CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Managed Care – MyCare Ohio

Rule Number(s): 5160-58-01.1, 5160-58-02.1 and 5160-58-03

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X	Amended		Rescinded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 that are 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. MyCare Ohio is a managed care program aimed at providing integrated care for individuals who are dual eligible (both Medicaid and Medicare recipients.)

5160-58-01.1 "MyCare Ohio plans: application of general managed care rules" sets forth the requirements for the MyCare Ohio program to follow the Medicaid managed care program rules outlined in OAC Chapter 5160-26. This rule is being proposed for amendment to update policy related to the administration of the Medicaid managed care program. Updates include: removed paragraph (B)(2) to align with the prior authorization updates in OAC rule 5160-26-03.1 and to comply with ORC 5160.34 (SB 129) requirements; paragraphs (B)(1) and (B)(3) were removed to reduce duplication of paragraph (C)(5); paragraph (B)(4) was merged with paragraph (B); paragraph (B)(5) was removed to align with changes made to OAC rule 5160-26-03.1; and other grammatical and technical edits.

5160-58-02.1 "MyCare Ohio plans: termination of enrollment" sets forth the reasons why a MyCare Ohio plan member may be terminated from enrollment in the plan, and the process for termination. This rule is being proposed for amendment in compliance with five year rule review and to update policy related to the administration of the Medicaid managed care program. Updates include: in paragraph (A)(4), updated the terminology for a developmental disabilities level of care and intermediate care facilities for individuals with developmental disabilities; in paragraph (C)(4), for individuals receiving long-term services and supports, the grounds for just cause for terminating or changing plan enrollment were updated in accordance with 42 C.F.R. 438.56; and other grammatical and technical edits.

5160-58-03 "MyCare Ohio plans: covered services" sets forth the services which must be covered by MyCare Ohio Plans (MCOPs) and addresses any exclusions or limitations for those services. It is being proposed for amendment to update policy related to the administration of the Medicaid managed care program. Updates include: in paragraph (A), the amendment clarified that MCOPs must cover Ohio Medicaid covered services; the Healthchek language was updated and notification requirements were removed to reduce duplication of the MCOP provider agreement; in paragraph (A)(3) updated the prior authorization language; medical necessity language in paragraph (B)(1) was updated to be member specific; in paragraph (E)(7), the amendment added a requirement that the MCOP must reimburse for emergency services until the member is stabilized and can be safely discharged; paragraph (I) was moved to paragraph (H)(7); language was added in paragraph (H)(8) to address payment for stays in an institution for mental disease when the member is no longer eligible for enrollment in a MCOP; and grammatical and technical edits.

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. Additionally, ODM has entered into a three-way contract with the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services and each MCOP to implement the MyCare Ohio demonstration program.

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

   These rules are consistent with federal managed care requirements outlined in 42 C.F.R Part 438 and the three-way contract.

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 help ODM ensure MCOP members' rights, protections, and health and safety by requiring plans to follow established guidelines.

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

   Through reporting requirements established within the managed care provider agreements, ODM is able to monitor compliance with the regulation. Successful outcomes are measured through a finding of compliance with established 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?

No concerns or comments were received as the changes were general updates, not resulting in significant changes to plan requirements.

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 the 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 MCOP 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 and the three-way contract with CMS.

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

All Medicaid regulations governing MCP/MCOPs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid managed care 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. The changes to the rules will not impact the plans' current business processes.

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 MCOPs in the State including: Aetna, Buckeye, CareSource, Molina, and UnitedHealthcare.

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

Rule 5160-58-01.1 requires the MCOP to give notice to a MyCare Ohio member when the plan is unable to obtain the information needed to make a prior authorization decision on a covered outpatient drug within 72 hours of receiving the request. The new draft of 5160-58-01.1 eliminates paragraph (B)(4), however, the substance of the notice requirement is simply moved in paragraph (B).

Rule 5160-58-02.1 requires the MCOP to provide documentation when a member requests termination of plan enrollment for just cause. It also requires the MCOP to submit a request for termination for a member when the member is uncooperative, disruptive or acts fraudulently.

Rule 5160-58-03 requires the MCOP to establish, in writing, the process and procedures for claims submissions from non-contracting providers and to maintain a record of any request for coverage of post-stabilization services.

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.

Plans 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 "2016 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 reporting and notice 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.

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

The 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 this rule must be applied uniformly and no exception is made based on an MCOP'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?

