013~~2017).

(5) The following requirements apply to an MCP licensed as a health insuring corporation (HIC) by the Ohio department of insurance (ODI):

(a) A copy of the MCP's current license or certificate of authority must be submitted to ODM 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 ODM. For purposes of this rule, "annual financial statement" is the annual statement of financial condition prescribed by the "National Association of Insurance Commissioners" (NAIC) and required by ODI in accordance with sections 1751.32 and 1751.47 of the Revised Code.

(c) The MCP must submit to ODM 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 in accordance with section 1751.321 of the Revised Code. The statement must be submitted annually to ODM.

(6) The following items must be submitted by each MCP as so indicated:

(a) Cost reports on ODM forms quarterly and annually as directed by ODM. The MCP must adhere to ODM provider agreement and cost report instructions;

(b) Financial disclosure statements to be submitted in conjunction with cost report submissions as specified in paragraph (B)(5)(b) of this rule for MCPs. 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) MCP physician incentive plan disclosure statements in accordance with 42 C.F.R. ~~438.6~~438.3 (October 1, ~~2013~~2017).

(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.

(3) A copy of the fully-executed reinsurance agreement to provide the specified coverage must be submitted to ODM 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 ODM.

(5) The reinsurance coverage must remain in force during the term of the provider agreement with ODM and must contain adequate provisions for contract extensions.

(6) The MCP shall provide written notification to ODM when directed by ODM, specifying the dates of admission, diagnoses, and estimates of the total claims incurred for all medicaid members for which reinsurance claims have been submitted.

(7) The MCP must give ODM prior written notice of any proposed changes or modifications in the reinsurance agreements for ODM review and approval. Such notice shall be submitted to ODM thirty days prior to the intended effective date of any proposed change and must include the complete and exact text of the proposed change. The MCP must provide copies of new or modified reinsurance agreements to ODM 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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5160-26-08.3 **Managed health care programs: member rights.**

(A) A managed care plan (MCP)~~MCPs~~ must develop and implement written policies in accordance with 42 C.F.R. 438.100 (October 1, 2017) ~~that~~ to ensure ~~that~~ each ~~members have~~ member has and ~~are~~is informed of ~~the following rights~~his or her right to:

(1) ~~To receive~~ Receive all services ~~that~~ the MCP is required to provide pursuant to the terms of their provider agreement with the Ohio department of medicaid (ODM).

(2) ~~To be~~Be treated with respect and with due consideration for their dignity and privacy.

(3) ~~To be~~ Be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history.

(4) ~~To be~~Be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.

(5) ~~To be~~Be given the opportunity to participate in decisions involving their health care.

(6) ~~To receive~~Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

(7) ~~To maintain~~ Maintain auditory and visual privacy during all health care examinations or treatment visits.

(8) ~~To be~~ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

(9) ~~To request~~ Request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.

(10) ~~To be~~Be afforded the opportunity to approve or refuse the release of information except when release is required by law.

(11) ~~To be~~ Be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision~~,~~ and documentation will be entered into the medical record accordingly.

(12) ~~To be~~ Be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of rule 5160-26-08.4 of the Administrative Code.

(13) ~~To be~~ Be provided written member information from the MCP:

(a) At no cost to the member,

(b) In the prevalent non-English languages of members in the MCP's service area, and

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

(14) ~~To receive~~ Receive necessary oral interpretation and oral translation services at no cost.

(15) ~~To receive~~ Receive necessary services of sign language assistance at no cost.

(16) ~~To be~~ Be informed of specific student practitioner roles and the right to refuse student care.

(17) ~~To refuse~~ Refuse to participate in experimental research.

(18) ~~To formulate~~ Formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio department of health.

(19) ~~To change~~Change primary care providers (~~-~~PCPs) no less often than monthly. The MCP must mail written confirmation to the member of his or her new PCP selection prior to or on the effective date of the change.

(20) ~~To appeal~~Appeal to or file 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.

(21) ~~To appeal~~ Appeal to or file directly with the ODM office of civil rights any complaints of discrimination on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status,

genetic information, ancestry, health status or need for health services in the receipt of health services.

(22) ~~To be~~ Be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way the MCP, the MCP's providers, or ODM treats the member.

