Ohio Administrative Code

Rule 5160-26-05 Managed health care programs: provider panel and subcontracting requirements.

Effective: July 19, 2020

(A) Subcontracts.

(1) A managed care organization (MCO) must provide or arrange for the delivery of covered health care services described in rule 5160-26-03 of the Administrative Code either through the use of employees or through subcontracts with network providers of health care services ("providers"). All subcontracts must be in writing and in accordance with paragraph (D) of this rule and 42 C.F.R. 434.6 and 438.6 (October 1, 2019). The MCO's execution of a subcontract with a provider does not terminate the MCO's legal responsibility to the Ohio department of medicaid (ODM) to ensure all of the MCO's activities and obligations are performed in accordance with Chapter 5160-26 or Chapter 5160-58 of the Administrative Code, as applicable, the MCO provider agreement, and all applicable federal, state, and local regulations.

(2) An MCO shall make all subcontracts with providers available to ODM upon request.

(3) Subcontracts may not include language that conflicts with the specifications identified in paragraphs (C) and (D) of this rule.

(4) When utilizing an out of panel provider, the MCO must establish a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph (D) of this rule. For medicaid-covered non-emergency hospital services outlined in rule 5160-26-03 of the Administrative Code, the compensation amount is identified in rule 5160-26-11 of the Administrative Code.

(B) Notification.

(1) Notwithstanding paragraph (D)(13) of this rule, an MCO must notify ODM of any addition to or deletion from its provider panel on an ongoing basis, and must follow the time restrictions contained in this paragraph unless the explanation of extenuating circumstances is accepted by ODM.

(2) At the direction of ODM, the MCO must submit evidence of the following:

(a) A copy of the provider's current licensure;

(b) Copies of written agreements with the provider, including but not limited to subcontracts, amendments and the medicaid addendum as specified in paragraph (D) of this rule;

(c) Notification to ODM of any hospital subcontract for which a date of termination is specified; and

(d) The provider's medicaid provider number and provider reporting number, if applicable.

(3) The MCO shall notify ODM in writing of the expiration, nonrenewal, or termination of any provider subcontract at least fifty-five calendar days prior to the expiration, nonrenewal or termination of the subcontract in a manner and format directed by ODM. If the MCO receives less than fifty-five calendar days' notice from the provider, the MCO must inform ODM in writing within one working day of becoming aware of this information. The MCO must also comply with the following:

(a) If the subcontract is for a hospital:

(i) Forty-five calendar days prior to the effective date of the expiration, nonrenewal or termination of the hospital's subcontract, the MCO shall notify in writing all providers who have admitting privileges at the hospital of the impending expiration, nonrenewal, or termination of the subcontract and the last date the hospital will provide services to members under the MCO subcontract. If the MCO receives less than forty-five calendar days' notice from the hospital, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the subcontract.

(ii) Forty-five calendar days prior to the effective date of the expiration, nonrenewal, or termination of the hospital's subcontract, the MCO shall notify in writing all members in the service area, or in an area authorized by ODM, of the impending expiration, nonrenewal, or termination of the hospital's subcontract. If the MCO receives less than forty-five calendar days' notice from the

hospital provider, the MCO shall send the notice within one working day of becoming aware of the expiration, nonrenewal, or termination of the subcontract.

(iii) The MCO shall submit a template for member and provider notifications to ODM along with the MCO's notification to ODM of the impending expiration, nonrenewal, or termination of the hospital's subcontract. The notifications shall comply with the following:

(a) The form and content of the member notice must be prior-approved by ODM and contain an ODM designated toll-free telephone number members can call for information and assistance.

(b) The form and content of the provider notice must be prior-approved by ODM.

(iv) ODM may require the MCO to notify additional members or providers if the impending expiration, nonrenewal, or termination of the hospital's subcontract adversely impacts additional members or providers.

