5160-26-03.1 **Managed health care programs: primary care and utilization management.**

(A) ~~Managed~~A managed care ~~plans~~ plan ~~(MCPs)~~(MCP) 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) An ~~MCPs~~MCP 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 (A)(1) of this rule.

(B) ~~The~~An 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~~An MCP 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~~, the following~~:

(a) The ~~specification of 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 MCP will monitor the impact of the UM program to detect and correct potential under- and over-utilization.

(2) ~~The~~ An MCP's UM program 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. An ~~MCPs~~MCP 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 MCP to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member.

(3) An ~~MCPs~~MCP must process requests for initial and continuing authorizations of services from their providers and members. An ~~MCPs~~MCP 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 the Ohio department of medicaid (ODM). 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~~MCP 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) ~~That any~~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 ~~rules~~ division 5101:6~~-2-35~~ and rule 5160-26-08.4 of the Administrative Code.

(e) 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~~ten calendar days following receipt of the request for service, except as specified in paragraph (B)(3)(g) 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 ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM 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.

(f) 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~~ forty-eight hours 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 ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM 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.

(g) Service authorization decisions not reached within the timeframes specified in paragraphs (B)(3)(e) and (B)(3)(f) of this rule constitute a denial, and the MCPs must give notice to the member as specified in ~~paragraph (C) of~~ rule 5160-26-08.4 of the Administrative Code.

(h) Prior authorization decisions for covered outpatient drugs as defined in 42 U.S.C. 1396r-8(k)(2) (as in effect January 1, 2017) 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 (C) of~~ rule 5160-26-08.4 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.~~

(i) MCPs must maintain and submit as directed by ODM, 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.

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

(5) Pursuant to section 5167.12 of the Revised Code, ~~MCPs~~ an MCP may, subject to ODM prior approval, implement strategies for the management of drug utilization. At a minimum, ~~MCPs~~an MCP must implement a coordinated services program (CSP) as described in rule 5160-20-01 of the Administrative Code. ~~MCPs must provide members with a notice of their right to a state hearing in accordance with rule 5101:6-2-40 of the Administrative Code before enrolling or continuing the enrollment of a member in CSP. 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~~An MCP must ~~also provide~~ offer care management services to any member enrolled in CSP.

(6) ~~MCPs~~An MCP may develop other ~~utilization management~~UM programs subject to ODM prior approval.

Effective:

Five Year Review (FYR) Dates: 7/1/2022

Certification

Date

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