

Provider and Consumer Protections	Commercial Market Requirements	Medicaid Managed Care Requirements
Physician/Plan Partnership Act ORC 1753.14	Standing Referral to Specialists for chronic medical conditions	Appendix G.3.c.v. of the Medicaid Managed Care Plan (MCP) Provider Agreement (PA) - Children with Special Health Care Needs; OAC rule 5101:3-26-03 (H) - direct access requirements for all
ORC 1751.73 - .75	Requires plans to have a physician directed quality assurance program for input into policies, contracts and agreements on basic health care services.	OAC rules 5101:3-26-05.1(B) and 5101:3-26-07.1
ORC 1751.13	Prohibits "Gag Clauses" in contracts	OAC rule 5101:3-26-05(D)(29)
ORC 1753.28	Establishes "Prudent Layperson" standard for ER services	OAC rule 5101:3-26-01(U)
ORC 1753.01 - .04	Creates a uniform credentialing form that must be used and requires plans to notify providers on status 120 days after they apply to be in the network	OAC rule 5101:3-26-05(C)(4)
ORC 1751.77 - .86	Plans to have a written utilization review program; specifies timeframes for Utilization Review determinations	OAC rule 5101:3-26-03.1(A)(7)
ORC 1753.06 - .10	Requires plans to submit certain information to contracting providers including reimbursement information, referrals, and dispute resolution	OAC rule 5101:3-26-05.1
ORC 1753.23 - .24	Requires Internal Appeals opportunity and external appeals for terminal conditions	OAC rules 5101:3-26-08.4 and 5101:3-26-08.5
Patient Protection Act of 1999 ORC 1751.83	Requires an internal appeals process for disputed decisions that must be decided within 7 if life threatening condition or 60 days	OAC rule 5101:3-26-08.4(D)
ORC 1751.84	Creates External Appeals Process by independent nationally recognized individuals for all disputes over medical necessity. Must be decided within 7 for life threatening or 30 days.	Medicaid is exempted from this provision but instead provides members access to the ODJFS State Hearing Process - OAC rule 5101:3-26-08.5
ORC 1751.831	Allows ODI to resolve disputes over claim denials due to contracting issues.	
ORC 1753.13	Females direct access to OB/GYNs without referral	OAC rule 5101:3-26-03(H)(6)
ORC 1751.11	Must provide a toll-free number during business hours for enrollees questions	OAC rules 5101:3-26-08.2(B) and -03.1(A)(6)
Ohio Prompt Pay Law ORC 3901.381 - .382	Health Plan must pay claims that needs no additional information in 30 days of receipt. If need additional information than must pay in 45 days of receipt. Law only applies to claims submitted electronically.	OAC rule 5101:3-26-09((B)(4) and MCP PA Appendix J.4. Applies to both paper and electronic claims. Some definitional differences.
ORC 3901.389	18% interest on claims paid late	MCP PA Appendix N outlines progressive penalties
ORC 3901.388	Payments considered final after one year - cannot take money back after that time	

Comprehensive Managed Care Plan (MCP) Program
Significant Program Changes Since Late 1990s

- **Actuarially-Sound MCP Capitation Rates** – ODJFS is now federally-required to provide certification to the Centers for Medicare and Medicaid Services (CMS) that our MCP capitation rates are actuarially sound. ODJFS currently uses Mercer Government Human Services Consulting, Inc. (Mercer), as our contracted actuary.
- **Prompt Pay Monitoring** – In addition to requiring the MCPs to submit regular reports to the ODJFS on the payment timeframes for the claims they receive, ODJFS also uses our contracting actuary, Mercer, to perform periodic onsite comprehensive reviews of each MCP's prompt payment compliance.
- **Improved MCP Solvency Requirements** – In 2000 Ohio's Risk Based Capital (RBC) for Insurers Act was passed. This law gives the Ohio Department of Insurance (ODI) the tools to ensure that each Ohio health plan (i.e., Health Insuring Corporations or HICs) maintains an amount of capital appropriate to support its overall business operations. The amount of capital and surplus required for each HIC is calculated using a formula that takes into account asset, credit, underwriting and other business risks. The RBC provisions allow ODI to take proactive regulatory steps if a health plan's total capital falls below the appropriate level and ensure that all HICs doing business in the state, including Medicaid MCPs, are in sound financial condition.
- **MCP Procurement Process** – ODJFS has recently modified its process for selecting MCPs in order to take advantage of the significant current interest in the Ohio Medicaid managed care program and to provide hospitals with the broadest possible range of MCPs to choose from. We're working closely with ODI and the Ohio Department of Health in order to better coordinate our various roles in the licensure and contracting processes. ODJFS has also substantially revised the "readiness review" process we utilize in order to determine that a health plan is thoroughly capable of meeting our program requirements before we sign a contract with them.
- **No More Direct Marketing** – MCP staff are now prohibited from direct marketing (i.e., making any unsolicited personal contact with eligible consumers for the purpose of marketing) and from any involvement in the MCP enrollment process. While MCP staff may be present at the County Department of Job and Family Services, health fairs, provider offices, etc., they must receive prior approval to do so and they must wait for eligible consumers to initiate any conversation with them regarding the MCP.

Comprehensive MCP - Significant Program Changes

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- **MCP Enrollment** - ODJFS now contracts with a private company (the ODJFS Selection Services Entity or SSE) which operates a toll-free hotline solely dedicated to providing unbiased and comprehensive information regarding all available MCP options and only the hotline staff can enroll a consumer in an MCP.
- **MCP Assignments** – If a consumer does not choose an MCP on their own, ODJFS no longer uses a “round robin” approach to assign these consumers to an MCP but now has the ability to match these consumers to the MCP that has their current health care providers or, failing that, the MCP with the strongest provider panel.
- **MCP Provider Panel Information** – MCPs are now required to update their provider panel information to ODJFS on at least a bi-monthly basis. ODJFS maintains this information on a database which is used by the SSE to assist consumers in picking the best MCP for their family and in assigning consumers to the most appropriate MCP when they don’t make a selection on their own.
- **MCP Disenrollment** – MCP members can now disenroll from their MCP for any reason during the first three months of their enrollment, in addition to their annual open enrollment month. Members can also request to disenroll for “cause” at any time and new members who are currently in a course of treatment can request a delay in their MCP enrollment to assure that their care is not disrupted until this treatment is concluded.
- **Increased MCP Information for Consumers** – ODJFS has expanded the MCP Consumer Guides that are provided at least annually to eligible consumers to include additional information on provider panels, additional benefits offered by the MCP, consumer satisfaction survey results, how to access services, and member rights. Also, ODJFS now issues two separate notices to consumers who need to select an MCP and the second notice indicates which MCP the consumer will be assigned to if they don’t make a selection on their own.