



Ohio Administrative Code

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

Effective: January 1, 2026

(A) A MyCare Ohio plan (MCOP) ensures each member has a primary care provider (PCP) who serves as an ongoing source of primary care and assists with care coordination appropriate to the member's needs.

(1) The MCOP ensures PCPs are in compliance with the following triage requirements. Members with:

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

(b) Persistent symptoms are 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 seen within thirty business days.

(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, if necessary; and

(e) Triageing members as described in paragraph (A)(1) of this rule.

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

(1) The UM program, based on written policies and procedures, includes, 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 is made available to both contracting and non-contracting providers; and

(d) A description of how the MCOP monitors the impact of the UM program to detect and correct potential under- and over-utilization.

(e) The MCOP cannot implement additional UM criteria for any MyCare Ohio waiver services which were identified and approved through the person-centered service planning process in accordance with rule 5160-44-02 of the Administrative Code.

(2) The MCOP's UM program ensures and documents 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 cannot 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, 2025).

(3) The MCOP processes requests for initial and continuing authorizations of services from their providers and members. The MCOP has written policies and procedures to process initial requests and continuing authorizations. Upon request, the MCOP's policies and procedures for initial and continuing authorizations are 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 are also made available to contracting and non-contracting providers . The MCOP ensures and documents 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, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

(d) That a written notice is 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 5160-58-08.4 of the Administrative Code.



(e) For standard authorization decisions, the MCOP provides notice to the provider and member as expeditiously as the member's health condition requires but no later than seven 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 submits 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 gives 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 carries 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 makes 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 submits 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 carries 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) (January 1, 2026), the MCOP has to make a decision within the timeframes specified in 42 CFR 423.568(b) (October 1, 2025) for standard decisions and 42 CFR 423.572(a) (October 1, 2025) 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 maintains and submits as directed by ODM, a record of all authorization requests,



including standard and expedited authorization requests and any extensions granted. The MCOP's records includes 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) Turnaround times for authorization decisions in paragraph (B)(3) of this rule also apply to organization determinations as described in 42 CFR 422.631 (October 1, 2025) for covered services by the medicare benefit for dual-benefits members enrolled with the MCOP.

(5) The MCOP may, subject to ODM approval, develop other UM programs.