This rule imposes 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 MCOPs may contact ODM directly through their assigned Contract Administrator.

5160-58-01.1 **MyCare Ohio plans: application of general managed care rules.**

(A) MyCare Ohio plans must comply with all of the requirements applicable to managed care plans (MCPs) in the following rules:

(1) Rule 5160-26-05 of the Administrative Code;

(2) Rule 5160-26-05.1 of the Administrative Code;

(3) Rule 5160-26-06 of the Administrative Code;

(4) Rule 5160-26-08.3 of the Administrative Code;

(5) Rule 5160-26-09 of the Administrative Code;

(6) Rule 5160-26-09.1 of the Administrative Code;

(7) Rule 5160-26-10 of the Administrative Code; and

(8) Rule 5160-26-11 of the Administrative Code.

(B) MyCare Ohio plans must comply with all of the requirements applicable to ~~managed care plans~~MCPs in rule 5160-26-03.1 of the Administrative Code, however, the following language replaces all of paragraph (B)(3)(h) for MyCare Ohio plans: "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 within the timeframes specified in 42 C.F.R. 423.568(b) (October 1, 2017) for standard decisions and 42 C.F.R. 423.572(a) (October 1, 2017) for expedited decisions. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the plan 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 rule 5160-58-08.4 of the Administrative Code." ~~with the following revisions:~~

~~(1) In paragraph (B)(3)(d), the references to rule 5160-26-08.4 of the Administrative Code should be replaced by a reference to rule 5160-58-08.4 of the Administrative Code.~~

~~(2)) The phrase "seventy-two hours" replaces the phrase "three working days" in paragraph (B)(3)(f).~~

~~(3) In paragraph (B)(3)(g), the reference to paragraph (C) of rule 5160-26-08.4 of the Administrative Code should be replaced by a reference to paragraph (C) of rule 5160-58-08.4 of the Administrative Code.~~

~~(4) The following language replaces all of paragraph (B)(3)(h) for MyCare Ohio plans: "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 within the timeframes specified in 42 C.F.R. 423.568(b) (October 1, 2016) for standard decisions and 42 C.F.R. 423.572(a) (October 1, 2016) for expedited decisions. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the plan 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 5160-58-08.4 of the Administrative Code."~~

~~(5) Only the first sentence in paragraph (B)(5) applies to MyCare Ohio plans.~~

(C) For all rules listed in paragraphs (A) and (B) of this rule, the following provisions apply to the MyCare Ohio program described in Chapter 5160-58 of the Administrative Code:

(1) All cross-references to rule 5160-26-01 of the Administrative Code are replaced by cross-references to rule 5160-58-01 of the Administrative Code.

(2) All cross-references to rule 5160-26-02 of the Administrative Code are replaced by cross-references to rule 5160-58-02 of the Administrative Code.

(3) All cross-references to rule 5160-26-02.1 of the Administrative Code are replaced by cross-references to rule 5160-58-02.1 of the Administrative Code.

(4) All cross-references to rule 5160-26-03 of the Administrative Code are replaced by cross-references to rule 5160-58-03 of the Administrative Code.

(5) All cross-references to rule 5160-26-08.4 of the Administrative Code are replaced by cross-references to rule 5160-58-08.4 of the Administrative Code.

(D) The following rules in Chapter 5160-26 of the Administrative Code do not apply to MyCare Ohio, as they are replaced by corresponding rules in Chapter 5160-58 of the Administrative Code:

(1) Rule 5160-26-02 of the Administrative Code

(2) Rule 5160-26-02.1 of the Administrative Code

(3) Rule 5160-26-03 of the Administrative Code, and

(4) Rule 5160-26-08.4 of the Administrative Code.

(E) When an MCP holds provider agreements with the Ohio department of medicaid (ODM) for the MyCare Ohio and medicaid managed care programs, ODM may apply all of the applicable provisions in Chapter 5160-26 of the Administrative Code separately to each of the contracts.

Effective:

Five Year Review (FYR) Dates: 7/1/2022

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5166.02, 5167.02
Rule Amplifies:	5160.34, 5164.02, 5166.02, 5167.02
Prior Effective Dates:	03/01/14, 07/01/17

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

(A) A member will be terminated from enrollment in a MyCare Ohio plan ("plan") for any of the following reasons:

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

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

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

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

(5) The member has third party coverage, excepting medicare coverage, and ODM determines ~~that~~ it is not in the best interest of the member to continue in the plan. The effective date of termination shall be determined by ODM but in no event shall the termination date be later than the last day of the month in which ODM approves the termination.

