AUTHENTICATED,
OHIO LEGISLATIVE SERVICE
COMMISSION
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Ohio Administrative Code

Rule 5160-26-03 Managed care: covered services.

Effective: July 18, 2022

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

(B) Except as otherwise provided in this rule, a managed care organization (MCO) and the single pharmacy benefit manager (SPBM) must ensure members have access to all medically necessary services, as applicable, covered by Ohio medicaid under the state plan. The MCO and SPBM must ensure:

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

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

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

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

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

(C) The MCO and SPBM may place appropriate limits on a service:

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

(2) For the purposes of utilization control, provided the services can be reasonably expected to achieve their purpose as specified in paragraph (B)(1) of this rule.

(D) Upon implementation of the SPBM will provide pharmacy services in compliance with rule 5160-9-03 of the Administrative Code, including all prescribing and prior authorization requirements, and any grandfathered drug classes as established by the Ohio department of medicaid (ODM) preferred drug list located at https://pharmacy.medicaid.ohio.gov/. The SPBM will not charge co-pays unless directed by ODM. Until implementation of the SPBM, the provisions outlined in this paragraph are applicable to the MCO.

(E) Services covered by an MCO.

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

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

(3) The MCO must ensure emergency services as defined in rule 5160-26-01 of the Administrative Code are provided and covered twenty-four hours a day, seven days a week. At a minimum, such services must be provided and reimbursed in accordance with the following:

(a) The MCO cannot deny payment for treatment obtained when a member had an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code.

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

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

(d) The MCO must cover medicaid-covered services related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the MCO, including but not limited to, the member's primary care provider (PCP) or the MCO's twenty-four-hour toll-free phone number.

(e) The MCO cannot deny payment of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.

(f) The MCO must cover emergency services as defined in rule 5160-26-01 of the Administrative Code when the services are delivered by a non-contracting provider of emergency services and claims for these services cannot be denied regardless of whether the services meet an emergency medical condition as defined in rule 5160-26-01 of the Administrative Code. Such services must be reimbursed by the MCO at the lesser of billed charges or one hundred per cent of the Ohio medicaid program reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program reimbursement rate) in effect for the date of service. If an inpatient admission results, the MCO is required to reimburse at this rate only until the member can be transferred to a provider designated by the MCO. Pursuant to section 5167.10 of the Revised Code, the MCO shall not compensate a hospital for inpatient capital costs in an amount that exceeds the maximum rate established by ODM.

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

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

(i) A member who has had an emergency medical condition may not be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

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(4) The MCO must establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services. Such information must be made available upon request to non-contracting providers, including non-contracting providers of emergency services. The MCO shall not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

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

(a) The MCO must designate a telephone line to receive provider requests for coverage of post-stabilization care services. The line must be available twenty-four hours a day. The MCO must document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The MCO must maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the MCO communicated the decision in writing to the provider.

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

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

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

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

(a) The MCO fails to respond within one hour to a provider request for authorization to provide such

services.

(b) The provider has documented an attempt to contact the MCO to request authorization, but the MCO connot be contacted.

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

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

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

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

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

(iv) The member is discharged.

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

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

(8) MCO members are permitted to self-refer to Title X services provided by any qualified family

planning provider (QFPP). The MCO is responsible for payment of claims for Title X services delivered by QFPPs not contracting with the MCO at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges in effect for the date of service.

(9) The MCO must permit members to self-refer to any women's health specialist within the MCO's network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated PCP if that PCP is not a women's health specialist.

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

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

(12) ODM may approve an MCO's members to be referred to certain MCO non-contracting hospitals, as specified in rule 5160-26-11 of the Administrative Code, for medicaid-covered non-emergency hospital services. When ODM permits such authorization, ODM will notify the MCO and the MCO non-contracting hospital of the terms and conditions, including the duration, of the approval and the MCO must reimburse the MCO non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the MCO non-contracting hospital. ODM will base its determination of when an MCO's members can be referred to MCO non-contracting hospitals pursuant to the following:

(a) The MCO's submission of a written request to ODM for the approval to refer members to a hospital that has declined to contract with the MCO. The request must document the MCO's contracting efforts and why the MCO believes it will be necessary for members to be referred to this hospital; and

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

impacted the hospital's business.

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

(14) The MCO is not responsible for payment of services provided through medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. The MCO must ensure access to medicaid-covered services for members who are unable to timely access services or unwilling to access services through MSP providers.

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

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

(17) The MCO must cover respite services as described in rule 5160-26-03.2 of the Administrative Code.

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

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

(G) The MCO and SPBM must ensure that eligible members receive all early and periodic screening, diagnosis and treatment (EPSDT) services, also known as healthchek services, in accordance with rule 5160-1-14 of the Administrative Code. The MCO will ensure healthchek exams:

(1) Include the components specified in rule 5160-1-14 of the Administrative Code. All components of exams must be documented and included in the medical record of each healthchek eligible member and made available for the ODM annual external quality review.

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