(b) If the subcontract is for a primary care provider (PCP):

(i) The MCO shall include the number of members that will be affected by the change in the notice to ODM; and

(ii) The MCO shall notify in writing all members who use or are assigned to the provider as a PCP at least forty-five calendar days prior to the effective date of the change. If the MCO receives less than forty-five calendar days prior notice from the PCP, the MCO shall issue the notification within one working day of the MCO becoming aware of the expiration, nonrenewal, or termination of PCP's subcontract. The form of the notice and its content must be prior-approved by ODM and must contain, at a minimum, all of the following information:

(a) The PCP's name and last date the PCP is available to provide care to the MCO's members;

(b) Information regarding how members can select a different PCP; and

(c) An MCO telephone number members can call for further information or assistance.

(4) ODM may require the MCO to notify members or providers for the expiration, nonrenewal, or termination of certain other provider subcontracts that may adversely impact the MCO's members.

(5) In order to ensure availability of services and qualifications of providers, ODM may require submission of documentation in accordance with paragraph (B) of this rule regardless of whether the MCO subcontracts directly for services or does so through another entity.

(6) In the event that an MCO's medicaid managed care program participation in a service area is terminated, the MCO must provide written notification to its affected subcontracted providers at least forty-five calendar days prior to the termination date, unless otherwise specified by ODM.

(C) Provider qualifications.

(1) The MCO must ensure that none of its employees or subcontracted providers are sanctioned or excluded from providing medicaid or medicare services. At a minimum, monthly, the MCO shall use available resources for identifying sanctioned providers, including, but not limited to, the following:

(a) The federal office of inspector general provider exclusion list;

(b) The ODM excluded provider web page; and

(c) The discipline pages of the applicable state boards that license providers or an alternative data resource, such as the national practitioner databank, that is as complete and accurate as the discipline pages of the applicable state boards.

(2) An MCO may not discriminate with regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. If an MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decision. This paragraph may not be construed to:

(a) Require the MCO to contract with providers beyond the number necessary to meet the needs of its

members;

(b) Preclude the MCO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(c) Preclude the MCO from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

(3) The MCO must have written policies and procedures for the selection and retention of providers that prohibit discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(4) When credentialing or recredentialing providers in connection with policies, contracts and agreements providing basic health care services, the MCO must use the standardized credentialing form and process as prescribed by the Ohio department of insurance under sections 3963.05 and 3963.06 of the Revised Code. Upon ODM's request, the MCO must demonstrate to ODM the record keeping associated with maintaining this documentation.

(D) Subcontracts.

All subcontracts, including single case agreements, must include a medicaid addendum that has been approved by ODM. The medicaid addendum must include the following elements, appropriate to the service being rendered, as specified by ODM:

(1) An agreement by the provider to comply with the applicable provisions for record keeping and auditing in accordance with Chapter 5160-26 of the Administrative Code.

(2) Specification of the medicaid population and service areas, pursuant to the MCO's provider agreement with ODM.

(3) Specification of the health care services to be provided.

(4) Specification that the subcontract is governed by, and construed in accordance with all applicable

laws, regulations, and contractual obligations of the MCO and:

(a) ODM shall notify the MCO and the MCO shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCO;

(b) The subcontract shall be automatically amended to conform to such changes without the necessity for written execution; and

(c) The MCO shall notify the provider of all applicable contractual obligations.

(5) Specification of the beginning date and expiration date of the subcontract, or an automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination.

(6) Specification of the procedures to be employed upon the ending, nonrenewal, or termination of the subcontract, including an agreement by the provider to promptly supply all records necessary for the settlement of outstanding medical claims.

(7) Full disclosure of the method and amount of compensation or other consideration to be received by the provider from the MCO.

(8) An agreement not to discriminate in the delivery of services based on the member's race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, ancestry, health status, or need for health services.

(9) An agreement by the provider to not hold liable ODM or members in the event that the MCO cannot or will not pay for services performed by the provider pursuant to the subcontract with the exception that:

(a) Federally qualified health centers (FQHCs) and rural health clinics (RHCs) may be reimbursed by ODM in the event of MCO insolvency.

