Ohio Administrative Code

Rule 5160-26-03.1 Managed care: primary care and utilization management.

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) A managed care organization (MCO) must ensure each member has a primary care provider (PCP) who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member's needs.

(1) The MCO must ensure PCPs are in compliance with the following triage requirements:

(a) Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site;

(b) Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site; and

(c) Members with requests for routine care must be seen within six weeks.

(2) PCP care coordination responsibilities include at a minimum the following:

(a) Assisting with coordination of the member's overall care, as appropriate for the member;

(b) Providing services which are medically necessary as described in rule 5160-1-01 of the Administrative Code;

(c) Serving as the ongoing source of primary and preventative care;

(d) Recommending referrals to specialists, as required; and

(e) Triaging members as described in paragraph (B)(1) of this rule.

(C) The MCO and the single pharmacy benfit manager (SPBM) must have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member. The MCO and the SPBM must ensure decisions rendered through the UM program are based on medical necessity.

(1) The UM program must be based on written policies and procedures that include, at a minimum:

(a) The information sources used to make determinations of medical necessity;

(b) The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria;

(c) A specification that written UM criteria will be made available to both contracting and non-contracting providers; and

(d) A description of how the MCO or SPBM will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(2) The MCO and SPBM's UM programs must also ensure and document the following:

(a) An annual review and update of the UM program.

(b) The involvement of a designated senior physician in the UM program.

(c) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions.

(d) The use of board-certified consultants to assist in making medical necessity determinations, as necessary.

(e) That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Administrative Code. The MCO may not impose conditions around the coverage of a medically necessary medicaid-covered service unless they are supported by such clinical practice guidelines.

(f) The reason for each denial of a service, based on sound clinical evidence.

(g) That compensation by the MCO or SPBM to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member.

(h) Compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K (October 1, 2021).

(3) The MCO and the SPBM must process requests for initial and continuing authorizations of services from their providers and members. The MCO and the SPBM must have written policies and procedures to process initial requests and continuing authorizations. Upon request, the MCO and SPBM's policies and procedures for initial and continuing authorizations must be made available for review by the Ohio department of medicaid (ODM). The MCO and SPBM's written policies and procedures for initial and continuing authorizations of services must also be made available to contracting and non-contracting providers upon request. The MCO and SPBM must ensure and document the following occurs when processing requests for initial and continuing authorizations of services:

(a) Consistent application of review criteria for authorization decisions.

(b) Consultation with the requesting provider, when necessary.

(c) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

(d) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an

amount, duration, or scope that is less than requested. The notice to the member must meet the requirements of division 5101:6 and rule 5160-26-08.4 of the Administrative Code.

(e) For standard authorization decisions, the MCO must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than ten calendar days following receipt of the request for service. If requested by the member, provider, or MCO, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCO, the MCO must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCO's extension request, the MCO must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCO must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(f) If a provider indicates or the MCO determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than forty-eight hours after receipt of the request for service. If requested by the member or MCO, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCO, the MCO must submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCO's extension request, the MCO must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCO must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(g) Upon implementation of the SPBM, for prior authorization of covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect January 1, 2022), the SPBM will provide a response to the provider by telephone or other telecommunication device within twenty-four hours of the initial request. Until implementation of the SPBM, all provisions outlined in this paragraph are applicable to the MCO.

(i) If the prior authorization request contains sufficient information to render a final decision, the SPBM must provide notice to the provider of the decision within twenty-four hours of receipt of the initial request.

(ii) If the prior authorization request contains insufficient information to render a final decision, the SPBM must notify the provider of the need for additional information within twenty-four hours of the initial request.

(iii) If the prior authorization request is for an emergency situation, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized while the SPBM reviews the prior authorization request.

(h) The MCO and the SPBM must maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. MCO and SPBM records must include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

(4) Upon implementation of the SPBM, the SPBM may, subject to ODM prior approval, implement strategies for the management of drug utilization, and the MCO may, subject to ODM approval, develop other UM programs.

(5) At a minimum, the MCO has to implement a coordinated services program (CSP) as described in rule 5160-20-01 of the Administrative Code. The MCO has to offer care management services to any member enrolled in CSP