ODM is removing barriers to care delivery, enhancing individual safety, and easing the burden on hospitals and providers across the health care system.

Working in conjunction with the Medicaid managed care plans (MCPs), the state agency has instituted several emergency provisions in its managed care provider agreements giving medical and behavioral healthcare providers greater flexibility to care for Medicaid beneficiaries during the COVID-19 pandemic. The changes fall under these broad categories:

- Service authorizations (aka prior authorizations)
- Claims payment
- Pharmacy benefits
- Telehealth services

The following answers some of the most common questions received as they relate to Medicaid’s managed care emergency provider agreement amendment. The managed care provider agreements may be found online at: https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans

Service Authorizations Under the Emergency Provider Agreement

**What are prior authorization requirements?**
Prior authorization is the utilization management process by which managed care plans ensure a Medicaid service is medically necessary. A provider must submit a prior authorization request to the MCPs for many services. Under the emergency managed care provider agreement amendment, almost all prior authorization requirements have been lifted.

**Who does this affect?**
Providers: Less time spent on administrative requirements, enabling more time for patient care.
Members: Faster access to treatment with fewer delays in receiving care.

**When does it go into effect?**
ODM instituted an amendment to the provider agreement with MCPs in response to the COVID-19 pandemic. Some requirements (see Appendix S) are effective as of March 9, and others take effect March 27. The changes will remain in effect until plans are directed by ODM in writing to cease the requirements.

**Do these emergency provisions apply to everyone the same?**
This guidance applies to MCPs. For information about waiver services authorized by MyCare Ohio plans, consult the Care Management Emergency Protocol. https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans#1910275-covid-19-info

**What is different?**
MCPs have lifted prior authorization requirements for most medically necessary services during the COVID-19 pandemic, although there will be exceptions. Plans will defer medical necessity determinations to providers, who must use their best clinical judgment in determining medical necessity for services or treatments. Providers must continue to document the services provided.

**Can I continue to request a prior authorization?**
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Providers have three available options:

<table>
<thead>
<tr>
<th>Option</th>
<th>Instructions</th>
<th>MCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue current process</td>
<td>Submit prior authorization requests; include clinical documentation.</td>
<td>Process request. Provide a prior authorization number.</td>
</tr>
<tr>
<td>Request administrative authorization</td>
<td>Request should include name, date of birth or Medicaid ID number, diagnosis, and for inpatient admissions, the date of admission and expected date of discharge.</td>
<td>Quick approvals Reference # provided for provider claims submission to minimize potential errors.</td>
</tr>
<tr>
<td>No authorization required</td>
<td>Provider does not obtain a prior authorization.</td>
<td>Pay claims without the authorization.</td>
</tr>
</tbody>
</table>

Please note that while there are three options available to providers, plans can help with discharge planning if they know of admissions ahead of time.

What services require prior authorization?

Prior authorization is required only for the following services:

- Pain pumps
- Transplants
- Cosmetic procedures
- The use of “miscellaneous” billing codes (e.g. E1399)
- Home health services after two weeks of service provision
- Elective surgical and dental procedures
- Investigational devices and procedures
- A mobility device exceeding $5,600

Prior authorization not required under Ohio’s declared state of emergency

- Private Duty Nursing (PDN) requests and DME: MCPs will pay for up to a 90-day supply of durable medical equipment without prior authorization and will cover requests for additional nursing hours without prior authorization for 90 calendar days.
- Prescriptions may be filled without prior authorization, and daily dose limits will be removed on all covered outpatient drugs under the pharmacy and medical benefit (with only a few exceptions).
- New nursing facility admissions: MCPs will not prior authorize new nursing facility (NF) admissions during this time. However, MCPs will continue to determine level of care prior to admission for NF stays and will continue concurrent reviews of NF stays as appropriate.

NOTE: Medicare primary services continue to require a prior authorization by the MCOP. The NF must notify the MCP/MCOP of all new NF admissions.

Are existing prior authorizations still valid?
All existing prior authorizations are extended for six months from the renewal or expiration date. The MCP shall honor any previously approved prior authorization for a treatment, procedure, or service for up to six months, if the treatment, procedure, or service has been postponed.