(b) The provider may bill the member when the MCO has denied prior authorization or referral for services and the following conditions are met:

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

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

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

(10) An agreement by the provider that with the exception of any member co-payments the MCO has elected to implement in accordance with rule 5160-26-12 of the Administrative Code, the MCO's payment constitutes payment in full for any covered service and the provider will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit nursing facilities or home and community-based services waiver providers from collecting patient liability payments from members as specified in rules 5160:1-6-07 and 5160:1-6-07.1 of the Administrative Code or FQHCs and RHCs from submitting claims for supplemental payments to ODM as specified in Chapter 5160-28 of the Administrative Code. Additionally, the MCO and provider agree to the following:

(a) The MCO shall notify the provider whether the MCO has elected to implement any member co-payments and if, applicable, the circumstances in which member co-payment amounts will be imposed in accordance with rule 5160-26-12 of the Administrative Code; and

(b) The provider agrees that member notifications regarding any applicable co-payment amounts must be carried out in accordance with rule 5160-26-12 of the Administrative Code.

(11) A specification that the provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the subcontract, and that provider and all employees of the provider have not been excluded from participating in federally funded health care programs.

(12) An agreement that MyCare Ohio waiver providers are currently enrolled as ODM providers with an active status in accordance with rule 5160-58-04 of the Administrative Code, and all other

providers are either currently enrolled as ODM providers and meet the qualifications specified in paragraph (C) of this rule, or they are in the process of enrolling as ODM providers;

(13) A stipulation that the MCO will give the provider at least sixty-days' prior notice in writing for the nonrenewal or termination of the subcontract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the subcontract be terminated sooner or when the contract is temporary in accordance with 42 C.F.R. 438.602 (October 1, 2019) and the provider fails to enroll as an ODM provider within one hundred twenty days.

(14) A stipulation that the provider may nonrenew or terminate the subcontract if one of the following occurs:

(a) The provider gives the MCO at least sixty days prior notice in writing for the nonrenewal or termination of the subcontract, or the termination of any services for which the provider is contracted. The effective date for any nonrenewal or termination of the subcontract, or termination of any contracted service must be the last day of the month.

(b) ODM has proposed action to terminate, nonrenew, deny or amend the MCO's provider agreement in accordance with rule 5160-26-10 of the Administrative Code, regardless of whether this action is appealed. The provider's termination or nonrenewal written notice must be received by the MCO within fifteen working days prior to the end of the month in which the provider is proposing termination or nonrenewal. If the notice is not received by this date, the provider must agree to extend the termination or nonrenewal date to the last day of the subsequent month.

(15) The provider's agreement to serve members through the last day the subcontract is in effect.

(16) The provider's agreement to make the medical records for medicaid eligible individuals available for transfer to new providers at no cost to the individual.

(17) A specification that all laboratory testing sites providing services to members must have either a current clinical laboratory improvement amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or certificate of registration along with a CLIA identification number.

(18) A requirement securing cooperation with the MCO's quality assessment and performance improvement (QAPI) program in all its provider subcontracts and employment agreements for physician and nonphysician providers.

(19) An agreement by the provider and MCO that:

(a) The MCO shall disseminate written policies in accordance with the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2020) and section 5162.15 of the Revised Code, regarding the reporting of false claims and whistleblower protections for employees who make such a report, and including the MCO's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(b) The provider agrees to abide by the MCO's written policies related to the requirements of 42 U.S.C. 1396a(a)(68) (as in effect July 1, 2020) and section 5162.15 of the Revised Code, including the MCO's policies and procedures for detecting and preventing fraud, waste, and abuse.

(20) A specification that hospitals and other providers must allow the MCO access to all member medical records for a period of not less than eight-years from the date of service or until any audit initiated within the eight year period is completed and allow access to all record-keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in rule 5160-26-06 of the Administrative Code.

(21) A specification, appearing above the signature(s) on the signature page in all PCP subcontracts, stating the maximum number of MCO members that each PCP can serve at each practice site for that MCO.

