

## **4123-6-03.2 MCO participation in the HPP MCO application.**

(A) Upon request by a managed care organization, the bureau shall mail a managed care organization an MCO application for certification.

(B) The MCO application for certification shall include a list of bureau certified providers.

(C) A provider identified by an MCO for inclusion in its panel of providers that is not a bureau certified provider may be assisted by the MCO in applying for bureau provider credentialing and certification.

(D) An MCO shall demonstrate arrangements and reimbursement agreements with a substantial number of medical, professional and pharmacy providers currently being used by injured employees.

(E) The MCO application for certification shall include, at a minimum, the following provisions, as more fully detailed within the MCO application for certification itself:

(1) A statement that the application is without misrepresentation, misstatement, or omission of a relevant fact or other acts involving dishonesty, fraud, or deceit. The managed care organization shall provide to the bureau any additional documentation requested and shall permit the bureau, upon reasonable notice, to conduct a review of the managed care organization.

(2) A description of the geographic area of the State of Ohio for which the managed care organization wishes to be certified by the bureau. The minimum geographic area shall be a county. The bureau shall certify MCO participation on a county basis, subject to the provisions in rule 4123-6-03.3 of the Administrative Code. The managed care organization may apply for coverage in more than one county or statewide.

(3) A description of the managed care organization that includes, but is not limited to a profile that includes a disclosure statement regarding the managed care organization's organizational structure, including subsidiary, parent and affiliate relationships. Historical and current data shall be provided. The managed care organization must identify its principals; provide the managed care organization's date of incorporation or formation of partnership or limited liability company, if applicable; provide any fictitious names the managed care organization is, or has been, doing business under; provide the number of years the managed care organization has operated in Ohio; provide a table of organization with the number of employees; identify other states in which the managed care organization is doing business or has done business in the last five years, and identify any banking relationships, including all account information with any financial institutions doing business in Ohio.

- (4) An explanation of how the managed care organization will provide timely, geographically convenient access to medical care.
- (5) A description of the managed care organization's treatment guidelines, including a description of the rationale underlying the development of the treatment guidelines.
- (6) A description of the managed care organization's utilization review process.
- (7) A description of the managed care organization's quality assurance/improvement standards program and process, including the use of satisfaction surveys.
- (8) A description of the managed care organization's medical dispute resolution process that meets the requirements of rule 4123-6-16 of the Administrative Code.
- (9) A description of the managed care organization's non-medical service grievance process.
- (10) A description of the managed care organization's information system capabilities and capacities.
- (11) A description of the managed care organization's medical case management policies and procedures.
- (12) A description of the managed care organization's policies and procedures regarding the confidentiality and protection of records.
- (13) A description of the managed care organization's policies and procedures regarding retention of information.
- (14) A description of the managed care organization's provider relations and education program.
- (15) A description of the managed care organization's employer and employee relations and education program; including but not limited to a description of methodologies to be used to explain options available to injured workers, including treatment by non-network providers and the dispute resolution process.
- (16) A description of the managed care organization's system for reporting the necessary data elements required for bureau calculation of performance measurements.
- (17) Other descriptions and requirements as contained in divisions (C)(1) to (C)(10) of section 4121.44 of the Revised Code.

(18) A description, with at least galley proofs or the equivalent, of the managed care organization's marketing materials to be used in marketing to employers.

(19) Proof of current public liability insurance, the adequacy of which shall be determined by the bureau.

(F) The MCO's application shall include the following, both where the MCO elects to retain a provider panel and where the MCO does not retain a provider panel but enters into arrangements with providers:

(1) A description of the structure of the health care provider panel or arrangements with providers to be offered by the managed care organization. The provider panel or arrangements with providers shall cover the geographic area in which the managed care organization determines it shall compete, and may include out-of-state providers.

(2) An explanation of how the managed care organization's provider panel or arrangements with providers shall provide a full range of medical services and supplies for injured workers and provide access for specialized services.

(3) A description of the process and methodology of credentialing of providers in the managed care organization's panel.

(4) A description of the managed care organization's payment process and methodology to providers in the managed care organization's provider panel or to providers with which the managed care organization has provider arrangements.

(5) A description of the managed care organization's policies and procedures for sanctioning and terminating providers in the managed care organization's panel; and a description of the managed care organization's methodology to notify the bureau, employers and employees of any changes in the provider panel or arrangements with providers.

(6) A description of the managed care organization's methodology for distributing provider panel directories or directories of arrangements with providers and updated provider panel directories or directories of arrangements with providers to employers and/or employees.

(G) The bureau shall review the application for certification submitted by the managed care organization. The bureau reserves the right to cross-check data with other governmental agencies or licensing or accrediting bodies.

(H) The bureau shall hold as confidential and proprietary the managed care organization's descriptions of process, methodology, policies, procedures and systems as required for the application for certification.

(I) The bureau shall not accept or approve any applications in which the managed care

organization proposes to subcontract or outsource any of the following functions: first report of injury (FROI) intake, medical case management, or bill processing and payment. However, this paragraph does not prohibit the bureau from accepting or approving applications for recertification of managed care organizations who subcontract or outsource one or more of these functions if the managed care organization subcontracted or outsourced the function or functions immediately prior to the effective date of this paragraph.

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Prior Effective Dates: 2/16/96, 1/1/99, 1/1/01