Ohio Administrative Code

Rule 5160-58-03.1 MyCare Ohio plans: primary care and utilization management.

Effective: July 18, 2022

(A) A MyCare Ohio plan (MCOP) will 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 MCOP will ensure PCPs are in compliance with the following triage requirements. Members with:

(a) Emergency care needs will be triaged and treated immediately on presentation at the PCP site;

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

(c) Requests for routine care will 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 (A)(1) of this rule.

(B) The MCOP will 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 MCOP will ensure decisions rendered through the UM program are based on medical necessity.

(1) The UM program, based on written policies and procedures, will 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 MCOP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(2) The MCOP's UM program will 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 MCOP will not impose conditions on 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 MCOP 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 MCOP will process requests for initial and continuing authorizations of services from their providers and members. The MCOP will have written policies and procedures to process initial requests and continuing authorizations. Upon request, the MCOP's policies and procedures for initial and continuing authorizations will be made available for review by the Ohio department of medicaid (ODM). The MCOP's written policies and procedures for initial and continuing authorizations of services will also be made available to contracting and non-contracting providers upon request. The MCOP will 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, will 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 has to meet the requirements of division 5101:6 and rule 5160-26-08.4 of the Administrative Code.

(e) For standard authorization decisions, the MCOP will 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 MCOP,

standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCOP, the MCOP has to submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCOP's extension request, the MCOP will 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 MCOP will 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 MCOP 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 MCOP will 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 MCOP, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCOP, the MCOP has to submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the MCOP's extension request, the MCOP will 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 MCOP will carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(g) For prior authorization of covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect July 1, 2022), the MCOP has to make a decision within the timeframes specified in 42 C.F.R. 423.568(b) (October 1, 2021) for standard decisions and 42 C.F.R. 423.572(a) (October 1, 2021) for expedited decisions. 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 MCOP reviews the prior authorization request.

(h) The MCOP will maintain and submit as directed by ODM, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. The MCOP's records will 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) The MCOP may, subject to ODM approval, develop other UM programs.