(22) A specification that the provider must cooperate with the ODM external quality reviews required by 42 C.F.R. 438.358 (October 1, 2019) and on-site audits as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel and other information.

(23) A specification that the provider must be bound by the same standards of confidentiality that apply to ODM and the state of Ohio as described in rule 5160-1-32 of the Administrative Code,

including standards for unauthorized uses of or disclosures of protected health information (PHI).

(24) A specification that any third party administrator (TPA) must include the elements of paragraph (D) of this rule in its subcontracts and ensure that its subcontracted providers will forward information to ODM as requested.

(25) A specification that home health providers must meet the eligible provider requirements specified in Chapter 5160-12 of the Administrative Code and comply with the requirements for home care dependent adults as specified in section 121.36 of the Revised Code.

(26) A specification that PCPs must participate in the care coordination requirements outlined in rule 5160-26-03.1 of the Administrative Code.

(27) A specification that the provider in providing health care services to members must identify and where necessary arrange, pursuant to the mutually agreed upon policies and procedures between the MCO and provider, for the following at no cost to the member;

(a) Sign language services; and

(b) Oral interpretation and oral translation services.

(28) A specification that the MCO agrees to fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCO's denial of payment of a service, as specified in rules 5160-26-08.4 and 5160-58-08.4 of the Administrative Code, utilizing the procedures and forms as specified in Chapter 5160:6-2 of the Administrative Code.

(29) The provider's agreement to contact the twenty-four-hour post-stabilization services phone line designated by the MCO to request authorization to provide post-stabilization services in accordance with rule 5160-26-03 of the Administrative Code.

(30) A specification that the MCO may not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient

for the following:

(a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the member needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment versus non-treatment; and

(d) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(31) A stipulation that the provider must not identify the addressee as a medicaid recipient on the outside of the envelope when contacting members by mail.

(32) An agreement by the provider that members will not be billed for missed appointments.

(33) An agreement that in the performance of the subcontract or in the hiring of any employees for the performance of services under the subcontract, the provider shall not by reason of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

(34) An agreement by the provider that it shall not in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, gender identity, genetic information, sexual orientation, age, disability, national origin, military status, health status, or ancestry.

(35) Notwithstanding paragraphs (D)(13) and (D)(14) of this rule, in the event of a hospital's proposed nonrenewal or termination of a hospital subcontract, an agreement by the subcontracted hospital to notify in writing all providers who have admitting privileges at the hospital of the impending nonrenewal or termination of the subcontract and the last date the hospital will provide

services to members under the MCO contract. The subcontracted hospital must send this notice to the providers with admitting privileges at least forty-five calendar days prior to the effective date of the nonrenewal or termination of the hospital subcontract. If the contracted hospital issues less than forty-five days prior notice to the MCO, the notice to providers with admitting privileges must be sent within one working day of the subcontracted hospital issuing notice of nonrenewal or termination of the subcontract.

(36) An agreement by the provider to supply, upon request, the business transaction information required under 42 C.F.R. 455.105 (October 1, 2019).

(37) An agreement by the provider to release to the MCO, ODM or ODM designee any information necessary for the MCO to perform any of its obligations under the ODM provider agreement, including but not limited to compliance with reporting and quality assurance requirements.

(38) An agreement by the provider that its applicable facilities and records will be open to inspection by the MCO, ODM or its designee, or other entities as specified in rule 5160-26-06 of the Administrative Code.

(E) In lieu of including a medicaid addendum as required by paragraph (D) of this rule, an MCO may permit a benefit manager that assists in the administration of health care services including pharmaceutical, dental, vision and behavioral health services on behalf of the MCO's members, to include elements in paragraphs (D)(1) to (D)(38) of this rule in subcontracts with entities that provide for the direct provision of health care services to MCO members. The MCO must receive written evidence that the benefit manager complied with this paragraph and has informed the entities of the obligation to provide health care services to the MCO's members.