(6) The provider agreement between ODM and the plan is terminated or not renewed. The effective date of termination shall be the last day of the month of the provider agreement termination or nonrenewal.

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

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

(1) Such terminations may occur either in a mandatory or voluntary service area;

(2) All such terminations occur at the individual level;

(3) Such terminations do not require completion of a consumer contact record (CCR)~~.~~;

(4) If ODM fails to notify the plan of a member's termination from the plan, ODM shall continue to pay the plan the applicable monthly premium rate for the member. The plan shall remain liable for the provision of covered services as set forth in rule 5160-58-03 of the Administrative Code, until ~~such time as~~ ODM provides the plan with documentation of the member's termination.; and

(5) ODM shall recover from the plan any premium paid for retroactive enrollment termination occurring as a result of paragraph (A) of this rule.

(C) Member-initiated terminations.

(1) A dual-benefits member may request disenrollment from the plan and transfer between plans on a month-to-month basis any time during the year. Plan coverage continues until the end of the month of disenrollment.

(2) A medicaid-only member may request a different plan in a mandatory service area as follows:

(a) From the date of initial enrollment through the first three months of plan enrollment, whether the first three months of enrollment are dual-benefits or medicaid-only enrollment periods;

(b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.

(3) A medicaid-only member may request a different plan if available or be returned to medicaid fee-for-service in a voluntary service area as follows:

(a) From the date of enrollment through the initial three months of plan enrollment;

(b) During an open enrollment month for the member's service area as described in paragraph (E) of this rule; or

(c) At any time, if the just cause request meets one of the reasons for just cause as specified in paragraph (C)(4)(e) of this rule.

(4) The following provisions apply when a member either requests a different plan in a mandatory service area, requests disenrollment in a voluntary service area, or qualifies as voluntary population as set forth in ~~paragraph (A)(2) of~~ rule 5160-58-02 of the Administrative Code:

(a) The request may be made by the member, or by the member's authorized representative.

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

(c) If a member requests disenrollment because he or she meets any of the requirements in ~~paragraph (A)(2) of~~ rule 5160-58-02 of the Administrative Code, the member will be disenrolled after the member notifies the consumer hotline.

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

(e) In accordance with 42 C.F.R. 438.56~~(d)(2)~~ (October 1, ~~2015~~2017), a change or termination of plan enrollment may be permitted for any of the following just cause reasons:

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

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

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

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

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

~~(v)~~(vi) The member cannot access medically necessary medicaid-covered services or cannot access the type of providers experienced in dealing with the member's health care needs;

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

(f) The following provisions apply when a member seeks a change or termination in plan enrollment for just cause:

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

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

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

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

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

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

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

(viii) If a member submits a request to change or terminate enrollment for just cause, and the member loses medicaid eligibility prior to action by ODM on the request, ODM shall assure that the member's plan enrollment is not automatically renewed if eligibility for medicaid is reauthorized.

(D) The following provisions apply when a termination in plan enrollment is initiated by a plan for a medicaid-only member:

(1) A plan may submit a request to ODM for the termination of a member for the following reasons:

(a) Fraudulent behavior by the member; or

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

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

(3) The plan must provide covered services to a terminated member through the last day of the month in which the plan enrollment is terminated.

(4) If ODM approves the plan's request for termination, ODM shall notify in writing the member, the authorized representative, the medicaid consumer hotline and the plan.

(E) Open enrollment

Open enrollment months will occur at least annually. At least sixty days prior to the designated open enrollment month, ODM will notify eligible individuals by mail of the opportunity to change or terminate enrollment in a plan and will explain how the individual can obtain further information.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5166.02, 5167.02
Rule Amplifies:	5164.02, 5166.02, 5167.02
Prior Effective Dates:	03/01/14, 08/01/16

5160-58-03 **MyCare Ohio plans: covered services.**

(A) A MyCare Ohio plan ~~(plan)~~(MCOP) must ensure ~~that~~ members have access to all medically-necessary medical, drug, behavioral health, nursing facility and home and community-based services (HCBS) covered by Ohio medicaid. After consideration of verified third party liability including medicare coverage pursuant to rule 5160-26-09.1 of the Administrative Code, the ~~plan~~MCOP must ensure ~~that~~:

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

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

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

~~(3)~~(4) Medicaid coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code; and practice guidelines specified in ~~paragraph (B) of~~ rule 5160-26-05.1 of the Administrative Code; and

~~(4)~~(5)) If a member is unable to obtain medically-necessary medicaid services from ~~a plan~~ an MCOP panel provider, the plan must adequately and timely cover the services out of panel until the plan is able to provide the services from a panel provider.