(23) ~~To be~~ Be assured ~~that~~ the MCP must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.

(24) ~~To choose~~ Choose his or her health professional to the extent possible and appropriate.

(25) For female members, to obtain direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to a member's designated PCP if the PCP is not a woman's health specialist.

(26) ~~To be~~ Be provided a second opinion from a qualified health care professional within the MCP's panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for a second opinion outside the network, at no cost to the member.

(27) ~~To receive~~ Receive information on their MCP.

(B) ~~MCPs~~An MCP must advise members via the member handbook of the member rights specified in paragraph (A) of this rule.

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5160-26-11 **Managed health care programs: managed care plan non-contracting providers.**

(A) For the purposes of this rule, the following terms are defined as follows:

(1) "Managed care plan (MCP) non-contracting provider" means any provider with ~~a~~ an Ohio department of medicaid (ODM) provider agreement ~~with ODM~~ who does not contract with the MCP but delivers health care services to that MCP's member~~(s)~~, as described in paragraphs (C) and (D) of this rule.

(2) "~~Managed care plan (~~MCP~~)~~ non-contracting provider of emergency services" means any person, institution, or entity that does not contract with the MCP but provides emergency services to an MCP member, regardless of whether ~~or not~~ that provider has ~~a medicaid~~ an ODM provider agreement ~~with the Ohio department of medicaid (ODM)~~.

(B) MCP non-contracting providers of emergency services must accept as payment in full from the MCP 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. 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.

(C) When ODM has approved an MCP's members to be referred to an MCP non-contracting hospital pursuant to rule 5160-26-03 of the Administrative Code, the MCP non-contracting hospital must provide the service for which the referral was authorized and must accept as payment in full from the MCP one hundred per cent of the current Ohio medicaid program reimbursement rate in effect for the date of service. 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. MCP non-contracting hospitals are exempted from this provision when:

(1) The hospital is located in a county in which eligible individuals were required to enroll in an MCP prior to January 1, 2006;

(2) The hospital is contracted with at least one MCP serving the eligible individuals specified in paragraph (C)(1) of this rule prior to January 1, 2006; and

(3) The hospital remains contracted with at least one MCP serving eligible individuals who are required to enroll in ~~MCPs~~an MCP in the service area where the hospital is located.

(D) MCP non-contracting qualified family planning providers (QFPPs) must accept as payment in full from the MCP the lesser of one hundred per cent of the Ohio medicaid program reimbursement rate or billed charges, in effect for the date of service.

(E) An MCP non-contracting provider may not bill an MCP member unless all of the following conditions are met:

(1) The member was notified by the provider of the financial liability in advance of service delivery.

(2) The notification by the provider was in writing, specific to the service being rendered, and clearly states that the recipient is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.

(3) The notification is dated and signed by the member.

(4) The reason the service is not covered by the MCP is specified and is one of the following:

(a) The service is a benefit exclusion;

(b) The provider is not contracted with the MCP and the MCP has denied approval for the provider to provide the service because the service is available from a contracted provider, at no cost to the member; or

(c) The provider is not contracted with the MCP and has not requested approval to provide the service.

(F) An MCP non-contracting provider may not bill an MCP member for a missed appointment.

(G) MCP non-contracting providers, including MCP non-contracting providers of emergency services, must contact the twenty-four hour post-stabilization services phone line designated by the MCP to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.

(H) MCP non-contracting providers, including MCP non-contracting providers of emergency services, must allow the MCP, ODM, and ODM's designee access to all ~~enrollee~~member medical records for a period not less than ~~eight~~ten years from the

date of service or until any audit initiated within the ~~eight~~ten year period is completed. Access must include copies of the medical ~~record(s)~~records at no cost for the purpose of activities related to the annual external quality review specified by 42.C.F.R. 438.358 (October 1, ~~2013~~2017).~~)~~

(I) When an MCP elects to impose member co-payments in accordance with rule 5160-26-12 of the Administrative Code, applicable co-payments shall also apply to services rendered by MCP non-contracting providers. When an MCP has not elected to impose co-payments in accordance with rule 5160-26-12 of the Administrative Code, MCP non-contracting providers are not permitted to impose co-payments on MCP members.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
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