Claims Payment

What are the timely filing changes?
MCPs/MCOPs are extending timely filing limits to accept claims from all provider types for up to 365 calendar days from the date of service.

What is the provider payment changes?
If the provider is enrolled with ODM, the MCP/MCOP will pay the provider for services to members at 100% the FFS rate or the providers submitted charge, whichever is less. In addition, ODM will require plans to cover COVID testing at the Medicare rate and without copays.

Pharmacy Benefits Provisions Under the Emergency Provider Agreement

What are the primary changes to pharmacy benefits under the emergency provider agreement amendment?
ODM’s emergency managed care plan provider agreement amendment allows:

- Members to obtain pharmacy benefits (prescriptions, counseling, etc.) from any pharmacy, regardless of in- or out-of-network status
- Prior authorizations to be waived for covered outpatient medications (some restrictions apply)
- Existing prior authorizations to be extended an additional six months from the authorization renewal or expiration date.
- Prescription refill thresholds are temporarily relaxed to ensure adequate access should a member be quarantined, home-bound or unable to acquire prescriptions easily.
- Reimbursement assurance for any pharmacy provider who dispenses an emergency refill of a medication without a prescription
- Pharmacy providers to dispense and receive payment for many over the counter (OTC) medications without a prescription, not to exceed a 30-day supply
- ODM to temporarily waive member co-pays for all medications, regardless of whether the use of the medication is related to COVID-19
- Ninety-day supplies on many maintenance medications

MCP Telehealth Service Expansion

Governor DeWine has implemented two emergency telehealth rules for Medicaid members and beneficiaries in response to the COVID-19 pandemic. In addition to provisions laid out in under ODM’s telehealth rule, Medicaid members and beneficiaries may seek telehealth services from any authorized provider regardless of in-network or out-of-network status.

The Ohio Department of Medicaid (ODM) and the Ohio Department of Mental Health and Addiction Services (OhioMHAS), in partnership with the Governor’s Office, executed emergency

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rules to expand and enhance telehealth options for Ohioans served by Medicaid, and their providers. These rules relax regulations so more people can be served safely in their homes, rather than needing to travel to health care providers’ facilities.

ODM’s emergency rule will be implemented by Medicaid fee-for-service, Medicaid Managed Care Plans (MCPs), and MyCare Ohio Plans (MCOPs).

The provisions expand telehealth access, loosens requirements for patient/provider interactions, broadens the network of providers that can bill Medicaid, the MCPs, and the MCOPs for telehealth services, and greatly expands the list of services that can be billed by these providers using telehealth. Remote care (including telehealth) keeps patients home with in-hospital care reserved for the sickest.

ODM’s emergency rule is retroactively effective to coincide with the date Governor DeWine declared a state of emergency in Ohio: March 9, 2020.

More information is available about ODM’s emergency telehealth rule at: https://medicaid.ohio.gov/Portals/0/For%20Ohioans/Telehealth/ODM-Emergency-Telehealth-Rule.pdf

NOTE: ODM’s emergency provider agreement allows beneficiaries to seek telehealth services through any authorized provider regardless of in-network or out-of-network status with Medicaid MCPs.

Key Contacts

Who should I call if I have questions about these emergency provider provisions?

Contact information for each Medicaid managed care plan is available in the chart below.

<table>
<thead>
<tr>
<th>Aetna</th>
<th>Buckeye</th>
<th>CareSource</th>
<th>Molina</th>
<th>Paramount</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 855-364-0974</td>
<td>Phone 866-246-4359</td>
<td>Phone 800-488-0134</td>
<td>Phone (questions only) 855-322-4079</td>
<td>Phone 419-887-2520 800-891-2520</td>
<td>Phone 800-366-7304</td>
</tr>
<tr>
<td>Fax 855-734-9389</td>
<td>Fax 888-752-0012</td>
<td>Fax 800-961-5160</td>
<td>Online <a href="http://127.0.0.1:8080">Molina Provider Portal</a></td>
<td>Fax 419-887-2028 866-214-2024</td>
<td></td>
</tr>
</tbody>
</table>

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