(B) The ~~plan~~ MCOP may place appropriate limits on ~~services~~a service;

(1) On the basis of medical necessity for the member's condition or diagnosis; or;

(2) Except as otherwise specified in this rule, to available panel providers; or

(3) 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 ~~plan~~ MCOP must cover annual physical examinations for adults.

(D) At the request of a member, ~~a plan~~ an MCOP 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 plan's panel, the plan must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.

(E) The ~~plan~~MCOP must ~~assure that~~ 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 ~~plan~~MCOP may not deny payment for treatment obtained when a member had an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.

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

(3) The ~~plan~~ MCOP must cover all emergency services without requiring prior authorization.

(4) The ~~plan~~ MCOP 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 plan including but not limited to the member's primary care provider (PCP) or the plan's twenty-four-hour toll-free call-in-system.

(5) The ~~plan~~ MCOP 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 rule, "non-contracting provider of emergency services" means any person, institution, or entity who does not contract with the ~~plan~~MCOP but provides emergency services to ~~an~~a plan member, regardless of whether ~~or not~~ that provider has a medicaid provider agreement with ODM. The plan 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. 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 plan at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service

reimbursement rate) in effect for the date of service. If an inpatient admission results, the plan is required to reimburse at this rate only until the member can be transferred to a provider designated by the plan.

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

~~(7)~~(8) The ~~plan~~MCOP must adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The plan may establish arrangements with hospitals whereby the plan 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) The ~~plan~~MCOP 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. These written policies and procedures must be made available to non-contracting providers, including non-contracting providers of emergency services, on request. The plan may not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

(G) The ~~plan~~MCOP must ~~assure that~~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 ~~plan~~MCOP 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, seven days a week. The plan must document ~~that~~ the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The plan 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 plan 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 ~~plan~~MCOP must cover services obtained within or outside the plan's panel that have not been pre-approved in writing by a plan provider or other plan representative.

(b) ~~-~~If the ~~plan~~ MCOP does not respond within one hour of a provider's request for preapproval of further services ~~that were~~ administered to maintain the member's stabilized condition, the plan must cover the services, whether or not they were provided within the plan's panel.

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

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

(ii) The ~~plan~~ MCOP cannot be contacted.

(iii) The ~~plan's~~ MCOP'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 plan 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 ~~plan's~~ MCOP'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 after the member is transferred to another facility;

(c) A plan representative and the treating provider reach an agreement concerning the member's care; or

(d) The member is discharged.

(H) ~~Exclusions, limitations and clarifications.~~MCOP responsibilities for payment of other services.

(1) The ~~plan~~MCOP must permit members to self-refer to Title X services provided by any qualified family planning provider (QFPP). The plan is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the plan 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.

(2) The ~~plan~~MCOP must permit members to self-refer to any women's health specialist within the plan'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 primary care provider (PCP) if that PCP is not a women's health specialist.

(3) The ~~plan~~MCOP must ensure access to covered services provided by all federally qualified health centers (FQHCs) and rural health clinics (RHCs).

(4) Where available, the ~~plan~~MCOP must ensure access to covered services provided by a certified nurse practitioner.

(5) The ~~plan~~MCOP is not responsible for payment of services provided through the medicaid schools program ~~(MSP) providers~~ pursuant to Chapter 5160-35 of the Administrative Code.

(6) The ~~plan~~MCOP 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 healthchek eligible members and ~~assure that services are delivered and monitored as follows:~~ensure healthchek exams:

(a) ~~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.

~~(b) The plan or its contracting provider must notify members of the appropriate healthchek exam intervals as specified in Chapter 5160-14 of the Administrative Code.~~

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

~~(I)~~(7) ~~A plan~~An MCOP is not required to cover services provided to members outside the United States.

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

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5166.02, 5167.02
Rule Amplifies:	5164.02, 5166.02, 5167.02
Prior Effective Dates:	3/1/14