5101:3-26-03.1 **Managed health care programs: care coordination.**

(A) MCP care coordination responsibilities.

(1) MCPs must ensure that each member has a PCP who will serve as an ongoing source of primary care and assist with care coordination appropriate to the member's needs.

(2) MCPs must ensure that 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.

(3) At the request of the member, MCPs must provide for a second opinion from a qualified health care professional within the MCP's panel. If such a qualified health care professional is not available within the MCP's panel, the MCP must arrange for the member to obtain a second opinion outside the panel, at no cost to the member.

(4) Care coordination with ODJFS-designated providers.

(a) MCPs are required to share specific information with ODJFS-designated <u>non-panel</u> providers ~~such as ODMH community mental health centers, ODADAS certified medicaid providers, FQHCs/RHCs, and QFPPs~~. Such information includes, but is not limited to, the MCP's contact information, prior authorization procedures, and a list of panel laboratories and pharmacies.

(b) Upon request, MCPs must provide information to ODJFS to document the non-contracting providers identified by the MCP under paragraph (A)(4)(a) of this rule and the information the MCP provided to each provider.

(5) MCPs that require referrals to specialists must ensure that information on referral approvals and denials is made available to ODJFS upon request.

(6) MCPs must provide a centralized toll-free call-in system that is available nationwide twenty-four hours a day, seven days a week.

(a) The call-in system must be staffed by trained medical professionals who will provide members with medical advice and direct members to the appropriate care setting. Such system must also provide information to members and/or providers as necessary to assure access, including, but not limited to, membership status. MCPs may not require members to contact their PCP or any other entity prior to contacting the twenty-four-hour toll-free call-in system for advice or direction concerning emergency and/or after-hours services.

(b) A log for the twenty-four-hour toll-free call-in system must be maintained, and accessible, by the MCP and must include at a minimum:

(i) Identification of the member;

(ii) Date and time of call;

(iii) Member's question, concern, or presenting problem;

(iv) Disposition of call;

(v) PCP or other provider if contacted by MCP; and

(vi) Name and title of person taking the call.

(c) The twenty-four-hour toll-free call-in system must have services available to assist:

(i) Hearing impaired members; and

(ii) LEP members in the primary language of the member.

(7) The MCP 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. MCPs must ensure that decisions rendered through the UM program are based on medical necessity.

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

(i) The specification of the information sources used to make determinations of medical necessity;

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

(iii) A specification that written utilization management criteria will be made available to both contracting and non-contracting providers; and

(iv) A description of how the MCP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(b) The MCP's UM program must also assure and document the following:

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

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

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

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

(v) That UM decisions are consistent with clinical practice guidelines as specified in paragraph (B) of rule 5101:3-26-05.1 of the Administrative Code. MCPs may not impose conditions around the coverage of a medically necessary medicaid-covered service unless they are supported by such clinical practice guidelines.

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

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

(c) MCPs must process requests for initial and continuing authorizations of services from their providers and members. MCPs must have written policies and procedures to process requests and, upon request, the MCP's policies and procedures must be made available for review by ODJFS. The MCP'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 MCPs must assure and document the following occurs when processing requests for initial and continuing authorizations of services:

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

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

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

(iv) 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 rules 5101:6-2-35, 5101:3-26-08.4, and 5101:3-26-08.5 of the Administrative Code.

(v) For standard authorization decisions, the MCP must provide notice to the provider and member as expeditiously as the member's health condition requires but no later than fourteen calendar days following receipt of the request for service, except as specified in paragraph (A)(7)(c)(viii) of this rule. If requested by the member, provider, or MCP, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ODJFS for prior-approval, documentation as to how the extension is in the member's interest. If ODJFS approves the MCP's extension request, the MCP 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 MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(vi) If a provider indicates or the MCP 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 MCP 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 three working days after receipt of the request for service. If requested by the member or MCP, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the MCP, the MCP must submit to ODJFS for prior-approval, documentation as to how the extension is in the member's interest. If ODJFS approves the MCP's extension request, the MCP 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 MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(vii) Service authorization decisions not reached within the timeframes specified in paragraphs (A)(7)(c)(v) and (A)(7)(c)(vi) of this rule constitute a denial, and the MCPs must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code.

(viii) Pursuant to Section 1927(d)(5) of the Social Security Act, prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (January 1, 2007) must be made by telephone or other telecommunication device within twenty-four hours of the initial request. When an emergency situation exists, a seventy-two hour supply of the covered outpatient drug that was prescribed must be authorized. If the MCP is unable to obtain the information needed to make the prior-authorization decision within seventy-two hours, the decision timeframe has expired and the MCP must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code. All other pharmacy prior authorization decisions must be made by no later than the end of the second working day

following receipt of the request, or as expeditiously as the member's condition warrants.

(ix) MCPs must maintain and submit as directed by ODJFS, a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. MCP 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.

(d) MCPs must implement the ODJFS-required emergency department diversion program for frequent users.

(e) Pursuant to section 5111.172 of the Revised Code, MCPs may, subject to ODJFS prior approval, implement strategies for the management of drug utilization. ~~Pharmacy utilization management strategies that will be considered for ODJFS approval may include the development of a preferred drug list, requiring prior authorization for certain drugs, placing limitations on the type of provider and locations where certain medications may be administered, and enrolling members at high risk for fraud and abuse involving controlled substances in a program through which prior authorization may be required for controlled substances and/or the member may be restricted to designated providers for the prescribing and/or filling of controlled substances as defined in section 3719.01 of the Revised Code.~~ At a minimum, MCPs must implement a coordinated services program (CSP) as described in rule 5101:3-20-01 of the Administrative Code. MCPs must provide members with a notice of their right to a state hearing in accordance with ~~rule~~rules 5101:3-26-08.5 and 5101:6-2-40 of the Administrative Code before enrolling or continuing the enrollment of a member ~~them~~ in CSP ~~a controlled substances and member management (CSMM) program~~. If a member requests a state hearing regarding CSP enrollment within the fifteen day prior notice period set forth in rule 5101:6-4-01 of the Administrative Code, an MCP shall enroll the member into CSP no sooner than the hearing decision mail date. If a member requests a timely hearing regarding continued enrollment in CSP, CSP enrollment shall continue until the hearing decision is rendered. MCPs must also provide care management services to any member enrolled in CSP ~~an MCP's CSMM program~~.

(f) MCPs may develop other utilization management programs subject to ODJFS prior approval.

(8) MCPs must provide care management (CM) services to coordinate and monitor treatment rendered to members with specific diagnoses or who require high-cost or extensive services.

(a) MCPs must notify all members of the CM services they may be eligible to receive.

(b) The MCP's CM program must include and document the following, at a minimum:

(i) Identification of members who potentially meet the criteria for care management;

(ii) Assessment of the member's health conditions to determine the need for care management;

(iii) Assignment of the member to a risk stratification level;

(iv) Notification to the member and his or her PCP of the member's enrollment in the MCP's care management program;

(v) Development, implementation, and ongoing monitoring of a care treatment plan for members in care management; and

(vi) Assignment of an accountable point of contact.

(c) MCPs must report care management program-related data to ODJFS, as required.

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

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

(2) Serving as the ongoing source of primary and preventive care;

(3) Recommending referrals to specialists, as required;

(4) Triaging members as described in paragraph (A)(2) of this rule;

(5) Participating in the development of care management care treatment plans; and

(6) Notifying the MCP of members who may benefit from care management.

Effective:

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Certification

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Date

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