Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen Corcoran, Director

COVID-19 Managed Care Plan Emergency Provisions

April 9, 2020

Background

In late 2019, the world was alerted to a new and fast spreading virus caused by exposure to a novel coronavirus now commonly referred to as COVID-19. Faced with the potential of a global pandemic, Ohio Governor Mike DeWine took a leading role to prepare the state during this impending health crisis.

On March 9, 2020, Governor DeWine issued Executive Order 2020-01D to declare a state of emergency in Ohio and protect the wellbeing of citizens from the effects of COVID-19. Under his direction, state agencies came together to ensure continuous healthcare and financial assistance for those at risk.

Policy Proposal

In response to the Executive Order 2020-01D, the Ohio Department of Medicaid (ODM), in collaboration with the Medicaid Managed Care Plans (MCPs) and MyCare Ohio Plans (MCOPs)*, has implemented emergency provider agreement changes affecting pharmacy benefits, telehealth services and service authorization requirements. These changes are intended to remove barriers to care, and to safeguard individual health and wellbeing while reducing burdens on hospitals and providers. While Medicaid Fee-for-Service is implementing similar changes, this paper specifically addresses changes made by Managed Care Plans.

ODM's emergency policy changes are designed to achieve three overarching goals:

1. Remove barriers to care to ODM members and recipients during this emergency health crisis
2. Sustain/maintain individual health and wellbeing throughout the community to reduce hospital admissions and undue strain on the state's health care system, and
3. Reduce provider administrative requirements to enable physicians, specialist and support technicians to safely care for patients

Pharmacy Initiatives – Managed Care Plans and MyCare Ohio Providers

To ensure members can receive current, and new prescriptions timely, ODM, through its work with MCPs and MCOPs, has eased several restrictions in their pharmacy benefits. This change will cover both managed care and fee-for-service providers. The emergency provider agreement:

1. Allows members to receive new prescriptions, by-pass prior authorization requirements on covered outpatient drugs - with limited exceptions.
2. Enables members to receive pharmacy benefits regardless of the pharmacy's status as an in-network or out-of-network provider.
3. Relaxes the current medication refill threshold on selected pharmaceuticals – billing documents should include the code to SCC 13 when submitting claims.
4. Authorizes reimbursements to pharmacies to dispense an emergency medication refill without a prescription in accordance with ORC section 4729.281.

* For the MCOPs, the guidance is only applicable services where Medicaid is the primary payer.

5. Will reimburse pharmacies dispensing over the counter (OTC) medications without a prescription, not exceed a 30-day supply. Providers should use clinical judgment on appropriate count and types of OTCs to dispense and should include an NPI number in the prescriber field when submitting a claim for payment.
6. Waives member co-pays temporarily, regardless of whether the use is related to COVID-19.
7. Authorizes 90-day supplies of certain maintenance medications will continue through this time.

For questions regarding this guidance, please contact Medicaid_pharmacy@medicaid.ohio.gov

Timely Filing of Claims

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

Prior Authorizations Relaxed – Managed Care Plans

The MCPs have committed to lifting prior authorization requirements for all but a few medically necessary services. There will be exceptions for a small number of circumstances in which a prior authorization is necessary for safety.

Effective March 27, 2020, ODM managed care plans will defer medical necessity determinations to providers. Providers must use clinical judgment in determining medical necessity for services being provided. There following represent the options providers have at their disposal.

1. **Maintain the Current Course**: Continue to submit prior authorization requests as you do today and include clinical documentation. The plans will process these and provide a prior authorization number. This will help ensure medical necessity and prevent retrospective reviews/takebacks later.
2. **Seek Administrative Authorization**: Request an administrative authorization using the method described in the chart below for each plan. An administrative authorization can be provided quickly and gives notice to the plan that their member is receiving services and gives the provider an authorization number for their claim submission. A minimum number of member identifiers are needed including name, date of birth or Medicaid ID number, diagnosis, and for inpatient admissions the date of admission and expected date of discharge. Having the number on the claim will minimize claims denial errors.
3. **Bypass prior authorization**: No authorization is required. If a provider does not obtain a prior authorization of any kind, the claims will continue to pay without the authorization. However, please keep in mind that plan systems are being quickly updated to allow claims to pay without prior authorization. All plan systems will be updated no later than April 20, 2020, to allow for claims payment without prior authorization. Providers and plans must work together when a claim is inappropriately denied due to systems' changes.

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Administrative Authorization by Plan

Please note, prior authorization will only be required for the following services:

- Pain pumps
- Transplants
- Cosmetic procedures
- The use of miscellaneous 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

In addition to the aforementioned, the following new requests will be allowed without prior authorization:

- Private Duty Nursing (PDN) requests, including requests for additional hours, will be allowed as requested without prior authorization for 90 calendar days and MCPs will pay for up to a 90-day supply of DME without prior authorization.

- Prescriptions will be allowed 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.

Leveraging Managed Care Plans Assistance

The MCPs are committed to helping hospitals, and other facilities, with discharge planning to minimize barriers to care in the community. As plan case managers assess the members, they can wrap additional services, or resources, around the member if comorbidities are identified. Plans will be able to help providers with discharge planning activities to ensure appropriate care and preparation for minimal disruption in services in the outpatient setting. Facilities must notify MCPs and MCOPs of all member admissions for proper preparation. For information about waiver services authorized by MyCare Ohio plans, please read the Care Management Emergency Protocol.

All existing prior authorizations will be 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 when the treatment, procedures, or services has been postponed.

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Aetna	Buckeye	CareSource	Molina	Paramount	UHC
Phone 855-364-0974 **Fax** 855 734 9389 **Waiver Services** 855-364-0974	**Phone** 866-246-4359 **Fax** 1-866-753-7547	**Phone** 800-488-0134 **Fax** 1-888-752-0012	**Phone** (questions only) 855-322-4079 **Fax** 800-961-5160 **Provider Portal**	**Phone** 419-887-2520 800-891-2520 **Fax** 419-887-2028 or 866-214-2024	**Phone** 800-366-7304

MCP/MCOP 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 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 travelling to health care providers' facilities. They loosen requirements for patient-provider interactions, broaden the network of providers that can bill Medicaid, the MCPs, and the MCOPs for telehealth services, and greatly expand the list of services that can be billed. Additionally, ODM's emergency provider agreement allows Medicaid manage care plan beneficiaries to seek telehealth services through any authorized provider, regardless of the provider in/out-of-network status.

ODM's emergency rule will be implemented by Medicaid fee-for-service, Medicaid Managed Care Plans (MCPs), and MyCare Ohio Plans (MCOPs). and is effective as of Governor DeWine's state of emergency declaration issued 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 For a copy of Executive Rule 2020-09D expanding telehealth authority, click here.

ODM, the Managed Care Plans and MyCare Ohio Plans are committed to offering the support Medicaid beneficiaries and their providers need during the COVID-19 pandemic.

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